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

APPEAL NO. 06F-04682

PETITIONER,

Vs.

AGENCY FOR PERSONS
WITH DISABILITIES (APD)
DISTRICT: 07 Seminole

RESPONDENT.

_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer in Orlando, Florida, on August 21, 2006 at 1:24 p.m. The petitioner was present and was represented by Roger Zhuang, clinical director and board certified behavior analyst with [redacted] Group Homes. Also present to testify on her behalf were: Valoria Boydon, LPN with the group home; Renee Goehring, board certified associate behavior analyst with [redacted] Group Homes; Lushell Anderson, home manager, coordinator of consumer services with [redacted] Group Homes; and Janice Smith waiver support coordinator. The respondent was represented by attorney Diana Esposito, with testimony available from Leslie Varhol, human service analyst. Also present by telephone on behalf of APD were Chun Hee Youn, RN consultant reviewer with MAXIMUS and Emma Guilarte, EdD, MAXIMUS consultant reviewer. Notary public, by telephone, was Cheryl Starkgraf.

ISSUE

At issue was whether or not APD action was correct to reduce hours of residential LPN nursing services, reduce residential nursing service at the RN level, and reduce hours of residential habilitation service at the behavior focus level. Burden of proof was on the respondent.

FINDINGS OF FACT

The petitioner is a young adult (date of birth [redacted] with developmental and medical challenges including episodes of aggressive behavior and insulin-treated brittle diabetes, who is undisputedly eligible for service under the APD Developmental Services Home and Community-Based (HCBS) Medicaid Waiver. She lives in the community with several other disabled young women, at a supervised group home, administered by [redacted] Group Homes.

As an APD-HCBS recipient, support plans are required and completed for the petitioner. The support plan was updated by the waiver support coordinator effective June 1, 2006, with anticipation that recent past levels of support (Respondent's Exhibit 3) would remain in place for the upcoming cost plan period of June 1, 2006 to May 31, 2007. The June 1, 2005 to May 31, 2006 residential habilitation request was authorized at 15 hours daily, rather than the previously requested 18 hours. Those 18 hours had previously been authorized between March 1, 2005 and May 31, 2005, due to transitioning from "incarceration to a group home situation..." During prior authorizations, PSA review statements "recommended that during this time, staff be trained to recognize signs and symptoms of health and behavioral issues and how to report and document such incidences for proper analysis and action." March 2005

review also declared "Alternate placement may be needed if the level of supports continue at the current intensive level."

Prior Service Authorization (PSA) review #39953 for period June 1, 2006 to May 31, 2007, was conducted by the APD contracting agency MAXIMUS using materials in Respondent's Exhibit 2. During the June 2006 cost plan review and August 2006 reconsideration review by MAXIMUS staff, APD determined that, in addition to approved services, three significant reductions were intended (Respondent's Exhibit 1). The approved services were: behavior analysis, behavior assistant services, adult day training, support coordination, one way transportation, medication review and dental services. The approvals along with reductions or denials were set forth in notice of June 27, 2006, with reductions now under challenge.

Residential habilitation behavior focus level request effective June 1, 2006 was for continuation of 15 hours daily. APD approval occurred at 175 days for 13 hours daily, with a plan for further reduction to 12 hours daily in the next 175 day period. Additionally, residential nursing services at LPN level were requested for 12 hours per day, and APD approved at four hours per day. Residential nursing services at RN level were requested for four hours per week and APD approved at three hours per year. Relevant excerpts of the #39953 review results show the following:

> RESIDENTIAL NURSING SERVICES – LPN...requires 12 hours per day of nursing service to provide monitoring of blood glucose level four times a day at 8:00 AM, 12:00 PM, and 4:00 PM as needed. ... hourly schedule submitted indicates that direct care staff already has been trained to assist ... The identified tasks do not require one-on-one nursing services for 12 hours a day. ...
> RESIDENTIAL NURSING SERVICES – RN...The nursing care management plan submitted includes insulin injection, assessment of self-care with noncompliance, training... The information provided does not

> identify any tasks that cannot be provided by a Licensed Practical Nurse or trained direct care staff. ...
> RESIDENTIAL HABILITATION – BEHAVIOR FOCUS...This level (15 hours daily) of support was previously approved ... transitioned from incarceration to a group home situation. ... incidences of target behaviors is low and that she has been stable in her medical needs. ... Efforts have been successful in the reduction of the intensity of services and the information warrants that this effort be ongoing. ... If the level of supports needed continue at the current level, it is recommended that Ms. H...be considered for Residential Habilitation – Intensive Behavior supports.

The preceding information was extracted from the initial June 21, 2006 review of PSA #39953. An additional and independent reconsideration by another reviewer and physician occurred on August 2, 2006 and results were essentially the same. Both reviews along with the notice under challenge were included in Respondent's Exhibit 1, with relevant procedural guidelines included in Respondent's Exhibit 4.

According to the most recent support plan completed by the waiver support coordinator and included in Respondent's Exhibit 2, for review by APD, the petitioner:

> ...would like to experience living on her own one day...is ambulatory, verbal and hearing. She is able to complete her own hygiene without any staff assistance, but often needs verbal prompting to complete her hygiene routine... will often refuse medical treatment, which places her in a medical crisis, exhibits physical aggression, elopement and inappropriate verbalizations. ... has shown some improvement but intensive behavior services are still needed. Her elopement behavior had only one incident during the reporting year. ... blood sugars still "bottoms out" occasionally, but she has been trained how to recognize the symptoms...

The Behavior Assessment and Annual Progress Report dated February 27, 2006 informed the petitioner had been diagnosed with "mild mental retardation...insulin dependent diabetic...has been in many unsuccessful and restrictive placements...behavior history includes highly dangerous physical aggression injuring

staff and peers...repeatedly refused medical treatment." The narrative described her placement at the facility since December 1, 2004, following a four month incarceration due to injuring two caretakers at the state hospital. It informed she is "making progress on current training programs," with "increase in skill acquisition performance" and with target behavior remaining at high intensity while low in frequency. Total episodes of medication refusal between June 2005 and January 2006 were approximately 38.

The training schedule dated January 24, 2006 showed the petitioner was receiving 103.5 direct care hours weekly. As an example, 3.5 hours a day Monday through Friday was received from 6 – 9:30 in the morning, for hygiene, dressing, blood sugar check (nurse), meal preparation and eating. Also, 40 hours weekly was shown from 2-10 p.m. Monday through Friday, and 32 hours on weekends from 6:00 a.m. till 10:00 p.m. Additionally, the document reflected diabetes care from 8:00 to 8:30, other medication from 9:00 to 9:30, blood sugar attention from 2:00 to 2:15, and again from 4:00 to 4:30 as well as 8:00 to 8:15. That narrative reflected need for one-to-one staffing at the facility and direct supervision and prompting for "all aspects of her daily routine and daily management of her medical needs." On February 9, 2006, Dr. Malik prescribed 12 hour daily nursing service, included in Respondent's Exhibit 2. The March 9, 2006 description of concerns in Respondent's Exhibit 2 reflected the petitioner continued noncompliance with diet, exercise and medication plans. The March 9, 2006 summary declared she "continues to require licensed nursing care to educate, monitor & provide assistance to her to maintain a healthy lifestyle w/ minimum complications of her IDDM. ... no seizure activity on EEG."

April 17, 2006 memo from the clinical director confirmed a plan of fading, and noted the petitioner "has been making steady progress." The memo addressed areas of residential habilitation, behavior analysis and behavior assistance. It described the "first 6 months of 2005" as "major improvement" with beneficial response to the program.

CONCLUSIONS OF LAW

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

> (5) Service Limitations – General. The following general limitations and restrictions apply to all home and community-based services waiver programs:
>
> (a) Covered services are available to eligible waiver program participants only if the services are part of a waiver plan of care ("care plan", "individual support plan", or "family support plan"). Care plan requirements are outlined in subsections (6) and (8) of this rule.
>
> (b) The agency or its designee shall approve plans of care based on budgetary restrictions, the recipient's necessity for the services, and appropriateness of the service in relation to the recipient, prior to their implementation for any waiver recipient.
>
> (6) Program Requirements – General. All HCB services waiver providers and their billing agents must comply with the provisions of the Florida Medicaid Provider Reimbursement Handbook, Non-Institutional 081, October 2003, which is incorporated by reference and available from the Medicaid fiscal agent. The following requirements are applicable to all HCB services waiver programs:
>
> (f) The plan of care will identify the type of services to be provided, the amount, frequency, and duration of each service, and the type provider to furnish each service.
>
> (12) Developmental Services Waiver – General. This rule applies to all Developmental Services Waiver Services providers enrolled in the Medicaid program. All Developmental Services Waiver Services providers enrolled in the Medicaid program must comply with the Developmental Services Waiver Services Florida Medicaid Coverage and Limitations Handbook, October 2003, incorporated by reference, and the Florida Medicaid Provider Reimbursement Handbook, Non-Institutional 081, October 2003. Both handbooks are available from the Medicaid fiscal

agent. The Developmental Disabilities Waiver Services Provider Rate Table, November 2003, is incorporated by reference. The Developmental Disabilities Waiver Services Provider Rate Table is available from the Medicaid fiscal agent.

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.

(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** (emphasis added).

In accord with the rules, Florida Medicaid **Developmental Disabilities Waiver Services Coverage and Limitations Handbook** October 2003, revised June 23, 2005, Chapter 2, **Covered Services, Limitations, and Exclusions** establishes the following standards:

Residential Habilitation Services

Description
Residential habilitation provides supervision and specific training activities that assist the recipient to acquire, maintain or improve skills related to activities of daily living. The service focuses on personal hygiene skills related to activities of daily living. The service focuses on personal hygiene skills such as bathing and oral hygiene; homemaking skills such as food preparation, vacuuming and laundry; and on social and adaptive skills that enable the recipient to reside in the community. This training is provided in accordance with a formal implementation plan, developed with direction from the recipient and reflects the recipient's goals(s) from their current support plan.
Recipients with challenging behavioral disorders may require more intense levels of residential habilitation services described as behavioral residential habilitation, or intensive behavioral residential habilitation. The necessity for these services is determined by specific recipient behavioral characteristics that impact the immediate safety, health, progress and quality of life for the recipient, and the determination that less intensive services have not been sufficient to alter these behaviors. The need for more intense levels of residential habilitation, behavioral residential or intensive behavioral residential habilitation will be verified by the Developmental Disabilities Program Office.
Note: Refer to special considerations under behavioral analysis and behavioral assistant services for additional requirements. ...
Limitations
Children or adults whose primary problem is behavioral in nature, should receive services through the behavior assistant services. ...
Special Consideration ...
Residential Habilitation with a Behavioral Focus ...
The service provides for comprehensive monitoring of staff skills and their implementation of required procedures...
Provides for the eventual transitioning of behavioral improvement of the recipient, to a less intense service alternative, through formalized procedures incorporated into implementation plans. ...
The provider must document evidence of continued need as well as evidence that the services are assisting the service provider in meeting the needs of the recipient so that transition to less restrictive services may be possible.

The same handbook addresses standards for nursing services, informing:

Skilled Nursing
Description
Skilled nursing is a service prescribed by a physician and consists of part-time or intermittent nursing care provided by registered or licensed practical nurses, within the scope of Florida's Nurse Practice Act.

> **Limitations**
> This service supplements nursing services available through the Medicaid State Plan. ...
> Nursing services not available to recipients under the Medicaid State Plan, or which are insufficient in quantity to meet their needs, may be paid for by the DD Waiver, if the appropriate, qualified professional determines, on behalf of the Department, that the standards for medical necessity set forth in Chapter 59G-1.010(166)(a), F.A.C., are met. The DD Waiver may pay only for those medically necessary services not covered by the Medicaid State Plan. ...

Detailed review of the materials submitted by both the petitioner and respondent has occurred, along with careful consideration of the arguments offered. Ample evidence confirmed the petitioner has made significant positive strides under the care she has received from the placement facility since her admission at the end of 2004. Episodes of aggression and noncompliance have been reduced and instruction with supervision has achieved improvement in many areas of concern. The facility is one which has caregivers present at all times. If a caregiver notes a problem, assistance could be requested. During the APD MAXIMUS review services of behavior analysis, behavior assistance and adult day training were authorized at the levels requested.

Based upon the evidence, it cannot be concluded that continuation of residential habilitation behavior focus at fifteen hours per day is warranted. If that level were to continue such would be excessive, and duplication or overlapping of other services would occur. Reduction to thirteen hours, followed by reduction to twelve hours should suffice, given the other services in place, and placement at this type of supervised living group home. If the APD reduction plan is implemented and is unsuccessful, another review could be requested, or another placement might be requested.

Regarding nursing hours, despite the prescription and without a more thorough justification of need, evidence simply has not demonstrated need for twelve hours daily at LPN level, nor has evidence shown need for RN service at four hours daily. Moreover, the administrative rule directs that the prescription, in and of itself, does not fulfill the criteria for establishing need. The prescription is not necessarily controlling to the APD authorization standard. The petitioner clearly has unfortunate health problems, but not to a level which would justify the requested nursing levels. There are four or five periods of checking, monitoring and medication administration and it should be possible to achieve adequate nursing care with four hours a day of intermittent nursing service at the LPN level. There were no recent seizures and no seizure activity shown on EEG. Additional annual attention of three hours by a registered nurse should also suffice. Evidence has adequately demonstrated that the nursing levels and hours as authorized by APD should meet the documented needs of the petitioner. The APD review was well reasoned and was founded upon appropriate consideration of the information presented.

It is recognized this situation poses many challenges for facility staff and fading of hours has been ongoing. However, the APD review has been carefully scrutinized, along with all information introduced at the hearing, and it is concluded the evidence simply does not justify continuation of services at the previous levels. APD determinations of reduction were justified as issued.

DECISION

The appeal is denied and the agency action is upheld.

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 10th day of October, 2006, in Tallahassee, Florida.

J W Alper
Hearing Officer
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850-488-1429

Copies Furnished To:

M. Catherine Lannon, Sr. Assistant Attorney General
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STATE OF FLORIDA
DEPARTMENT OF CHILDREN AND FAMILIES
OFFICE OF APPEAL HEARINGS

PETITIONER,

APPEAL NO. 06F-04538

Vs.

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

CASE NO.

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned-hearing officer on September 5, 2006, at 1:40 p.m., in Orlando, Florida. The petitioner did not appear. Laura Mohesky, petitioner's waiver support coordinator and authorized representative, appeared for the petitioner. [redacted], registered nurse and owner of petitioner's resident group home, appeared as witness for the petitioner. Diana Esposito, assistant attorney general, appeared and represented the agency. Yolanda Rivera, government operations consultant I, appeared as a witness. Gary Reavis, registered nurse and consultant reviewer with Maximus, appeared via telephone as a witness for the agency.

ISSUE

At issue is the agency's action of June 23, 2006, denying the petitioner's request for an increase in residential habilitation hours from eight hours per day to nine hours per day due to lack of medical necessity. The petitioner bears the burden of proof in this appeal.

FINDINGS OF FACT

The petitioner is a consumer currently receiving services through the agency's Home and Community-Based Services Waiver Program. He is fifty-eight years old. His diagnoses include: mental retardation, dementia, diabetes, osteoporosis, hypertension, and hyponutrimia. He resides in a group home. His current plan of care includes private duty nursing, residential habilitation, consumable medical supplies, medication review, non-residential support services, and support coordination (Respondent's Composite Exhibit 1).

The petitioner entered his current group home in 2004. Since residing there, he has made marked improvement in his residential habilitation goals. He has been receiving eight hours of residential habilitation services per day. The group home staff has actually been providing him with nine or ten hours per day due to his fragile medical conditions including the newly diagnosed condition of hyponutrimia (the body's inability to maintain a sufficient sodium level).

The petitioner's waiver support coordinator had been previously told that the agency would not grant approval for a consumer to receive more than eight hours of residential habilitation. As a result, even though the petitioner has been receiving in excess of eight hours per day, she thought the request would be

denied automatically. Because of the petitioner's constant need for care and increasing medical complexities, she was prompted to go ahead and request for an increase in services from eight hours per day to nine hours per day. She submitted all necessary documentation for the request to the agency (Respondent's Composite Exhibit 2). The agency, in turn, forwarded this documentation to its contracted agent, Maximus, which reviews services for approval or denial.

Maximus assigned the request to one of its consultant reviewers, in this case, a registered nurse (RN). Upon examining the documentation, the reviewer decided that because the petitioner's needs appeared to be met and because he was progressing in his residential habilitation goals, a one hour increase was not medically necessary. The request was thus denied (Respondent's Composite Exhibit 2). The agency issued notice of the decision on June 23, 2006 (Respondent's Composite Exhibit 1).

At the hearing, the petitioner's representative stated that even though the petitioner has made significant progress in his therapeutic goals, his medical condition has become more fragile. This results in the need for twenty-four hour care and supervision of the petitioner's status and needs. He could slip into a hypoglycemic state at any time and is not able to communicate this to anyone because he doesn't understand what is happening to him. Also, the petitioner has acquired a new condition, hyponutrimia, which adds to the need for constant monitoring. The petitioner is totally dependent on direct-care staff for all of his daily living needs except eating and some ambulation. Thus, he needs total

assistance with bathing, grooming, hygiene, dressing, and toileting. The group home has been giving the petitioner nine to ten hours of day in residential habilitation services but is only being paid for eight.

The agency's witness, the reviewer of the request, stated that the information presented did not justify the increase. Group homes are mandated by law to provide twenty four hour supervision of residents. The petitioner shows progress in his care plan goals thereby resulting in failing to show that medical necessity has been demonstrated for one more hour of residential habilitation.

CONCLUSIONS OF LAW

Fla. Admin. Code 59G-13.080 establishes:

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

The petitioner meets the criteria to be served under the waiver and resides in a home-like setting.

Developmental Disabilities Waiver Services Coverage and Limitations Handbook, June 23, 2005, p. 2-66 states in relevant part:

> Residential Habilitation Services...Description...Residential habilitation provides supervision and specific training activities that assist the recipient to acquire, maintain, or improve skills related to

> activities of daily living. The service focuses on personal hygiene skills such as bathing and oral hygiene; homemaking skills such as food preparation, vacuuming and laundry; and on social and adaptive skills that enable the recipient to reside in the community...Recipients with challenging behavioral disorders may require more intense levels of residential habilitation. The necessity for these services is determined by specific recipient behavioral characteristics that impact the immediate safety, health, progress and quality of life for the recipient, and the determination that less intensive services have not been sufficient to alter these behaviors...

Medical Services that are covered under Medicaid are defined as being "medically necessary" and are set forth in Fla. Admin. Code 59G-1.010(166)(a)(c), as follows:

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

The petitioner's conditions make him medically fragile. He currently receives a combination of services to meet his needs including residential habilitation and non-residential support services (NRSS). Non-residential support services are activities conducted and held outside the home. Because of his health, on some days the petitioner is unable to attend NRSS and instead requires care in the home. His hours of residential habilitation and nursing must take effect on these days to ensure that he is supervised and cared for.

The facility is currently providing 9-10 hours of residential habilitation per day because anything less will not adequately meet the petitioner's medical needs. The petitioner's most recent diagnosis of hyponutrimia makes medical monitoring and supervision of the petitioner even more critical. The agency did not take this most recent diagnosis into its consideration of the request for increase in services. However, the hearing officer has the authority to take this evidence under advisement in rendering a decision.

Based on the evidence and testimony presented, including the new medical evidence, the hearing officer concludes that the petitioner has shown justification that medical necessity does support the level of service requested.

DECISION

The appeal is granted. The agency is ordered to approve a service increase in hours of residential habilitation from eight hours per day to nine hours per day.

NOTICE OF RIGHT TO APPEAL

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

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

DONE and ORDERED this 25th day of October 2006,

in Tallahassee, Florida.

Jeannette Estes

Jeannette Estes
Hearing Officer
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STATE OF FLORIDA
DEPARTMENT OF CHILDREN AND FAMILIES
OFFICE OF APPEAL HEARINGS

PETITIONER,

Vs.

APPEAL NO. 06F-03701

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

RESPONDENT.

_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned-hearing officer on September 7, 2006, at 2:20 p.m., in Gainesville, Florida. The petitioner was present. Present representing the petitioner was Darlene Strimple, waiver support coordinator. Present as witnesses for the petitioner were Janet Torres-Martinez, residential director, Alachua ARC, Sheila Bacon, group home manager, Alachua ARC and Claudia Dozier, clinical director, Alachua ARC. The respondent was represented by Lucy Goddard-Teel, District 3 legal counsel. Present testifying by telephone on behalf of the respondent was Dr. Emma Guilarte of Maximus.

Hearings were scheduled for July 24, 2006, August 14, 2006 and August 18, 2006, however, continuances were granted as stipulated by both parties.

ISSUE

The petitioner is appealing the respondent's action to change his adult day training level of supervision through the Developmental Disabilities Home and

Community-Based Services Waiver Program from one to five to a level of supervision of one to six-ten. The petitioner is also appealing the respondent's action to terminate his behavior analysis services.

FINDINGS OF FACT

The petitioner is a resident of Alachua County, Florida and was eligible to receive benefits through the Developmental Disabilities Home and Community-Based Services Waiver Program. The petitioner is 50 years old and is developmentally disabled. The petitioner lives at in a group home and attends adult day training at the Alachua ARC.

The respondent's Developmental Disabilities Program has contracted with MAXIMUS to perform Prior Service Authorization (PSA) reviews on certain requested services or when costs of a support plan exceed certain levels.

The petitioner through his waiver support coordinator submitted a support plan, which was to be effective May 1, 2006. In the support plan, the waiver support coordinator requested 5,760 quarter hours of adult day training at a one staff to five recipients ratio to provide a meaningful day activity and to manage problem behavior. To determine the medical necessity for the request for the one staff to five recipient level of supervision, Maximus requested that the petitioner, through his support coordinator, provide a behavior analysis services plan that would be implemented in the adult day training, a plan for fading services and an annual report. Maximus received an annual report and a behavior analysis services plan that was undated and contained references to data from 2004. Maximus also received an undated update to the behavior analysis services plan, however, it did not contain plans for fading the adult day training service ratio. Maximus also requested data related to the adult day training

for the past 12 months and the effect it had on the petitioner. However, no data was received. Maximus provided the petitioner with a notice listing the information that was missing. However, they received a duplicate of the information that was previously submitted. Maximus determined that the adult day training of one to five level of supervision was not justified based on the information that was provided. Therefore, the adult day training level of supervision was reduced to one to six-ten.

The petitioner through his waiver support coordinator requested 20 hours of behavior analysis services which was a continuation of the service that he was receiving. To determine the medical necessity for the request for the behavior analysis service, Maximus requested that the petitioner, through his support coordinator, provide a behavior analysis services plan including a plan for fading services with a reviewed or revised date of no more than 12 months prior to the date of request, data displays for services covering the preceding 12 months, including a summary of the data and phase lines and an explanation and analysis of effects of variables on behavior and projected course of treatment. A notice listing and requesting the missing information was issued to the petitioner. In response to the notice, Maximus received an undated behavior analysis services plan containing references to data from 2004, along with an undated update to the behavior plan. Based on the information received from the petitioner, Maximus could not determine the medical necessity of the behavior analysis services. Therefore, the behavior analysis service was terminated.

CONCLUSIONS OF LAW

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

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

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

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

medical care, be effectively furnished more economically on an outpatient basis or in an inpatient facility of a different type.
(c) The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services does not, in itself, make such care, goods or services medically necessary or a medical necessity or a covered service.

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

Adult Day Training Services and ADT Off-Site Services, will be billed based on the published stepped rate for the services at the 1 staff to 10 recipient ratio rate level. Exceptions to this rate level shall be made only when it has been determined through use of the Department approved assessment and the support planning process that a recipient requires a different support staffing ratio. The rate and staffing ratio shall be identified in the individual's support plan and cost plan, and on the authorization for service submitted to the provider by the recipient's support coordinator. The rate ratio is determined by what is the usual and customary service delivery pattern and does not fluctuate with incidental absences of one or more recipients included in the rate ratio.

Personal care assistance services shall be billed at the standard rate level for the service based on the published rate system. The standard rate is paid when a recipient requires minimal assistance, through instructional prompts, cues, and supervision to properly complete the basic personal care areas of eating, bathing, toileting, grooming and personal hygiene. A rate other than the standard rate level for this service shall only be authorized when it has been determined through use of the Department approved assessment and the support planning process that an individual requires an enhanced level of supports.

Indicators of a one staff to five recipient staffing rate ratio level include:

Recipients who have a moderate level of support for personal care services on the Department approved assessment may receive the rate level identified as moderate for the service. The moderate rate is paid when a recipient routinely requires prompts, supervision and physical assistance to complete the basic personal care areas of eating, bathing, toileting, grooming, and personal hygiene; or

> A recipient who is on a behavioral services plan that is implemented by the adult day training provider, and who requires visual supervision during all waking hours and occasional intervention as determined by a Certified Behavioral Analyst. The recipient does not have to live in a licensed residential facility.

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

> **Behavior analysis services** are provided to assist a person or persons to learn new behavior, to increase existing behavior, to reduce existing behavior, and to emit behavior under precise environmental conditions. The term "behavior analysis services" includes the terms "behavior programming" and "behavioral programs." Behavior analysis includes the design, implementation and evaluation of systematic environmental modifications for the purposes of producing socially significant improvements in and understanding of human behavior based on the principles of behavior identified through the experimental analysis of behavior. It includes the identification of functional relationships between behavior and environment. It uses direct observation and measurement of behavior and environment. Contextual factors, establishing operations, antecedent stimuli, positive reinforcers and other consequences are used, based on identified functional relationships between behavior and environment, in order to produce practical behavior change.
>
> Behavioral services must include procedures to insure generalization and maintenance of behaviors. The services are designed to engineer environmental modifications including ongoing styles of interactions, and contingencies maintained by significant others in the recipient's life. Training for parents, caregivers and staff is also part of the services when these persons are integral to the implementation or monitoring of a behavior analysis services plan. Services should be provided for a limited time and discontinued as the significant others gain skills and abilities to assist the recipient to function in more independent and less challenging ways.
>
> Documentation of services must comply with Chapter 65B-4.030(9) and (10), F.A.C. Reimbursement* and monitoring documentation to be maintained by the provider includes:
>
> 1. *Copy of claim(s) submitted for payment;
> 2. *Copy of service log;

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

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

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

The Developmental Services Waiver Services Florida Medicaid Coverage and Limitations Handbook states that indicators of a one staff to five recipient staffing rate ratio level includes an individual who requires prompts on a routine basis, supervision and physical assistance to complete the basic personal care areas of eating, bathing, toileting, grooming, and personal hygiene or who is on a behavioral services plan that is implemented by the adult day training provider and who requires visual supervision during all waking hours and occasional intervention as determined by a Certified Behavioral Analyst.

The Findings of Fact show that the petitioner did not provide Maximus with the information requested to determine the medical necessity for a one to five level of supervision for adult day training. Therefore, it is determined that the respondent correctly reduced the petitioner's adult day training level of supervision to one to six-ten.

The Findings of Fact show that, during the petitioner's previous support plan period, he was receiving 20 hours of behavior analysis services. In order to determine whether the level of service could be continued, the respondent requested information that showed that the behavior analysis services was medically necessary. However, the information received was undated, unsigned and contained old information. The evidence presented to the respondent did not show that behavior analysis services were medically necessary. Therefore, it is concluded that the respondent correctly terminated the behavior analysis services.

DECISION

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

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 18th day of October, 2006,

in Tallahassee, Florida.

Morris Zamboca

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

Copies Furnished T

eneral

Darlene Strimple, WSC
Lucy Goddard-Teel

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

PETITIONER,

Vs.

APPEAL NO. 06F-02542

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

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned-hearing officer on August 29, 2006 at 3:05 p.m., in Jacksonville, Florida. The petitioner was not present. However, he was represented by his attorney, Andrea Socol, North Florida Legal Services Inc. Appearing as witnesses for the petitioner were [redacted] father, [redacted] sister, Erin K. Smith, Independent Support Coordinator, Queen Hicks, Program Director . . Ann Cocheu, attorney, Office of the Attorney General, represented the agency. Appearing as witnesses for the agency were Alethea Oliphant, Agency for Persons with Disabilities and Dr. Emma Guilarte, Maximus, Inc. Dr. Guilarte participated in the hearing by telephone.

Sheryl Starkgraf appeared as a notary for the telephone witness. Attorney, Paula Moser-Barlett appeared as an observer. The hearing was previously scheduled for June 19, 2006. Both parties agreed to a continuance and the appeal was rescheduled.

ISSUE

The petitioner is appealing the agency's action of April 5, 2006 to deny "residential habilitation – standard" of 16 hours per day, due to not being determined to be medically necessary. The petitioner has the burden of proof.

PRELIMINARY STATEMENT

The record was held open through September 8, 2006. Additional evidence was received on September 19, 2006 from the petitioner, which was not considered in the decision as the record was closed.

FINDINGS OF FACT

The petitioner is a 42 year old participant in the Home and Community-Based Services Medicaid Waiver Program. The petitioner is diagnosed with cerebral palsy, mental retardation and is quadriplegic and totally dependent on others for all activities of daily living (ADLs). The petitioner is non-ambulatory, confined to a wheelchair, incontinent and has no use or muscle control of his extremities. The petitioner had a stroke in 1970 and is unable to grasp anything due to contractual deformities. He is dependent on others to prepare, deliver, and physically provide all meals. The petitioner's communication ability is extremely limited and he is difficult to understand.

The petitioner lived with his family for 41 years with his mother being his primary caregiver. In April 2005 his mother passed unexpectedly. The petitioner moved into the Group Home in May 2006.

The agency approved a 30 day period of residential habilitation services – standard, for 16 direct care hours per day, while the new request was being processed through Maximus Inc. A support plan was submitted requesting residential habilitation at the standard level with 16 hours of direct care staff per day. The petitioner also attends an Adult Day Training Program (ADT) at Cerebral Palsy of Jacksonville from 8:00 to 2:30, five days a week.

The agency evaluated this request and determined that 12 hours of direct care staff per day of residential rehabilitation services was more appropriate and medically necessary, combined with the ADT Program. The agency notified the petitioner of its action on April 5, 2006.

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

> "The request is for 188 days of Residential Habilitation at the standard level with 16 hours of direct care staff per day for...as he moves from his sister's home to a group home. The information indicates...depends on staff for all personal care and activities of daily living. He is reported to be quadriplegic and uses a wheelchair and requires full assistance with transfers. Special attention is provided to maintain skin integrity...is on a regular diet. Attendance to the Adult Day Training Service program is reported to be important to...and he goes regularly...is reported to sleep through the night requiring checks to maintain fresh disposable briefs...is reported to have no significant behavioral issues.
> Medical necessity is demonstrated for Residential Habilitation at the standard level but not at the intensity requested. Residential Habilitation at the standard level with 12 hours of direct care staff per day is approved for...in order to provide him with the supports and supervision he needs, with personal care, physical management and activities of daily living. Although...needs, significant amounts of staff supports...sleeps through the night, presents no significant behavioral issues, has a normal diet and no other significant health issues. This level of supports also considers transitional issues during this period."

Maximus is contracted by the Agency for Persons with Disabilities. The prior service authorization (PSA) completed by Maximus is a paper document review which involves the Medicaid Waiver Support Coordinator submitting information to Maximus along with the requests for services to be paid for by the Medicaid Waiver Plan for the cost plan year. All reviewers employed by Maximus are approved by the Agency for Persons with Disabilities as qualified expert professionals to make the PSA determinations. Any services totaling $80,275 must be reviewed by a consultant physician and any service reduction must be reviewed by a consultant physician. Maximus is restricted from making contact with the petitioner's medical providers or the petitioner. All contact must be in writing which is the reason for the form 2 when additional documentation is needed. Dr. Guilarte asserted that in accordance with their process, a Maximus reviewer would be disqualified if this strict procedure was not followed. This ensures decisions are made in a consistent and objective manner statewide. The support plan is a federal requirement and the PSA review process follows the federal requirements. Page 2-4 and 2-5 of the Developmental Services Wavier Services Coverage and Limitations Handbook establishes that an appropriate, qualified professional make the determination that the standards for medical necessity set forth in the Florida Administrative Code are met before a service is approved. This reference also indicates that because a provider prescribes a service does not in itself make the services medically necessary.

Dr. Emma Guilarte was the lead reviewer for the original determination of denying 16 hours and instead approving 12 hours of residential habilitation – standard. Dr. Guilarte is not a medical doctor. Because the request was for 16 hours, the

determination was reviewed by Dr. Amelia Cardona, who is a medical doctor. Dr. Cardona agreed that 12 hours of residential habilitation – standard was demonstrated as medically necessary.

A reconsideration was requested which included a five page report. The report states, "REST AND SLEEP... is unable to reposition himself and requires two (2) people to reposition him every two hours throughout the night. He requires a diaper change at least once in the middle of the night to avoid skin breakdown and infection. Should he soil himself, a bed linen and clothing change is necessary." The reconsideration determination was made by Dr. Mary Seay who is also a medical doctor. The decision was to uphold the original determination.

Dr. Emma Guilarte gave extensive testimony on what she used to make the original determination that 16 hours of residential habilitation – standard was not demonstrated as medically necessary and that 12 hours was determined medically necessary. The categories addressed on form 1a were reviewed. The first was program participation and the amount of direct care staff required for that activity. The petitioner attends Adult Day Training (ADT) for six hours per weekday and has a level of support of one to three while at the ADT. This equates to two hours of actual one on one support. If this same level of supports were continued while he is at home, he would require only eight hours of residential habilitation. This demonstrates that he is capable of functioning with less intensive direct care than the one to one ratio. Even considering the transition to the group home, Dr. Guilarte believes 12 hours of residential habilitation is appropriate.

Dr. Guilarte considered functional status in making the decision. The petitioner requires total assistance with his ADLs and personal care. Two people are needed on transfer. The Medicaid Waiver covers durable medical equipment such as wheelchairs and lifts that are a one time purchase. This assistance would cause less dependence on paid staff and would reduce the number of hours needed of residential habilitation, although the 12 hours determined to be medically necessary did not take lifts or chairs into account. As part of the functional status the petitioner's sleep and awake patterns were considered. The documents submitted to Maximus indicated there were no concerns with sleep habits.

The third area considered was behavioral. There were no behavioral problems to address.

The fourth area was physical status. The significant documentation addressed the requirement to be repositioned and toileting the petitioner during the middle of the night, which is considered physical management. There was no other medical condition to enhance his need for a higher level of support.

There is no question the petitioner depends on one to one support for his ADLs. The petitioner receives nine types of services under the Medicaid Waiver Program. Maximus considered that the petitioner is not at ADT during weekends and also considered that weekends are not as rigid with schedules. Also considered was the fact that the petitioner may be at home rather than ADT on some days if he is ill. Dr. Guilarte determined that the 12 hours per day of direct care staff one on one of residential habilitation – standard, could be used more on some days and less on others over the year. As part of a provider receiving residential habilitation, there is also

someone available 24 hours per day at the facility. The 12 hours of direct one on one care was considered adequate and not in excess of the petitioner's need for personal care and ADLs, as he sleeps well and is stable healthwise. This also gave consideration to someone checking the petitioner during the night every 30 minutes for soiling and skin integrity. The amount of time it would take him to be groomed, dressed, eat, etc. whether at home or at ADT was considered in determining the 12 hours.

Medical necessity was considered and each criteria identified in the Florida Administrative Code was evaluated in making the determination. The level of service must be reflective of the needs and resources to remain safe.

The fact that the [redacted] Group Home will not keep an individual for less than 16 hours of residential habilitation under the Medicaid Waiver is not something that can be considered in making the medical necessity decision. Other services statewide have to be taken into consideration; not just services of one particular provider. Medical necessity is based on the individual's medical needs rather than the provider's proposal for staffing. Dr. Guilarte believes an individual requiring more than 12 hours residential habilitation per day along with ADT, is significant and should be considered for an Intermediate Care Facility.

A statement from the petitioner's treating physician dated June 16, 2006, was submitted at the hearing. The physician stated he was aware of the agency's definition of medical necessity and the definition for residential habilitation services. The treating physician, Dr. Fara M. Nadal, stated it was "expert medical opinion that [redacted] requires 24 hour care for his medical conditions and for his impaired level of functioning. It is my recommendation that [redacted] receive no less than 16 hours of residential

rehabilitation services. Having less than 16 hours of residential rehabilitation services will put [redacted]t risk for functional decline, developing decubitus ulcers, which lead to pain, infections and hospitalizations and risk of death." (Petitioner's Exhibit 1).

CONCLUSIONS OF LAW

Florida Administrative Code 59G-1.010 definitions, states in part:

"The following definitions are applicable to all sections of 59G, F.A.C., unless specifically stated otherwise in one of those sections. These definitions do not apply to any Medicaid program rules other than those in 59G, F.A.C...(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."

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

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

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

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

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

The petitioner requested that the Medicaid Waiver pay for 16 hours daily of residential habilitation - standard services. In considering the information related to the request, the agency determined that the request for 16 hours daily of residential habilitation - standard services was not demonstrated as medically necessary. As such, the agency determined that 12 hours daily of residential habilitation - standard services was demonstrated as medically necessary.

In making a determination of what a word means, the normal and ordinary meaning for the word is typically used. However, by rule, the term "medical necessity"

has special meaning. The rule specifically defines matters that have to be taken into consideration in determining medically necessary.

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

The agency notification states the reason for the denial of the 16 hours as "have not been determined to be medically necessary." The agency's contracted qualified professional approved 12 hours daily of residential habilitation – standard, as this amount was demonstrated to be medically necessary.

At the hearing, a statement from Dr. Fara M. Nadal, the petitioner's treating physician was submitted into evidence. Occasionally, in a Medicaid or Public Assistance Program a doctor's statement is the threshold determination factor as to whether benefits are provided. For those cases, the program authorities set forth that requirement. The test for eligibility or review is whether or not the statement is received. The contents of the statement is not subject to evaluation or review. For purposes of receiving benefits through the Development Services Medicaid waiver the threshold is higher than the mere receipt of such a statement. The Development Services Handbook definition of medically necessary states in part:

> Waiver services shall only be provided when the service or item is medically necessary. Chapter 59G-1.010(166)(a)(c) of the F.A.C. defines medical necessity as:..
> (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 Dr. Nadal statement is subject to review and challenge to determine how the hearing officer may rely upon it determining whether the medical necessary requirement for a particular service is met. In determining the weight to be afforded the contents of the statement, it must first be evaluated under the evidence requirements for an administrative hearing. In this case, the treating physician completed a statement that was submitted at the hearing. The physician did not appear at the hearing and there was no sworn testimony received from the physician.

The Florida Administrative Code 28-106.213, Evidence, states in part:

> (3) Hearsay evidence, whether received in evidence over objection or not, may be used to supplement or explain other evidence, but shall not be sufficient in itself to support a finding unless the evidence falls within an exception to the hearsay rule as found in Chapter 90, F.S.

Florida Statute 90.801, Hearsay; definitions; exceptions, states in part:

> (1) The following definitions apply under this chapter:
> (a) A "statement" is:
> 1. An oral or written assertion; or
> 2. Nonverbal conduct of a person if it is intended by the person as an assertion.
> (b) A "declarant" is a person who makes a statement.
> (c) "Hearsay" is a statement, other than one made by the declarant while testifying at the trial or hearing, offered in evidence to prove the truth of the matter asserted.

The statement submitted appeared to be a statement that was created to be presented at the hearing. It does not meet the medical record hearsay exemption

(s.90.803(4) F.S.). There was no custodian to establish that it would meet the business record hearsay exception. The hearsay nature of this evidence and particularly the inability to cross examine the witness is a special concern when the witness is an expert offering opinions. There is no ability to cross examine the witness to determine the underlying facts or data the expert relied upon. Therefore, the statement cannot be relied upon to make a finding of fact; it can only be relied upon as it supports other testimony or evidence.

The petitioner offered other evidence and testimony which was considered and did not establish medical necessity for 16 hours of residential habilitation. In the alternative, the respondent's expert witness offered testimony to show 12 hours daily of residential habilitation –standard to be medically necessary and correct in consideration of the petitioner's needs

Therefore, the hearing officer concludes after weighing all of the evidence that the petitioner did not meet the burden to prove medical necessity for 16 hours daily of residential habilitation – standard.

DECISION

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

NOTICE OF RIGHT TO APPEAL

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

be the petitioner's responsibility.

DONE and ORDERED this 5th day of October, 2006,

in Tallahassee, Florida.

James Abdur-Rahman

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

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Ann Cocheu, Esq.
Catherine Lannon, Esq.

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

APPEAL NO. 06F-05425

PETITIONER,

Vs.

CASE NO. 1234025523

DEPARTMENT OF ELDER AFFAIRS:
09 Palm Beach
UNIT: 88626

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on October 10, 2006, at 9:17 a.m., in Lake Worth, Florida. The petitioner was not present. Representing the petitioner was J[redacted] son. Representing the department was David King, management analyst, Agency for Health Care Administration (AHCA). Appearing as witnesses were: Robert Schemel, president, American Eldercare, Inc., service provider; Barbara Miller, assessor, Elder Affairs; Vicki Sexton, Elder Affairs; and David Oropallo, senior management analyst, Elder Affairs. Ms. Sexton and Mr. Oropallo appeared via telephone at their request.

ISSUE

At issue is whether the department was correct in denying a request to have the petitioner receive home care services from the Nursing Home Diversion Program. Also,

the representative is requesting that the department pay an outstanding bill of approximately $1,200 from a nursing facility. The petitioner carries the burden.

FINDINGS OF FACT

The petitioner is a ninety-two year old (DOB [redacted]) resident of Palm Beach County, Florida. He is eligible for the Medicaid Waiver Program and subsequently subscribed to the Nursing Home Diversion Program. This provided for additional services not normally associated with the Medicaid Waiver.

The petitioner spends 8 hours per day, 5 days per week at a daycare center. His son wanted to have his father at his home 8 hours per week and have the Diversion Program pay for the service.

The provider explains that it is his obligation to provide the most cost effective and least restrictive services possible for the clients, not necessarily for the family members. Thus, it is most cost effective to have the petitioner in the daycare setting, not at home. The son's request was denied because of this factor.

However, upon reconsideration of the petitioner's circumstances, the provider is now willing to accept the son's request and accommodate the petitioner for home care by offering 4 hours of home care twice per week.

The son also has a request that the department pay for an outstanding bill of approximately $1,200 that was billed by a nursing facility for the father's stay following a rehabilitation of a fractured arm. The provider indicates that when the son switched his Medicare Humana coverage to fee-for-service, a 3 day hospital stay was not satisfied prior to the rehabilitation.

CONCLUSIONS OF LAW

The Nursing Home Diversion Program contract contains funding from the Federal Government and shall comply with 45 CFR, Part 74, and/or 45 CFR, Part 92, and other applicable regulations as specified in Attachment I. The provider has now agreed to the request for 8 hours of home care and this satisfies the son's request.

Fla. Admin Code 65-2.042 **Applicant/Recipient Fair Hearings** states in part:

> The Department of Children and Family Services, hereinafter referred to as Department or Agency, is required to provide notice and an opportunity of a hearing to any applicant or recipient when the Department's action, intended action or failure to act would adversely affect the individual's or family's eligibility for an amount or type of Financial Assistance, Medical Assistance, Social Services, or Food Stamp Program Benefits, or where action on a claim for such assistance or services is unreasonably delayed.
>
> (1) The hearings covered by Rule 65-2.042, F.A.C., et seq., are those within the Department of Children and Family Services in the execution of those social and economic programs administered by the former Division of Family Services of the Department of Health and Rehabilitative Services prior to the reorganization effected by Chapter 75-48, Laws of Florida.

The billing from the nursing home is based upon a Medicare Program; i.e. Humana or fee-for-service. Pursuant to this Rule, this hearing officer has no jurisdiction concerning the payment of the outstanding bill of the nursing home. The hearing officer may only concern himself with Medicaid, not Medicare, issues.

DECISION

The hearing is found as both. The appeal is granted for the 8 hour request by the son because the provider has agreed to two 4 hour increments. The appeal is denied for the outstanding payment due to jurisdictional issues.

NOTICE OF RIGHT TO APPEAL

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

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

in Tallahassee, Florida.

Melvyn Littman ss

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

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

APPEAL NO. 06F-05274

PETITIONER,

Vs.

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

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned-hearing officer on October 3, 2006, at 1:32 p.m., at the Opa Locka Service Center, in Opa Locka, Florida. The petitioner was present, but was represented at the hearing by, Nicole Bain, group home manager. Also present on behalf of the petitioner was Bolatita Idowu, support coordinator. Present as witnesses for the petitioner were Alexander Bain, owner of the group home and Lola Bain, co-owner of the group home. The agency was represented by Ann Blanford, assistant attorney general, Attorney General Office. Also present on behalf of the agency, via the telephone, was George Gill, prior authorization reviewer, from Maximus. Maximus is located in Tallahassee, Florida.

ISSUE

At issue is the agency's action on August 2, 2006, to deny the request for nine hours a day of residential habilitation as a standard service as a Developmental

Disabilities Medicaid Waiver service for the petitioner, but provide four hours a day on average, based on: "Have not been determined to be medically necessary." and "Do not meet the Developmental Services Home and Community Based Services Medicaid Waiver service limitations/exclusions or requirements." The petitioner has the burden of proof. Additionally at issue is the same date agency action to terminate specialized mental health services as a Developmental Disabilities Medicaid Waiver service for the petitioner, based on: "Do not meet the Developmental Services Home and Community Based Services Medicaid Waiver service limitations/exclusions or requirements." as the service is offered though State Plan Medicaid. The respondent has the burden of proof.

FINDINGS OF FACT

The petitioner is a recipient of the Medicaid Waiver Program under the Developmental Disabilities Program, is nineteen years of age and has a diagnosis of mental retardation. The petitioner lives in a group home called . . . .

Maximus is the private agency that evaluates services for eligible recipients, for the agency, under the Medicaid Waiver Program. They also complete Prior Service Authorization reviews.

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

Maximus or the agency determined as part of medical necessity and determining Medicaid Waiver services coverage and limitations that residential habilitation services were to be approved for four hours a day on average. The petitioner was receiving eight

hours a day on average of what is called "live in daily rate", which is a residential habilitation service provided for group home with three or less consumers. The request made by the petitioner's representatives was for residential habilitation at the standard level service at nine hours a day. The agency considers the above request as a new request for services.

The agency's reason for the above noted decision for services was based on: "Have not been determined to be medically necessary." and "Do not meet the Developmental Services Home and Community Based Services Medicaid Waiver service limitations/exclusions or requirements." The agency cited the Developmental Services Waiver Services Florida Medicaid Coverage and Limitations Handbook, 2-66.

The information that was submitted to Maximus was in the form of a support plan; individual program plan and other information provided to Maximus as part of the petitioner's request for services, Respondent Composite Exhibit 1. Maximus determined, that more specifically, based on the above information: "She completes almost all of her basic self-care tacks independently. She is able to prepare simple meals, participate in household chores and enjoys leisure activities..."

The agency also terminated specialized mental health services as a Developmental Disabilities Medicaid Waiver service for the petitioner, based on: "Do not meet the Developmental Services Home and Community Based Services Medicaid Waiver service limitations/exclusions or requirements." as the service is offered though State Plan Medicaid. The petitioner's representatives had requested 416 quarter hours of the service as part of the new cost plan request. As part of the agency's effort to determine eligibility of the above noted service, a notification of missing information (form) was sent to the

petitioner's support coordinator. This form requested that the petitioner (petitioner's support coordinator) needed to provide documentation to Maximus to indicate if the request for the service was made through Medicaid State Plan, or if made, if Medicaid provided a denial notice or not. The agency did not receive any of the requested information from the petitioner's representatives, thus the above termination of benefits was made by the agency. The agency also cited the Developmental Services Waiver Services Florida Medicaid Coverage and Limitations Handbook, 2-84.

The agency had also approved the petitioner for non-residential support services.

CONCLUSIONS OF LAW

In accordance with Fla. Admin. Code 59G-1.010:

(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 agency's Developmental Services Waiver Services Florida Medicaid Coverage and Limitations Handbook dated June 14, 2005, page 2-66, addresses residential habilitation services under description and states in part:

> Residential habilitation provides supervision and specific training activities that assist the beneficiary to acquire, maintain or improve skills related to activities of daily living.

The agency's Developmental Services Waiver Services Florida Medicaid Coverage and Limitations Handbook dated June 14, 2005, page 2-84, addresses specialized mental health services under limitations and states in part:

> This service supplements mental health services available under the Medicaid State Plan.

As shown in the Findings of Fact, Maximus determined that residential habilitation as a standard service as a Developmental Disabilities Medicaid Waiver service for the petitioner, would be provided at four hours a day and not for nine hours a day as requested, based on: "Have not been determined to be medically necessary." and "Do not meet the Developmental Services Home and Community Based Services Medicaid Waiver service limitations/exclusions or requirements." Additionally, Maximus determined

determined that specialized mental health service as a Developmental Disabilities Medicaid Waiver service for the petitioner, will be terminated, based on: "Have not been determined to be medically necessary." and "Do not meet the Developmental Services Home and Community Based Services Medicaid Waiver service limitations/exclusions or requirements."

The petitioner's representatives argued that they recently had to replace the previous support coordinator, based on poor performance and thus this was the reason for information not being properly submitted to Maximus. The petitioner's representatives also argued that the petitioner is in need of the increased request for residential habilitation benefits, based on the facility's staff having to assist the petitioner with her socialization skills and for transportation.

The respondent argued that the petitioner could be better served through the non-residential support service for the above noted petitioner's argument. The Maximus witness also suggested that the petitioner's representative could question the local agency staff about the status of the group home in reference to submitting a request for the residential habilitation service previously received and thus submit a new request for the residential habilitation service. The petitioner's representative agreed that they were going to submit a new request for all of the services.

After considering the evidence, the Florida Administrative Code Rule and all of the appropriate authorities set forth in the findings above, the hearing officer affirms the agency's action to deny the request for nine hours a day of residential habilitation as a standard service as a Developmental Disabilities Medicaid Waiver service for the petitioner, but provide four hours a day on average, based on: "Have not been

determined to be medically necessary." and "Do not meet the Developmental Services Home and Community Based Services Medicaid Waiver service limitations/exclusions or requirements." Additionally, the hearing officer affirms the agency's action to terminate the specialized mental health service as a Developmental Disabilities Medicaid Waiver service for the petitioner, based on: "Have not been determined to be medically necessary." and "Do not meet the Developmental Services Home and Community Based Services Medicaid Waiver service limitations/exclusions or requirements."

DECISION

Both appeals are denied and the agency's action affirmed.

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 19th day of October, 2006,

in Tallahassee, Florida.

Robert Akel

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

Copies Furnished T

[illegible]
M. Catherine Lannon, Sr. Assistant Attorney General
Hilda Fluriach

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

PETITIONER,

APPEAL NO. 06F-04688

Vs.

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

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned-hearing officer on August 22, 2006, at 12:25 p.m., at the Caleb Service Center, in Miami, Florida. The petitioner was not present, but was represented at the hearing by his mother, [redacted]. Also present on behalf of the petitioner was [redacted] a friend of the petitioner's mother. The agency was represented by David Glantz, assistant attorney, Attorney General Office. Also present on behalf of the agency was Ileana Rodriguez-Ramirez, counselor, from the Agency For Persons with Disabilities. Present as an observer was Anne Blanford. Marisa Pisani was present as an interpreter. The hearing was reconvened before the undersigned-hearing officer on September 26, 2006, at 1:11 p.m., at the Opa Locka Service Center, in Opa Locka, Florida. All of the above representatives and witnesses were again present at this hearing. Anne Blanford and Marisa Pisani were not present. Present as a witness for the agency, via the

telephone, was Dr. Hilda Lopez, clinical psychologist. Cecilia Lawinski was present as an interpreter.

ISSUE

At issue is the agency's action of April 4, 2006 to deny the petitioner's request for Developmental Services Home and Community Based Service Waiver benefits based on: "You have not been determined to have a qualifying disability to be enrolled in the DS/HCBS Waiver Program as defined in Section 393.063(12) F.S.." The petitioner has the burden of proof.

FINDINGS OF FACT

The petitioner is approximately six years of age and he or his representative filed an application for Developmental Services Home and Community Based Service Waiver benefits with the agency. The petitioner applied for these benefits alleging Autism.

The agency submitted as evidence, Respondent Exhibit 1, which is a copy of a Psychological Evaluation for the petitioner. This evaluation contains results of several tests administered to the petitioner to help in the evaluation of the petitioner's representative's request for Developmental Services Home and Community Based Service Waiver benefits for the petitioner. It was completed by Maite Schenker, Ph. D, a licensed psychologist. The agency evaluated this "evaluation" and based on the information within; and the appropriate Florida Statute that applies; had determined that the petitioner did not meet the requirements to be found eligible for the Developmental Services Home and Community Based Service Waiver benefits under autism.

The petitioner submitted as evidence, Petitioner Exhibit 1, which is a copy of neurological follow up consultation statement, dated March 27, 2006 and signed by

Veronica Trevilla P.A.C., regarding the petitioner. Under assessment it states; Autism, also ADHD ODD and Anxiety. This statement does not explain how this assessment decision was arrived at.

The petitioner submitted as evidence, Petitioner Exhibit 2, which is a copy of a communication re-assessment of the petitioner and it is dated February 28, 2006. The petitioner also submitted as evidence, Petitioner Exhibit 3, which is a copy of a special education plan from the Miami-Dade County school system. The first page is in Spanish. It indicates "Autism" on the form. No explanation was provided as to how this diagnosis was arrived at by the signer of this statement.

The petitioner also submitted as evidence, Petitioner Exhibit 4, which is a copy of a psychological evaluation report, signed by Hilda Lopez, Ph.D. (a licensed psychologist). It is dated August 16, 2006 and was completed two days before the first hearing. The hearing was reconvened to allow the author of the above psychological evaluation report to explain the evaluation; the results and to be questioned on her testimony by both parties.

The above noted evaluation report of the petitioner was divided into three main scales to measure for autism. The first scale under this evaluation is titled; "The Childhood Autism Rating Scale (CARS)." The second scale is called the; "Gilliam Autism Rating Scale (GARS)." The third one is called the; "Social Communication Questionnaire (SCQ)." In order to meet the definition of autism; the petitioner would have to meet all three scale criteria.

For the first scale noted above, the petitioner scored a total of 31 points. The score of 31 is considered as "mildly autistic" by category. A person receiving a score of below

30 points for this scale in general is considered not to be autistic. The second scale the petitioner scored an autistic index of 87. This index number indicates a probability of autism (for the petitioner) "as very likely." This scale was also broken down into three categories. For the petitioner he scored a seven on two of the categories and a six on one of the categories.

For the third scale the petitioner was evaluated under social interaction as the main point. Under this scale the petitioner scored a 6 on this scale. The score of "6" is considered; "not significantly deficient." Thus, the petitioner did not meet the autism category of the third scale. Based on this evaluation, the petitioner was not found to be considered autistic under the agency's guidelines. The petitioner was diagnosed with "Pervasive Developmental Disorder".

The petitioner also submitted Petitioner Exhibit 5, which is a copy of an Individual Education Plan for the petitioner dated September 15, 2006. Part of this exhibit is in Spanish. This exhibit does not mention the petitioner's condition.

CONCLUSIONS OF LAW

The Florida Statute Section 393.063(12) sets forth the definitions that apply to the Developmental Disabilities Program and states in relative part:

> (12) "Developmental disability" means a disorder or syndrome that is attributable to retardation, cerebral palsy, autism, spina bifida, or Prader-Willi syndrome and that constitutes a substantial handicap that can reasonably be expected to continue indefinitely...
>
> (2) "Autism" means a pervasive, neurologically based developmental disability of extended duration which causes severe learning, communication, and behavior disorders with age of onset during infancy or childhood. Individuals with autism exhibit impairment in reciprocal social interaction, impairment in verbal and nonverbal communication and

imaginative ability, and a markedly restricted repertoire of activities and interests.

As shown in the Findings of Fact, the agency denied the petitioner's request for Developmental Services Home and Community Based Service Waiver benefits based on: "You have not been determined to have a qualifying disability to be enrolled in the DS/HCBS Waiver Program as defined in Section 393.063(12) F.S.." The agency, through various evaluations determined that the petitioner did not meet the criteria under the Program to be considered autistic and thus eligible for the Program.

The petitioner's representative argued that the review by the psychologist noted in the Findings of Fact, was not a comprehensive evaluation of the petitioner. She also argued that according to the petitioner's teachers; therapists and other appropriate people have advised her that her son should meet the (agency's) criteria to be considered autistic and thus be eligible for DS/HCBS Waiver Program benefit. She argued that her son is autistic according to all of the evidence provided and by all of the experience she has had with her son.

The respondent argued that their witness had completed a comprehensive evaluation for the petitioner related to the eligibility criteria of the Program as provided through the witness' testimony. The respondent argued that according to the evidence and the appropriate Florida Statute, the petitioner did not meet the criteria to be considered eligible for the DS/HCBS Waiver Program. The hearing officer agrees with the respondent's argument.

After considering the evidence, the Florida Statute and all of the appropriate authorities set forth in the findings above, the hearing officer affirms the agency's action to

deny the request for Developmental Services Home and Community Based Service Waiver benefits based on: "You have not been determined to have a qualifying disability to be enrolled in the DS/HCBS Waiver Program as defined in Section 393.063(12) F.S.."

DECISION

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

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 19th day of October, 2006,

in Tallahassee, Florida.

Robert Akel

Robert Akel
Hearing Officer
Building 5, Room 203
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
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M. Catherine Lannon, Sr. Assistant Attorney General
Hilda Fluriach

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

APPEAL NO. 06F-04858

PETITIONER,

Vs.

AGENCY FOR PERSONS
WITH DISABILITIES
DISTRICT: 02 Taylor
UNIT: APD

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on September 21, 2006, at 9:40 a.m., in Madison, Florida. The petitioner was present and was represented by his aunt and guardian, [redacted]. Testifying on behalf of the petitioner was Moley Bostick, waiver support coordinator, Habilitation Management Services (HMS) and Janet Cobb, supported living coach, Taylor Advocacy and Resource Center (TARC). The respondent was represented by Gail Scott Hill, assistant general counsel, Agency for Persons with Disabilities (APD). Testifying on behalf of the respondent was Cheryl Smith, senior human services program specialist, APD. Also testifying on behalf of the respondent, via speakerphone, was Dr. Sandra Jensen, licensed clinical and forensic psychologist, APS Healthcare. Ms. Leigh Byrd, notary, administered the oath to Dr. Jensen. Present as an observer to the hearing was Amy Tolman, assistant general counsel, APD.

ISSUE

The petitioner is appealing the agency's action of June 21, 2006 to terminate Personal Care Assistance services (PCA) and to deny homemaker services to be funded through the Agency for Persons with Disabilities Medicaid Waiver Program based on the contention that the services do not meet criteria for medical necessity and do not meet waiver service limitations/exclusions or requirements. The agency bears the burden of proof in reference to the termination of PCA and the petitioner bears the burden of proof in reference to the denial of homemaker services.

FINDINGS OF FACT

The petitioner, who is 40 years old (DOB [redacted] is eligible to receive services from the agency's Developmental Services Home and Community Based-Care Services Waiver Program. The petitioner's primary disability is mental retardation. The petitioner lives alone in his own apartment. As part of the support plan, the petitioner requested adult day training off-site, transportation services, personal care assistance, homemaker services in the amount of 624 quarters hours annually, medication review and supported living coaching.

The support plan indicated that the petitioner was able to ambulate independent with no special assistance or assistive devices. There was no functional impairment of his vision or hearing and he required no special assistance or equipment to evacuate his home. He requires only minimal assistance in the form of verbal prompts with some words or the presentation of yes or no. The petitioner is capable of performing many or

most of the duties of the homemaking services. He is able to cook and does prepare his own meals. The petitioner indicated that while he is not physically incapable of performing these tasks, he does not do a through job and needs assistance with vacuuming or routine household cleaning in order to do these tasks thoroughly.

The petitioner requested personal care assistance in the amount of 2,920 quarter hours. The documentation submitted for review indicated that the petitioner takes numerous medications and needs help separating and taking them in the morning and evenings.

The respondent's Developmental Disabilities Program has contracted with APS Healthcare to perform Prior Service Authorization (PSA) reviews. APS Healthcare reviewed the petitioner's request for homemaker services and personal care assistance and determined that the requests were not supported by the documentation provided. The decision is based on the Developmental Disabilities (DD) Waiver Services Coverage and Limitations Handbook, hereafter referred to as the Handbook and a review of the support plan. According to page 2-47 of the Handbook, homemaker services are those general household activities such as meal preparation, laundry, vacuuming and routine household cleaning provided by a trained homemaker, when the person who usually handles these tasks is unable to perform them. The intent of this service is to ensure that the recipient's home environment remains clean, safe, and sanitary. Homemaker services are rendered only when the recipient is unable to manage the home, or the person who usually performs theses tasks is absent for an

extended period of time or unable to manage the home. A homemaker cannot provide hands on care to a recipient. Homemaker services shall be provided in the recipient's own home or family home. This service is available in the family home only when there is documentation as to why the family cannot provide the support. Examples of justification would include the advanced age or physical disability of the caregiver. The care plan indicated that the petitioner was independent or required only minimal assistance. According to page 2-5 of the Handbook, all services must meet the conditions of medical necessity as defined in the rule. Services must be individualized, specific, and consistent with symptoms of confirmed diagnosis of the illness or injury under treatment, and not in excess of the individual's needs; and be furnished in a manner not primarily intended for the convenience of the individual, the individual's caretaker, or the provider. As there was no documentation submitted to show that the petitioner lacked the ability to complete homemaker related tasks, it was determined that there was no medical necessity for the provision of this service and a recommendation was made to deny homemaker services request.

When considering the request for PCA services in the amount of 2,920 quarter hours per year, the APS Healthcare reviewer relied on page 2-58 of the Handbook definition of PCA in making its decision. According to page 2-58 of the Handbook, PCA is a service that assists a recipient with eating and meal preparation, bathing, dressing, personal hygiene, and other self care activities of daily living. The service also includes activities such as assistance with meal preparation, bed making and vacuuming when

these activities are essential to the health, safety and welfare of the recipient and when no one else is available to perform them. This service is provided on a one-on-one basis. Personal care assistance may not be used solely for supervision. The documentation submitted for review indicated that the petitioner takes numerous medications and needs help separating and taking them in the mornings and evenings. The documentation provided also indicated that the petitioner was independent in bathing, eating and drinking, toileting, dressing himself and needs minimal assistance in his personal hygiene. It was determined that the request for PCA did not meet the criteria of the Handbook because the task being performed is outside of the scope of the service. The recommendation was made to terminate the request for PCA service.

The recommendation was then reviewed by a peer review and submitted to a physician for his authorization. Dr. Stephen Quintero, M.D., agreed with the determination for Homemaker and PCA services on June 15, 2006, based on a review of the rationale and recommendations provided.

The petitioner was notified via letter dated June 21, 2006 of the termination of PCA and denial of homemaker services and was given an opportunity to have a reconsideration. The agency did not receive a request for reconsideration.

During the hearing the petitioner's representative indicated her belief that the petitioner needed help with homemaking services as he was not thorough in washing the dishes. In addition, the petitioner would wear the same clothing day after day rather than putting on clean clothing. The petitioner's representative expressed her concern

that he needed help taking his medication as he was apt to overdose himself. The supported living coach testified that she helps him with separating the medication but that her time is limited and she cannot see that he takes it appropriately.

The agency believes that the more appropriate service would be in-home support (IHS) or skilled nursing services. However, the support coordinator indicated that there were providers in the area to provide those services to the petitioner. In addition, the support coordinator believes that a request for reconsideration was filed on June 28, 2006. The agency has no record of the petitioner's request for reconsideration. There was no evidence presented to show that a reconsideration had been submitted. However, the petitioner may resubmit a new support plan or a new request for reconsideration.

CONCLUSIONS OF LAW

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

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

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

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

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

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

Homemaker services are those general household activities such as meal preparation, laundry, vacuuming and routine household cleaning provided by a trained homemaker, when the person who usually, handles these tasks is unable to perform them. The intent of this service is to ensure that the recipient's home environment remains clean, safe, and sanitary.

Homemaker services are provided only when there is no one else capable of accomplishing the household tasks. A recipient shall receive no more than 40 units of this service per day. A unit is defined as a 15 minute time period or portion thereof. This service is normally provided one or two days a week for two to four hours at a time. Homemaker services cannot be used for supervision or personal care of a recipient....

Homemaker services are rendered only when the recipient is unable to manage the home, or the person who usually performs these tasks is absent for an extended period of time or unable to manage the home. A homemaker cannot provide hands on care to a recipient.

Developmental Services Waiver Services Florida Medicaid Coverage and Limitations Handbook, Personal Care Assistance, in part states:

Personal care assistance is a service that assists a recipient with eating and meal preparation, bathing, dressing, personal hygiene, and other self care activities of daily living. The service also includes activities such as assistance with meal preparation, bed making and vacuuming when these activities are essential to the health, safety and welfare of the recipient and when no one else is available to perform them. This service is provided on a one-on-one basis. Personal care assistance may not be used solely for supervision.

Personal care assistance services shall be billed at the standard rate level for the service based on the published rate system. The standard rate is paid when a recipient requires minimal support, through instructional prompts, cues, and supervision to properly complete the basic personal support areas of eating, bathing, toileting, grooming and personal hygiene. A rate other than the standard rate level for this service shall only be authorized when it has been determined through use of the Department approved assessment and the support planning process that an individual requires an enhanced level of supports....

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

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

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

The Findings of Fact show that the support plan stated that personal care assistance was being requested in part to help the petitioner separate and take his medication in the mornings and evenings. The documentation provided indicated that the petitioner was independent in bathing, eating and drinking, toileting, dressing himself and needed minimal assistance in his personal hygiene. The evidence presented did not show that the petitioner met the requirements to receive this service. Further, the Findings of Fact show that the petitioner is capable of performing

household tasks with little or no supervision and is capable of preparing his meals and cleaning his own home. The Agency determined that the homemaker services were not medically necessary to avoid or delay nursing home placement and that both personal care assistance and homemaker services were not justified. The hearing officer considered the above rules and regulations and has concluded that the respondent correctly terminated personal care assistance (PCA) services and denied Homemaker Services.

DECISION

The appeal is denied on both issues. The agency's action is affirmed.

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 19th day of October, 2006,

in Tallahassee, Florida.

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

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M. Catherine Lannon, Sr. Assistant Attorney General

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

APPEAL NO. 06F-05539

PETITIONER,

Vs.

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

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned-hearing officer on September 22, 2006, at 2:37 p.m., in Miami, Florida. The petitioner was not present. Representing the petitioner was Tanzenie Moore, manager, [redacted] Group Home. Present, on behalf of the petitioner were: Maria Dausa, support coordinator, Unike Support Services; Marlene Gusman, supervisor, Unike Support Services; and [redacted], mother/legal guardian. Representing the agency was Anne Blanford, assistant attorney general, Office of the Attorney General. Appearing as a witness for the agency was Dr. Bob Roberts, consultant reviewer, Maximus. Dr. Roberts appeared via telephone.

ISSUE

At issue is the agency's action of July 25, 2006, to approve with change residential habilitation standard service in the Home and Community-Based Waiver Services Program, due to lack of medical necessity. The petitioner has the burden of proof.

FINDINGS OF FACT

The petitioner is a 36 year-old developmentally disabled adult, approved to receive authorized services through the Home and Community-Based Services Medicaid Waiver Program. She currently resides in a licensed group home in Dade County Florida.

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

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

Maximus reviewed the petitioner's request for residential habilitation standard service in the amount of 350 days at the intensity of nine direct care staff hours per day.

On or about July 25, 2006, the agency notified the petitioner that residential habilitation standard service would be approved with change because there is no determination that the service(s) is medically necessary. The agency notes that the documents submitted for review do not offer evidence that any significant change has taken place in the petitioner's social, vocational, medical or behavioral conditions or circumstances to demonstrate the medical necessity for the increase in the intensity of service being requested. (Respondent Composite Exhibit 1)

At the hearing, the agency's witness from Maximus, Dr. Roberts, explained that in the prior cost plan year the petitioner was approved for 350 days of residential habilitation standard service at the intensity of six direct care staff hours per day. In this cost plan year the request was for nine hours, an increase of 50% in services for [redacted] Dr. Roberts stated that in the documents that were submitted there was no clear evidence to him that the petitioner was in need of additional residential habilitation services; however, he stated there is no doubt that the information provided shows the petitioner's need for additional behavioral intervention services. Dr. Roberts noted that even though 15 hours per week of behavior assistant services was recommended by the behavior analyst on May 23, 2006, none was requested by the support coordinator for the current cost plan.

The agency cited the Developmental Disabilities Waiver Services Florida Coverage and Limitations Handbook, making specific reference to page 2-66, which addresses residential habilitation services under limitation and states in part: "Children or adults whose primary problem is behavioral in nature, should receive services through the behavior assistance services."

The petitioner's representative purported that [redacted] current behavior is out of control. She claims that the petitioner's behavioral problems have worsened since the time the services were requested, and asked the respondent if she could submit a new Form 1 with additional information about her current condition.

Dr. Roberts recommended the support coordinator to submit a cost plan amendment to her current cost plan, and to request the services that are medically

necessary and that correspond to [redacted] needs. He advised her to read carefully the part of the Handbook that deals with behavior assistant services.

CONCLUSIONS OF LAW

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

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

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

> Developmental Services Waiver – General. This rule applies to all Developmental Services Waiver Services providers enrolled in the Medicaid program. All Developmental Services Waiver Services providers enrolled in the Medicaid program must comply with the Developmental Services Waiver Services Florida Medicaid Coverage and Limitations Handbook, October 2003...

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

Description .-
Residential habilitation provides supervision and specific training activities that assist the recipient to acquire, maintain or improve skills related to activities of daily living. The service focuses on personal hygiene skills such as bathing and oral hygiene; homemaking skills such as food preparation, vacuuming and laundry; and on social and adaptive skills that enable the recipient to reside in the community. This training is provided in accordance with a formal implementation plan, developed with direction from the recipient and reflects the recipient's goal(s) from their current support plan. Recipients with challenging behavioral disorders may require more intense levels of residential habilitation services described as behavioral residential habilitation, or intensive behavioral residential habilitation. The necessity for these services is determined by specific recipient behavioral characteristics that impact the immediate safety, health, progress and quality of life for the recipient, and the determination that less intensive services have not been sufficient to alter these behaviors. The need for more intense levels of residential habilitation, behavioral residential or intensive behavioral residential habilitation will be verified by the Developmental Disabilities Program Office. Note: Refer to special considerations under behavioral analysis and behavioral assistant services for additional requirements.

Limitations
Residential habilitation services are provided to adults, 18 years of age and older, living in their own home or family home, or living in a licensed facility...Children or adults whose primary problem is behavioral in nature, should receive services through the behavior assistance services.

As the Findings of Fact shows the petitioner requested residential habilitation standard services at an intensity of nine hours of direct care staff per day. The agency does not dispute the petitioner's need for residential habilitation services. The evidence shows that the petitioner is justified in receiving residential habilitation services, but not at the intensity requested. According to the information provided to the agency, medical necessity was demonstrated for six hours of direct care staff hours per day. The Findings of Fact further show that the petitioner has many behavioral problems that should be addressed by behavior assistant services.

After considering the evidence, the Florida Administrative Code and all of the appropriate authorities set forth in the findings above, the hearing officer finds the agency acted correctly in approving six hours of residential habilitation standard service per day for 350 days.

DECISION

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

JUDICIAL REVIEW

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

DONE and ORDERED this 11th day of October, 2006,

in Tallahassee, Florida.

Alfredo Fernandez Sr

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

Copies Furnished To:

Gail Scott Hill
M. Catherine Lannon, Sr. Assistant Attorney General
Hilda Fluriach

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

APPEAL NO. 06F-04942

PETITIONER,

Vs.

CASE NO.

AGENCY FOR PERSONS WITH DISABILITIES
DISTRICT: 14 Polk
UNIT: APD

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on September 8, 2006, at 9:36 a.m., in Lakeland, Florida. The petitioner was present and represented himself. The agency was represented by Allison Becker, assistant attorney general. Present as a witness for the petitioner was Walter Hayward, in home support provider. Present as a witness for the agency was Connie Miller, program administrator.

ISSUE

At issue is the June 8, 2006 action by the agency reducing the petitioner's transportation and Adult Day Training services.

FINDINGS OF FACT

The petitioner is 33 years old and receives benefits through the Developmental Disabilities Home and Community-Based Services Waiver Program (DD-HCBS). His waiver support coordinator submitted his cost plan for review for the period of May 1, 2006 through April 30, 2007. The Department contracts with Maximus to perform Prior Service Authorization (PSA) reviews on certain requested services, or when the cost on a support plan exceeds certain levels. The PSA unit reviews these requests to determine if the service(s) meets the established criteria for medical necessity.

On April 25, 2006, Maximus requested further information from the petitioner. They requested a copy of the mental health assessment by a psychiatrist, psychologist, or other mental health professional; a summary of progress towards meeting the Mental Health Services Treatment Plan goal(s) and the continued benefits of providing this service; and a copy of the Mental Heath Treatment Plan. The deadline to return the information was May 9, 2006. The petitioner did not return the requested information.

On May 25, 2006, Maximus approved portions of the petitioner's cost plan, denied two services, and reduced another. They denied the petitioner's request for 5760 quarter hours of Adult Day Training Services at a 1:1 ratio. They approved him for 5760 quarter hours of Adult Day Training Services at a 1:5 ratio. They terminated his Specialized Mental Health Therapy Services. Since his Specialized Mental Health Therapy Services were terminated, Maximus denied transportation services hours that were to transport him for this service. They approved the transportation services hours to transport him to Adult Day Training.

The petitioner needs assistance in transferring himself from his wheelchair to the shower chair and bed, and putting his pants on. On July 21, 2003, the petitioner was ordered to serve two years of community control and 10 years of probation. The court order specifies that due to past criminal actions, he cannot have "contact with children, or with disabled adults. He is approved for Adult Day Training activities only if there is a 1:1 supervision by program officials at all times." The petitioner is not allowed by the court to participate in Adult Day Training (ADT) activities with a lesser ratio of supervision.

Maximus determined that the petitioner did not demonstrate "medical necessity" for a 1:1 ratio of ADT since he did not have a behavioral services plan to be implemented by the ADT provider. This plan would be developed by a certified behavior analyst, implemented and tracked by the ADT provider, and approved by the District Local Review Committee. The petitioner did not submit a behavior services plan and did not submit a description of his problem behaviors. Furthermore, nothing was submitted to the District Local Review Committee for review. Services must be reflective of the level of services that can safely be furnished and not in excess of the individuals needs. Therefore, Maximus determined that the petitioner met "medical necessity" for a 1:5 ratio.

The petitioner filed for a reconsideration of the lowering of the intensity level of the Adult Day Training to a 1:5 ratio and the reduction in transportation hours. He did not file for a reconsideration of the denial of Specialized Mental Health Therapy services. He did not request an appeal on the denial of Specialized Mental Health Therapy Services.

On July 17, 2006, the reconsideration reviewer upheld the decisions regarding Adult Day Training staff ratio and the reduction in transportation hours. The reviewer noted the requirement that a 1:1 ratio of Adult Day Training requires a behavioral services

plan approved by a local review committee. The reviewer upheld the approval of transportation service hours for Adult Training only.

CONCLUSIONS OF LAW

Fla. Admin. Code 59G-13.080 establishes:

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

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

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

The Florida Administrative Code at 59G-1.010 (166) defines medically necessary follows:

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

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

The DS/HCBS Waiver Service Limitation and Rate Consideration Checklist dated July 10, 2003 discusses the ratio of staff to customers and states in relevant part:

Adult Day Training is a service which presumes that there is a standard ratio between the number of staff and the number of clients that is typical in the community of providers of this service. This differs from other stepped rates wherein there is an assumption that the likelihood of any of the staff to client ratios is the same. For Adult Day Training, the standard rate is that for any ratio between 1 – 6 and 1 – 10.

The items of information that will be needed to select the appropriate rate for the client are the following:

- Will the service be performed in a zip code that would make it eligible for a geographic factor differential?
- Will the client be attending for a full day (six hours) or for a portion of the day?
- How many clients are simultaneously receiving the service from the same staff person (ratio)?

1 staff to 5 consumers:

- A moderate level of *personal care support services (to include such areas as specialized eating techniques and positioning needs) as indicated on a department approved assessment; OR
- A recipient who is on a behavioral services plan that is implemented by the Adult Day Training provider, and who requires consistent visual supervision hours and occasional intervention as determined by a Certified Behavioral Analyst. The individual does not exhibit the characteristics required for a behavioral residential habilitation service. (The recipient does not have to live in a licensed residential

facility.)

1 staff to 3 consumers:

- An intense level of *personal care support services (to include such areas as specialized eating techniques and positioning needs) as indicated on a department approved assessment; OR
- A recipient who is on a behavioral services plan that is implemented by the Adult Day Training provider, and who exhibits the characteristics required for behavioral residential habilitation services as determined by a Certified behavioral Analyst, (The recipient does not have to live in a licensed residential facility.)"

1 staff to 1 consumer:

- A recipient who is on a behavioral services plan that is implemented by the Adult Day Training provider, and who exhibits the characteristics required for behavioral residential habilitation services or intensive behavioral residential habilitation services as determined by a Cerfified Behavior Analyst. The need for this level of supervision must be verified in writing by the district Local Review Committee Chair. (The recipient does not have to live in a licensed residential facility.)

The Findings of Fact show that the petitioner requested that the staffing ratio for the Adult Training Program remain at 1:1 for the cost plan at issue. The cost plan was reviewed by Maximus to see if the services met the "medical necessity criteria." It is not in dispute that the petitioner failed to submit proof of a behavioral services plan that was approved by the LRC justifying an intensive 1:1 staff ratio. The policy handbook lays out specific requirements in order to receive 1:1 staffing ration for Adult Day Training. The petitioner did not follow through on these requirements. It should be further noted that both the times the petitioner was informed in writing of the denial, the petitioner was informed of these requirements. Although, the petitioner has probationary requirements that require a 1:1 ratio if he is to attend an Adult Day Training Program, a court order alone does not meet the medical necessity requirements for the services to paid by the

waiver program. Therefore, the hearing officer concludes that the agency correctly established the staffing ratio at 1:5 based on the documented medical necessity.

The Developmental Services Waiver Services Florida Medicaid Coverage and Limitations Handbook states in relevant part regarding Transportation Services on page 2 -111:

> Transportation
> Description
> Transportation services are the provision of rides to and from the recipient's home and their community-based waiver services, enabling the recipient to receive the supports and services identified on both their support plan and approved cost plan, when such services cannot be accessed through natural (i.e., unpaid) supports.

The Findings of Fact show that the agency reduced the petitioner's transportation service hours that were allotted to transport him to Specialist Mental Health Therapy. According to the above cited policy, transportation services are approved only for approved services on the cost plan. Therefore, the department correctly denied this service.

DECISION

The appeal is denied.

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 25th day of October, 2006,

in Tallahassee, Florida.

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

Copies Furnished

M. Catherine Lannon, Sr. Assistant Attorney General
Jerome Major, District legal counsel

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

APPEAL NO. 06F-03120

PETITIONER,

Vs.

CASE NO.

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

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned-hearing officer on August 31, 2006, at 2:55 p.m., in Orlando, Florida. The petitioner did not appear. Rick Culbertson, attorney ad litem, appeared and represented the petitioner. Raushanah Ricks, adoptions counselor with Kids Hope United, appeared as a witness for the petitioner. Kimah Burrell, adoptions counselor with Kids Hope United, appeared as an observer of the proceeding.

Stacy Robinson, senior attorney with the Department of Children and Families (DCF), appeared and represented the Agency for Persons with Disabilities (APD). Dr. Cydney Yerushalmi, senior psychologist (APD), and Margarita O'Ferral, senior human services counselor supervisor, appeared as witnesses for the agency.

ISSUE

At issue is the agency's action of February 15, 2006, denying the petitioner's application for eligibility in the Home and Community-Based Services Waiver program due to not having a qualifying disability. The petitioner bears the burden of proof in this appeal.

FINDINGS OF FACT

The petitioner is a fifteen-year old young man currently under the care and supervision of the Department and Children and Families Foster Care Program. He resides in a therapeutic foster care home. The petitioner's case manager from Kids Hope United was made aware of the difficulties the petitioner experiences in the areas of intellect, academics, behavior, and self-care. His foster mother expressed her concerns to the case manager as well about his lack of abilities in various areas. Because of this, the case manager referred the petitioner to Star Consultants in 2005 for a complete psychological evaluation (Petitioner's Exhibit 2).

On June 14, 2005, a psychologist from Star Consultants, Dr. Terry Mattingly, conducted an examination of the petitioner. The results of this exam yielded the following diagnoses: Schizoaffective Disorder, Oppositional Defiant Disorder, and Mild Mental Retardation. The psychologist administered an intelligence test and an adaptive behavior test. The psychologist tested the petitioner with the Wechsler Intelligence Scale for Children and his full-scale intelligence score was 50 (Petitioner's Exhibit 2). The Vineland Adaptive Behavior Scale was also administered with the petitioner's foster care mother.

This test assesses an individual's abilities in the areas of daily living skills (eating, dressing, hygiene, etc.) and socialization. The petitioner scored in the Very Low range which indicated significantly subaverage functioning for his age (Petitioner's Exhibit 2). The combination of these two test scores provided the basis for the psychologist's diagnosis of Mild Mental Retardation.

The petitioner's case manager decided to seek help from the Agency for Persons with Disabilities (APD) with the belief that the petitioner was developmentally disabled. The case manager submitted supporting documentation, including the 2005 evaluation, along with the application for placement into the Home and Community-Based Services Waiver program. The petitioner applied based on the diagnosis of mental retardation.

The agency received the application and assigned it to its senior psychologist, Dr. Cydney Yerushalmi. Dr. Yerushalmi, an expert in the field of psychology, reviewed all of the documentation submitted with the application. She also met with the petitioner and conducted her own independent psychological evaluation with him. Because the petitioner had been somewhat recently tested with the Weschler Intelligence Scale for Children (within the prior year – 2005), she decided to use the Stanford-Binet Intelligence Scale (Respondent's Exhibit 2). The petitioner scored a full-scale score of 70 on this exam. Dr. Yerushalmi listed on her report a history of the petitioner's scoring on previous intelligence tests which included the years 1999, 2000, 2001, 2002, 2003, and 2005. This list showed the petitioner receiving full-scale I.Q. scores ranging from 50 to 75 (Respondent's Exhibit 2).

Based on the petitioner's test score on the Stanford-Binet and in consideration of the great variance in scores on previous tests, Dr. Yerushalmi decided that she did not need to conduct another Vineland Adaptive Behavior Scale test. She opined that the petitioner was not mentally retarded but suffered from a learning disability and emotional and behavioral disorders (Respondent's Exhibit 2). She denied his eligibility for services through the waiver program due to lack of having the developmental disability of mental retardation. The agency issued its notice to the petitioner and his representative informing them of this denial on February 15, 2006 (Respondent's Exhibit 1).

At the hearing, the petitioner stated that his low level of adaptive skills along with the consistently low I.Q. score render him mentally retarded. He is medically challenged and is a current patient under the purview of Children's Medical Services (CMS) which specializes in children with complex medical issues. He wears diapers, is constantly irritable, and is unable to care for himself without prompting. He has poor personal hygiene and is delayed in his gross motor skills. His school has crafted an Individualized Education Plan for him and has him in special education classes. He is speech-impaired and needs constant supervision. Without services provided under the waiver program, once he turns eighteen he will be out on the streets unable to care for himself.

The agency stated, through its witness Dr. Yerushalmi, that the petitioner is capable of learning. The wide range of I.Q. scores received on the tests previously administered, along with the current score of 70, shows that the results are unreliable. Variance in scores affects reliability and that is what has

occurred in this case. Variance in scores also means that the individual has other issues going on such as mental health concerns and learning disabilities. Because his score was 70, an adaptive assessment wasn't necessary. Even though the petitioner's last adaptive functional assessment was low enough to possibly show him developmentally disabled, the petitioner's needs in this area could actually be met with the services of a behavior analyst who could teach him daily living skills. If the family could secure the services of a behavior analyst, the petitioner's needs could be met.

CONCLUSIONS OF LAW

Fla. Admin. Code 59G-13.080 establishes:

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

The above-cited authority establishes the agency's ability to administer the waiver program under which the petitioner is seeking services.

Fla. Stat. § 393.063 states in relevant part:

> Definitions...For the purposes of this chapter: ...(38) "Retardation" means significantly subaverage general intellectual functioning existing concurrently with deficits in adaptive behavior and manifested during the period from conception to age 18. "Significantly subaverage general intellectual functioning," for the purpose of this definition, means performance which is two or more standard deviations from the mean score on a standardized

> intelligence test specified in the rules of the agency. "Adaptive behavior," for the purpose of this definition, means the effectiveness or degree with which an individual meets the standards of personal independence and social responsibility expected of his or her age, cultural group, and community.

In this case, the petitioner scored exactly two standard deviations below the mean on the test administered by the agency. The 2005 evaluation shows that the petitioner scored even lower. Based on this criterion alone, the petitioner appears to meet the definition of mental retardation. However, the statute goes on to say that there is another part to the equation of finding an individual retarded and that part is the criterion of deficit adaptive behaviors. The 2005 test shows that the petitioner meets this criterion as well. However, a current adaptive assessment was not completed by the agency's expert because of the great degree of variance amongst the I.Q. scores.

Fla. Admin. Code 65B-4.033 establishes:

> Intelligence Tests to be Administered. (1) For the purposes of Chapters 393 and 916, F.S., the Stanford-Binet Intelligence Scale or the Wechsler Adult & Infant Intelligence Scale, administered by or under the direct supervision of a psychologist or school psychologist licensed under Chapter 490, F.S., shall be used to determine mental retardation and the level of intellectual functioning. **(2) Notwithstanding subsection (1), if, given the condition of the individual to be tested, the Stanford-Binet Intelligence Scale or the Wechsler Adult & Infant Intelligence Scale are not valid and reliable as determined by the person authorized to administer such tests as specified in subsection (1), an alternative test or evaluation procedure, administered and interpreted in conformance with instructions provided by the producer of the tests or evaluation materials, may be used. The results of the testing or evaluation must include reference to published validity and reliability data for the specified test or evaluation procedure.** [emphasis added]

This rule states that when a score is not reliable, such as a large variance in scores which is the case here, the agency has the option of administering another alternative test. This option was not exercised in this case.

The Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV-TR) states in relevant part:

> Diagnostic Features...The essential feature of Mental Retardation is significantly subaverage general intellectual functioning (Criterion A) that is accompanied by significant limitations in adaptive functioning in at least two of the following skill areas: communication, self-care, home living, social/interpersonal skills, use of community resources, self-direction, functional academic skills, work, leisure, health, and safety (Criterion B). The onset must occur before age 18 years (Criterion C)...General intellectual functioning is defined by the intelligence quotient (IQ or IQ-equivalent) obtained by assessment with one or more of the standardized, individually administered intelligence tests (e.g. Wechsler Intelligence Scales for Children, 3rd edition; Stanford-Binet, 4th edition; Kaufman Assessment Battery for Children). Significantly subaverage intellectual functioning is defined as an IQ of about 70 or below (approximately two standard deviations below the mean). It should be noted that there is a measurement error of approximately 5 points in assessing IQ, although this may vary from instrument to instrument (e.g., a Wechsler IQ of 70 is considered to represent a range of 65-75). Thus, it is possible to diagnose Mental Retardation in individuals with IQs between 70 and 75 who exhibit significant deficits in adaptive behavior. Conversely, Mental Retardation would not be diagnosed in an individual with an IQ lower than 70 if there are no significant deficits or impairments in adaptive functioning...When there is significant scatter in the subtest scores, the profile of strengths and weaknesses, rather than the mathematically derived full-scale IQ, will more accurately reflect the person's learning abilities. When there is a marked discrepancy across verbal and performance scores, averaging to obtain a full-scale IQ score can be misleading. **Impairments in adaptive functioning, rather than a low IQ, are usually the presenting symptoms in individuals with Mental Retardation.** [emphasis added]. Adaptive functioning refers to how effectively individuals cope with common life demands and how well they meet the standards of personal independence expected of someone in their particular age group, sociocultural background, and

community setting...

There is evidence in this case that shows the petitioner to have below average adaptive functioning. The 2005 Vineland assessment shows that he is deficient in significant areas. The above-cited authority states that an individual who is mentally retarded likely has a low I.Q., but the main symptoms are exhibited by deficient adaptive functioning.

Based on the evidence and testimony presented, the hearing officer concludes that the petitioner meets the statutorily-enacted definition of mentally retarded. This is based on the previous Vineland assessment with his caretaker along with the history of scores on prior I.Q. tests, as well as the most recent exam. Together, these factors cause the petitioner to fall within the required parameters of the statute's scoring requirement for eligibility under the waiver.

DECISION

The appeal is granted. The agency is ordered to approve the petitioner's eligibility for services through the waiver based on the developmental disability of mental retardation.

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 10th day of October, 2006,

in Tallahassee, Florida.

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

Copies Furnished T

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

APPEAL NO. 06F-04862

PETITIONER,

Vs.

AGENCY FOR PERSONS
WITH DISABILITIES
DISTRICT: 15 St. Lucie
UNIT: APD

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on September 26, 2006, at 9:10 a.m., in Fort Pierce, Florida. The petitioner was present. She was represented by her mother, [redacted] and support coordinator, Ardella Alberts. Jeff Mahl, attorney, Office of the Attorney General, represented the Agency for Persons with Disabilities (APD). Cordroy V. Charles, human service program analyst, APD, was present as a witness for the respondent. Appearing by telephone as a witness for APD was Chun Hee Youn, consultant reviewer, prior service authorization unit, Maximus. Cheryl Starkgraf, notary, was present as Ms. Youn took the oath.

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

ISSUE

At issue is the action taken by the respondent to approve with changes the petitioner's request for environmental accessibility adaptations.

FINDINGS OF FACT

The petitioner is 26 years old and receives services from the Agency for Persons with Disabilities Medicaid Waiver Program, formerly known as the Developmental Disabilities Home and Community Based Services Medicaid Waiver Program. An amendment to the petitioner's cost plan was submitted requesting environmental accessibility adaptations in the amount of $19,850.00. The agency conducted a prior service authorization review of the request. The proposed adaptation includes removing an existing shower stall, toilet, wall hangings, floor coverings, wall, and sewer line, and constructing a new bathing area with a new wall, water line, shower floor area, and the installation of an institutional bath system with whirlpool, grab bars, walls, bi-fold doors, toilet, and drop down grab bars (Respondent's Exhibit 1).

The request for the environmental accessibility adaptations was reviewed by a consultant reviewer, peer reviewer, and physician from Maximus, the contracted agency that performs the prior service authorization reviews for APD. They believed that the petitioner lived in a rental property because she had a lease, and according to the Florida Medicaid Developmental Disabilities Coverage and Limitations Handbook, environmental accessibility adaptations in a rental property are limited to under $3500. The requested institutional bath system with a whirlpool tub is specifically excluded by the waiver according to Ms. Youn. Because of the service limitation and exclusion on the type of bathing system requested, and because rental property is limited to minor

adaptations under $3500, the reconsideration request was denied and the initial denial was upheld (Joint Exhibit 1). The agency approved $3499 of environmental accessibility adaptations due to a service limitation for rental property.

Ms. [illegible] resides in a mother-in-law apartment which is attached to her family home. She has had ownership interest in the home since 1998 (Petitioner's Exhibit 5). The petitioner's representative believes that Ms. [illegible] is entitled to more than the $3500 minor adaptations because she is a joint homeowner, not a renter. She presented her as a renter when securing in home supports to show her independence. She further believes that the type of bathing system they are requesting is medically necessary, not for recreational purposes. The requested system is a whirlpool bathing system with a swing open door and will allow the petitioner to meet her bathing needs adequately and safely (Petitioner's Composite Exhibit 3).

CONCLUSIONS OF LAW

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

> (1) Purpose. Under authority of section 2176 of Public Law 97-35, Florida obtained waivers of federal Medicaid requirements to enable the provision of specified home and community-based (HCB) services to persons at risk of institutionalization. Through the administration of several different federal waivers, Medicaid reimburses enrolled providers for services that eligible recipients may need to avoid institutionalization. Waiver program participants must meet institutional level of care requirements. The HCB waiver services are designed to allow the recipients to remain at home or in a home-like setting. To meet federal requirements, Medicaid must demonstrate each waiver's cost-effectiveness...
> (5) Service Limitations – General. The following general limitations and restrictions apply to all home and community-based services waiver programs: (a) Covered services are available to eligible waiver program participants only if the services are part of a waiver plan of care ("care

plan", "individual support plan", or "family support plan"). Care plan requirements are outlined in subsections (6) and (8) of this rule. (b) The agency or its designee shall approve plans of care based on budgetary restrictions, the recipient's necessity for the services, and appropriateness of the service in relation to the recipient, prior to their implementation for any waiver recipient...(6) Program Requirements- General. All HCB services waiver providers and their billing agents must comply with the provisions of the Florida Medicaid Provider Reimbursement Handbook. Non-Institutional 081, October 2003, which is incorporated by reference and available from the Medicaid fiscal agent. The following requirements are applicable to all HCB services waiver programs:...(f) The plan of care will identify the type of services to be provided, the amount, frequency, and duration of each service, and the type provider to furnish service... (12) Developmental Services Waiver – General. This rule applies to all Developmental Services Waiver Services providers enrolled in the Medicaid program. All Developmental Services Waiver Services providers enrolled in the Medicaid program must comply with the Developmental Services Waiver Services Florida Medicaid Coverage and Limitations Handbook, October 2003, incorporated by reference, and the Florida Medicaid Provider Reimbursement Handbook, Non-Institutional 081, October 2003. Both handbooks are available from the Medicaid fiscal agent. The Developmental Disabilities Waiver Services Provider Rate Table, November 2003, is incorporated by reference. The Developmental Disabilities Waiver Services Provider Rate Table is available from the Medicaid fiscal agent.

The Developmental Services Waiver Services Florida Medicaid Coverage and Limitations Handbook, June 2005, ch. 2 states in relevant part:

Environmental accessibility adaptations (EAA) are those physical adaptations to the home, required by the recipient's support plan, which are "medically necessary" to avoid institutional placement of the recipient and enable him to function with greater independence in the home. A Home Accessibility Assessment is an independent assessment by a professional rehabilitation engineer or other specially trained and certified professional to determine the most cost-beneficial and appropriate accessibility adaptations for a recipient's home...

Limitations
Environmental accessibility adaptation services are limited to the amount, duration and scope of the adaptation project described on the recipient's support plan and current approved cost plan. If multiple vendors are enrolled to provide this service, the recipient shall be encouraged to select

from among the eligible vendors based on availability, quality of workmanship, and best price.
Environmental accessibility adaptations covered under this waiver includes the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities or installation of specialized electric and plumbing systems required to accommodate the medical equipment and supplies, which are necessary for the welfare of the recipient.
Excluded are those adaptations or improvements to the home, which are of general utility and are not of direct medical or remedial benefit to the recipient, such as carpeting, roof repair, central air conditioning, etc.
Environmental accessibility adaptations (EAA) are approved when they are medically necessary. The Department must approve exceptions. To submit an exception request, the appropriate professional must complete an assessment documenting how the specific EAA is medically necessary, how it's directly related to the recipient's developmental disability, how it's directly related to accessibility issues within the home, and how, without the selected EAA, the recipient can not continue to reside in his current residence. The request will be reviewed by an appropriate, qualified professional to determine whether the standards for medical necessity set forth in Chapter 59G-1.010 (166), F.A.C., are met and to determine whether the requested item fairly meets the service definition. The Developmental Disabilities Medical Director shall also review the request, for the same purpose. This additional review will typically only be necessary if the District does not have an appropriate physician available to review the request. A recommendation will be made to the District for approval or denial.
Environmental accessibility adaptations include only adaptations to an existing structure, and must be provided in accordance with applicable state or local building codes. Adaptations, which add to the total square footage of the home, are excluded from this benefit.

SpecialConsiderations
Environmental accessibility adaptations shall be determined "medically necessary" before approved. This determination includes the following considerations:
• There are no less costly or conservative means to meet the recipient's need for accessibility within the home;
• The environmental accessibility adaptation is individualized, specific and consistent with the recipient's needs and not in excess of his needs; and,
• The environmental accessibility adaptation enables the recipient to function with greater independence in the home, and without which, the recipient would require institutionalization.

Environmental accessibility adaptations shall be approved for a recipient's own home or family home whether owned or leased, as needed, to make the home accessible to the recipient. No more than five units shall be billed per day. Once adaptations are made to a recipient's residence, adaptation to another residence cannot be made until five years after the last adaptation to the first residence except for extenuating circumstances, such as total loss of residence. The waiver program does not cover routine repairs to the existing EAA or general repairs to the home or residence. The waiver program cannot be used to fund corrections to any existing code violation(s) to the home.
If a recipient or family builds a home while the recipient is receiving waiver services, major or structural changes will not be covered. Environmental accessibility adaptations covered under these circumstances: the difference in the cost, if any, between a handicapped-accessible bathroom and a standard bathroom. However, the cost difference for each item and adaptation will have to be documented, with total cost not exceeding $3,500.
Rental property is limited to minor adaptations as defined below... Environmental accessibility adaptations shall be separated into two categories. Minor adaptations shall be defined as those EAA costing under $3,500 for all adaptations in the home. Major adaptations shall include those adaptations to a home when the total cost is $3,500 and over. Total EAA cannot exceed $20,000 during a five-year period. Major environmental accessibility adaptations require the assessment of a rehabilitation engineer or other professional qualified to make a home accessibility assessment. This home accessibility assessment shall include evaluation of the current home and describe the most cost beneficial manner to permit accessibility of the home for the recipient on the waiver...Examples of items not covered include replacement of carpeting and other floor coverings, roof repair, driveways, decks, patios, fences, swimming pools, **spas or hot tubs**, sheds, sidewalks, central heating and air conditioning, raised garage doors, storage (i.e., cabinets, shelving, closets), standard home fixtures (i.e., sinks, commodes, tub, stove, refrigerator, microwave, dishwasher, clothes washer and dryer, wall, window and door coverings, etc.), furnishings (i.e., furniture, appliances, bedding) and other non-custom items which may routinely be found in a home. Also, specifically excluded are any adaptations that will add square footage to the home.

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

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

includes definitions of services, specific requirements, and limitations on those services. The information that Maximus reviewed indicated that the petitioner was a renter, not the property owner. The bathing system the petitioner is requesting provides whirlpool action. It is a specifically excluded item according to the limitations listed above. The hearing officer affirms the agency's denial of the whirlpool type tub requested due to the exclusion in the handbook. However, at the hearing, the petitioner was able to show ownership interest in the property where she resides. It is therefore concluded that the $3500 limit for renters for minor adaptations does not apply here. Therefore, the hearing officer concludes that the agency erred when it limited the request due to a service limitation for rental property. The petitioner has ownership interest in the home and the agency is to apply the above authorities in determining the medically necessary

environmental adaptations to avoid institutional placement of the recipient, considering her an owner.

DECISION

The appeal is partially denied and granted. The appeal is denied in that the denial of the whirlpool type tub is affirmed. The appeal is granted in that the reduced approved amount of $3500 for environmental accessibility adaptations is hereby reversed as stated in the above conclusions.

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 9th day of November, 2006, in Tallahassee, Florida.

Margaret Poplin

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

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

APPEAL NO. 06F-04426

PETITIONER,

Vs.

CASE NO. 1170734189

FLORIDA DEPARTMENT OF
CHILDREN AND FAMILIES
DISTRICT: 04 Duval
UNIT: 88265

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on September 29, 2006, at 10:00 a.m., in Jacksonville, Florida. The petitioner was not present. However, she was represented by her son and Power of Attorney, [redacted], Esq. The department was represented by Robin Whipple-Hunter, attorney with the Department of Children and Families. Rycha Redden, economic services self-sufficiency specialist supervisor and Viola Dickinson, economic services self-sufficiency specialist appeared as witnesses for the department.

ISSUE

At issue is the department's action of June 26, 2006 to deny Institutional Care Program (ICP) Medicaid benefits for February, March and April 2006, due to failure to verify unearned income and excess income.

FINDINGS OF FACT

The petitioner applied for ICP in May 2005. A qualified income trust was set up and the petitioner was approved for ICP Medicaid. The petitioner receives income from a Civil Service Pension, the VA and social security. Based on the income the petitioner was receiving at the time of the approval, the income trust had to be funded with approximately $1000 a month to maintain ICP Medicaid eligibility.

In January 2006, the petitioner's income was increased to $2870, which consisted of $1094 civil service pension, $1155 in VA benefits and $621 in social security benefits. The petitioner's income was not disputed. Since the income limit for the ICP program was $1809, the petitioner would have had to fund the income trust with at least $1061 a month to continue to be eligible for ICP Medicaid benefits. All parties acknowledged at the hearing that during the months of February, March and April 2006 the income trust had not been properly funded and as a result, the petitioner's income was over the ICP Medicaid income limit of $1809. Both parties records showed for February 2006, $1000 of the petitioner's income was put into the trust, for March 2006, $900 was put in the trust and for April 2006, $900 of the petitioner's income was deposited into the trust.

On May 15, 2006, the department's representative sent the petitioner a recertification letter, requesting that the petitioner provide a completed interim contact

form along with verification of gross income and balances of all assets and the last eight months of bank statements for the qualified income trust, by June 15, 2006. This letter was mailed to the petitioner's last reported address. The petitioner had since moved from this address. As such, the petitioner's representative found out about the department's request for information from the nursing home. The department received the Interim Contact form, which also serves as an application on June 13, 2006, but all of the income verification was not received.

On June 26, 2006, the department notified the petitioner that ICP Medicaid was terminated due to failure to verify income from VA and Civil Service and failure to properly fund the income trust for the months of January 2006 through May 2006. It was clarified at the hearing that the petitioner had subsequently achieved ICP Medicaid eligibility for January and May 2006.

The petitioner's representative argued that he was not aware of the amount of the income increases since he only received the bank account statements for his mother. The petitioner's representative also noted that the petitioner is 90 years old and has moved several times in the last few months so there has been a problem keeping up with all of her mail. The petitioner's representative also acknowledged that he moved and failed to properly report his address change to the department.

CONCLUSIONS OF LAW

Pursuant to The Florida Administrative Code **65A-1.713 SSI-Related Medicaid Income Eligibility Criteria**. which 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 Rule 65A-1.713(2), F.A.C. Individuals with income over this limit may qualify for institutional care services by establishing an income trust which meets criteria set forth in Rule 65A-1.702(13)(a), F.A.C."

The department's Integrated Policy Manual 165-22, Appendix A-9, sets forth the income limit for an individual for ICP as $1809 effective July 2006. The department's Policy Transmittal P-05-11-0037 dated November 20, 2005 also establishes the ICP income standard for an individual at $1809 effective January 2006.

The department's Integrated Policy Manual 165-22, Section 1840.0110, Income Trusts (MSSI), states in part:

> The individual (or their legally authorized representative) must deposit sufficient income into the income trust account in the month in which the income is received to reduce their countable income (the income outside the trust) to within the program income standard. **The individual must make the deposit each month that eligibility is requested**.

The findings show the petitioner was approved for ICP Medicaid benefits from a May 2005 application. On May 15, 2006 the department sent the petitioner a redetermination letter requesting verification of income and the last eight months of bank statements from the qualified income trust be submitted by June 15, 2006. When all of the requested information was not received on June 26, 2006, the department notified the petitioner that ICP Medicaid was terminated effective June 30, 2006 due to failure to verify income from VA and Civil Service and failure to properly fund a qualified income trust from January 2006 through May 2006.

The petitioner's eligibility for January 2006 and May 2006 were not an issue at the hearing. It was undisputed that the petitioner had not provided the requested income verification by the deadline date of June 15, 2006. The department and the

petitioner's records showed that during the months of February, March and April 2006 the petitioner's income exceeded the ICP Medicaid income limit of $1809 because the petitioner's income trust had not been properly funded. The petitioner's total gross income of $2870 was not disputed.

Both parties' records showed for February 2006, $1000, of the petitioner's income was put into the trust, for March 2006, $900 was put in the trust and for April 2006, $900 of the petitioner's income was deposited into the trust. Since these deposits did not reduce the petitioner's monthly income below the income limit of $1809, the department's action to deny ICP Medicaid for February 2006 through April 2006 is a correct action that is consistent with the above cited authority.

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 30th day of October, 2006,

in Tallahassee, Florida.

James Abdur-Rahman

James Abdur-Rahman
Hearing Officer
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Tallahassee, FL 32399-0700
850-488-1429

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

APPEAL NO. 06F-06098

PETITIONER,

Vs.

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

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on October 26, 2006, at 2:54 p.m., in New Port Richey, Florida. The petitioner was present. He was represented by his parents, [redacted] The Agency was represented by Sherran Alferi, supervisor.

ISSUE

The petitioner is appealing the notice of September 5, 2006 for the respondent's action to deny 336 hours of private duty nursing for the service period of August 31, 2006 through October 29, 2006.

FINDINGS OF FACT

The petitioner was receiving private duty nursing. For the service period of August 31, 2006 through October 29, 2006 the provider on behalf of the petitioner applied for 336 hours of private duty nursing. Prior authorization for private duty nursing is done by KePRO. On September 5, 2006, KePRO denied 336 hours of private duty nursing.

October 16, 2006, the undersigned hearing officer received, from the respondent, a motion to dismiss the fair hearing. The respondent notified that hearing officer that KePRO overturned their decision. The respondent authorized the 336 hours of private duty nursing, as requested by the petitioner for the service period of August 31, 2006 through October 29, 2006. The respondent, having overturned the denial for the petitioners' private duty nursing upon reconsideration, had in essence granted the petitioner's full request for private nursing hours. Therefore, since the petitioner was receiving the service that was requested, the issue was moot and there were no further remedies that could be provided by the hearing process.

The hearing on the motion was held on October 26, 2006. As of the hearing, the petitioner was authorized by the respondent for the service of private duty nursing as requested, 336 hours of private duty nursing for the service period of August 31, 2006 through October 29, 2006. A PDN/PC Recipient Reconsideration - Denial Overturned notice was sent to the petitioner on October 10, 2006. With the private duty nursing services at the level requested by the petitioner, no further remedy for that denial could be made by the hearing

officer. There is nothing further that this hearing officer can order. Therefore, the motion to dismiss was granted since there is no action, reduction or denial of action that is contrary to the petitioner requests. As set forth in this order, the appeal is dismissed.

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 7th day of November 2006,

in Tallahassee, Florida.

Linda Jo Nicholson

Linda Jo Nicholson
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STATE OF FLORIDA
DEPARTMENT OF CHILDREN AND FAMILIES
OFFICE OF APPEAL HEARINGS

APPEAL NO. 06F-04237

PETITIONER,

Vs.

CASE NO. 1240180136

FLORIDA DEPT OF
CHILDREN AND FAMILIES
DISTRICT: 09 Palm Beach
UNIT: 88322

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on August 8, 2006. The petitioner was represented by Noreen Wiscovitch, attorney. The department requested a continuance. It was granted and the hearing was reconvened on September 7, 2006, at 9:30 a.m., in Riviera Beach, Florida. The petitioner was not present. She was represented by Noreen Wiscovitch, attorney. Doris Gibb, legal assistant, and Pat McCarthy, RN, were present as witnesses for the petitioner. Mildred Talbert, economic specialist II, represented the department.

ISSUE

At issue is whether the department correctly denied the petitioner's application for Institutional Care Program Medicaid based on the contention that she did not meet the disability requirements. The petitioner holds the burden of proof in this matter.

FINDINGS OF FACT

On March 23, 2006, an application for Institutional Care Program Medicaid (ICP) was submitted to the department on the petitioner's behalf. Retroactive Medicaid was requested for December 2005, January and February 2006.

The petitioner's date birth is [redacted] Because the petitioner was under 65 years of age, she did not meet the aged criteria for Medicaid benefits. Because she was not yet 65 years old or determined disabled by the Social Security Administration, the District Medical Review Team (DMRT) was required to make a disability determination. The petitioner applied for Social Security Disability Income (SSDI) benefits in August 2006; a decision had not been rendered at the time of this hearing. Medical information was gathered and submitted to the District Medical Review Team for review. They determined that she did not meet the disability requirement. They concluded that her impairment was not going to be disabling for a full 12 months (Petitioner's Exhibit 2). Because the petitioner was not considered disabled, the department denied the petitioner's application for ICP on May 14, 2006 (Respondent's Exhibit 1).

Prior to the petitioner's admission on December 19, 2005, to the nursing facility where she resides, she was hospitalized for respiratory arrest. She suffers from among other impairments, severe rheumatoid arthritis (RA), chronic liver disease, and chronic obstructive pulmonary disease (COPD). She has a history of alcoholism. She was hospitalized in October, November, and December 2005 for episodes of respiratory failure. She was bed bound upon her arrival at the nursing facility, but is now able to transfer with direct assistance. She does not walk because of the deformities of her feet

from the rheumatoid arthritis and is not able to dress or bathe herself because of the deformity of her hands from the RA she has had since she was 34 years old. She requires daily injections but is not able to self medicate.

The petitioner believes that she had been disabled for over 12 months prior to her application for ICP. She further believes that the DMRT did not review all of the petitioner's medical information supplied by her to the department, especially the information supplied about the multiple foot surgeries because of RA and the medication monitoring (Petitioner's Composite Exhibit 4).

No representative from DMRT was present at the hearing. The department's representative stipulated that she could not testify as to how DMRT made the decision concerning the petitioner's disability. There was a discrepancy in the copies of the medical evidence the petitioner presented and the packet the department submitted to DMRT. The department's representative stated she sent what she had for review. She advised that if there had been additional information or reapplication, they would resend a packet to DMRT to include the new information. If there was a worsening of conditions or new conditions present, they would resend to DMRT.

In the absence of direct testimony as to what information was reviewed when DMRT made the decision, and the discrepancy in the size of the medical information files, the undersigned is not able to find that all of the petitioner's medical information was reviewed based on speculation by the department's representative.

CONCLUSIONS OF LAW

The Florida Administrative Code, Section 65A-1.710 et seq., set forth the rules of eligibility for Elderly and Disabled Individuals Who Have Income of Less Than the

Federal Poverty Level. For an individual less than 65 years of age to receive benefits, he or she must meet the disability criteria of Title XVI of the Social Security Act appearing in 20 C.F.R. §416.905. The regulations state, in part:

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

The department Integrated Pub. Policy Manual passage 1440.1204 Blindness/Disability Determinations (MSSI, SFP) states in relevant part:

> If the individual has not received a disability decision from SSA, a blindness/disability application must be submitted to the Division of Disability Determinations (DDD) for individuals under age 65 who are requesting Community Medicaid under community MEDS-AD, Medically Needy, and Emergency Medicaid for Alien programs.
>
> State disability determinations for disability-related Medicaid applications must be done for all applicants with pending Title II or Title XVI claims unless SSA has denied their disability within the past year. If SSA has denied disability within the past year and the decision is under appeal with SSA, do not consider the case as pending. Use the decision SSA has already rendered. The SSA denial stands while the case is pending appeal.
>
> When the individual files an application within 12 months after the last unfavorable disability determination by SSA and provides evidence of a new condition not previously considered by SSA, the state must conduct an independent disability determination. Request a copy of the SSA denial letter. The SSA denial letter contains an explanation of all the conditions considered and the reason for denial...
>
> The District Medical Review Team (DMRT) handles all other necessary disability determinations (including ICP, OSS, HCBS, and PACE).
>
> Fla. Stat. 90.801 defines hearsay as:

> c) "Hearsay" is a statement, other than one made by the declarant while testifying at the trial or hearing, offered in evidence to prove the truth of the matter asserted.
> (2) A statement is not hearsay if the declarant testifies at the trial or hearing and is subject to cross-examination concerning the statement and the statement is:
> (a) Inconsistent with the declarant's testimony and was given under oath subject to the penalty of perjury at a trial, hearing, or other proceeding or in a deposition...

In order to meet the requirements for ICP Medicaid, an individual must meet all factors of eligibility including disability and level of care. The DMRT determined that the petitioner was not disabled based on the information received. There was confusion as to what information was actually sent to DMRT. Without direct testimony from DMRT, the matter was not resolved, and the department's representative had to speculate as to what information was reviewed and how they made their decision. This is considered hearsay. Therefore, the denial action is reversed and the case is remanded to the department. The department is ordered to ensure that complete medical information is submitted to DMRT and a new decision is rendered based on a complete medical record of the petitioner's impairments. The department is to issue written notification once the new determination is made, to include appeal rights.

DECISION

The appeal is granted and remanded as stated in the above conclusions..

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 19th day of October, 2006,

in Tallahassee, Florida.

Margaret Poplin

Margaret Poplin
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850-488-1429

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

APPEAL NO. 06F-05978

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 October 11, 2006, at 11:35 a.m., in Miami, Florida. The petitioner was present and represented herself. The agency was represented by Oscar Quintero, senior human service program specialist, Agency for Health Care Administration. Present as witnesses for the agency, via the telephone, were Dr. Amelia Tunanidas, medical director for KePRO; Susan Ziebell, review operations specialist at KePRO; and Diane Weller, KePRO contract manager for the state of Florida.

ISSUE

At issue is the agency's denial of a prior authorization of a total abdominal hysterectomy and subsequent hospitalization through September 4, 2006, for a total of three days acute inpatient hospitalization. The authorization request was denied pursuant to rule 59G-4.150. The petitioner has the burden of proof.

FINDINGS OF FACT

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

On August 25, 2006, KePRO received a request from the provider (Cedars Medical Center) for prior authorization of a total abdominal hysterectomy with possible unilateral or bilateral salpingo-oophorectomy procedure with acute impatient hospitalization through September 4, 2006.

The provider provided the following information: Diagnosis: "Menometrorrhagia (excessive uterine bleeding at and between menstrual periods) pelvic pain, anemia...Patient desires hysterectomy. She is tired of bleeding and being in pain all the time and having to take pain pills all the time. It interferes with her life. Patient does not want to be on birth pills...HRT (hormone replacement therapy) refused, refused OCP (oral contraceptive pills)."

On August 25, 2006, an initial screening review was performed by a KePRO nurse reviewer at the direction of AHCA using InterQual criteria to determine necessity for acute inpatient care. KePRO determined that the clinical information sent by the petitioner's physician's office did not meet InterQual criteria under Adult Procedures subset: Hysterectomy, Abdominal criteria.

On the same date, the case was referred to a physician consultant Board-Certified in Obstetrics/Gynecology who recommended denial based on the information provided for the petitioner where no failed conservative therapy was present prior to the major surgery.

On September 1, 2006, the provider requested a reconsideration and submitted additional information. The case was referred for reconsideration to a physician consultant Board-Certified in Obstetrics/Gynecology who had not issued the first denial to determine whether the initial decision was correct. The reconsideration physician agreed with the original determination, and the original decision was therefore upheld. The petitioner was notified on September 1, 2006 of the agency's decision.

The petitioner expressed that she does not understand why she was denied because her medical record from Virginia shows that she has been having female problems for the longest time, and documents all the type of medication she has been on. She alleges to be in constant pain, bleeding all the time and feels very weak.

The agency explained that it is the petitioner's responsibility to get that documentation from Virginia to her physician here in Florida and then this information must be provided to KePro. The agency noted that they did not receive any medical records, just a summary of her care from her physician in Florida.

The agency stated they would be willing to take another look at her case if it is documented that she already attempted several other medical therapies other than pain pills.

CONCLUSIONS OF LAW

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

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

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

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

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

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

These rules established guidelines for the definition and authorization of Inpatient Hospital Services. The agency has reviewed the petitioner's request for prior authorization to pay for inpatient hospital medical services from September 1 through

September 4, 2006, and determined that the information provided does not meet medical necessity criteria under any diagnosis for a hysterectomy.

Based on the evidence, testimony and above authorities, the hearing officer concludes that the agency was correct in its denial for inpatient hospital medical services from September 1 through September 4, 2006.

DECISION

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

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 31st day of October, 2006,

in Tallahassee, Florida.

Alfredo Fernandez SR

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

Copies Furnished

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

APPEAL NO. 06F-03820

PETITIONER,

Vs.

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

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, and the petitioner's good cause request for rescheduling, an administrative hearing was convened before the undersigned hearing officer at 12:10 p.m. on August 1, 2006 in Cocoa, Florida. The petitioner was not present but was duly represented by her mother, [redacted] The respondent was represented by Lisa Sanchez, Human Service Program Specialist with AHCA. Present to testify by telephone for AHCA was Jody Winter, physical therapy consultant reviewer.

ISSUE

At issue was whether or not AHCA prior authorization denial of a custom manual wheelchair with power accessory was correct. The petitioner had the burden of proof.

FINDINGS OF FACT

The petitioner is eligible for Medicaid and that is undisputed. She is a young adult who faces many physical challenges and that is also undisputed. She lives at

home in the community with her family. On her behalf, the provider Custom Mobility, Inc, submitted to AHCA a video along with a 34 page request document (Respondent's Exhibit 3). A small customized manual wheelchair, with power assist (convertible from manual to power), procedure code for durable medical equipment item K0009, was requested on behalf of the petitioner. Page 11 of the request document, said:

> Power add on unit to lightweight manual chair requested because client/family unable to transport a power chair, also allows for use when power unit down for repairs. Needed for community distances. Cannot use rigid frames due to need to fold for transport...not functional with power assisted push wheels.

AHCA reviewed information in Respondent's Exhibit 3 along with the video. Denial occurred on June 1, 2006 (Respondent's Exhibit 1). AHCA determined that eligibility criteria for powered mobility unit medical necessity standards were not established for the specific unit requested. The June 1, 2006 AHCA Prior Authorization Notice of denial advised "if you believe additional information will assist in a more favorable decision, please ask Custom Mobility, Inc to submit the request..." Additional AHCA explanation of June 20, 2006, (Respondent's Exhibit 2, page 2) informed:

> Based on the prior authorization documentation submitted by the physical therapist, you require powered mobility for access to the community which does not meet Medicaid criteria of need **within the home for basic activities of daily living** (emphasis added).
> Furthermore, this request is complicated by the request by the DME provider for a K0009 custom manual wheelchair, but with additional components that would change the chair to a powered wheelchair, which should be submitted as a K0014 custom powered wheelchair. The requested configuration of a manual wheelchair with powered components would not be the least costly means of providing powered mobility if it were determined you required it within your home.
> You should contact your durable medical equipment (DME) provider to discuss the reasons listed for this denial.

Respondent's Exhibit 3 also showed that the petitioner had outgrown her current model, had limited propulsion ability, and was "unable to propel in community." The provider also noted that there was "a caregiver available 24 hours a day" (page 14), she could self-propel 100 feet, had household access, was using both arms "unevenly & w/ great difficulty w/ r ue" and "assym strength...very slow w/ multiple rests..." A significant reason for the special equipment was energy conservation of the petitioner and a reserve or back-up power supply.

On June 30, 2006 (Respondent's Exhibit 5), the AHCA physical therapist agency reviewer further summarized the prior action and explained as follows:

- Wheelchairs are identified by specific HCPC codes. A custom manual wheelchair is a K0009; a custom power wheelchair is a K0014. A manual wheelchair base may have a power accessory component added which will then turn that chair into a powered wheelchair. Such a chair should be submitted as a K0014, since it is now a custom power wheelchair.
- A requirement for custom wheelchair and powered wheelchair funding is documentation of "medical necessity to accomplish basic ADLs (activities of daily living) within the home has been established",
- On page 2-4 of the DME Handbook, the definition of medical necessity states that services provided must be the least costly alternative available.
- The documentation (unsigned) provided state that powered assist is required because
    - She is "unable to propel in the community"
    - "needed for community distances"
- The physical therapy evaluation states that L... is able to propel household distances independently (100 feet). It also states "L...is 21 and requires increased community mobility with school and socially. She is able to independently move her chair around her home, but fatigues quickly." There is no further information related to her fatigue after 100 feet, or what ADL's entail mobility of greater than 100 feet.
- If additional clarification is submitted to justify powered mobility within the home, the requested equipment is not the least costly alternative to provide this.
- It is stated that the requested equipment (light weight manual wheelchair frame with added power accessories) is required because the family cannot transport a typical powered wheelchair. However there was no discussion of folding power wheelchairs which are available for ease of

transportation, and are significantly less costly than the requested equipment.

Between June 30, 2006 and July 18, 2006, the therapist and doctors of the petitioner wrote a letter of medical necessity for a motorized wheelchair with a joystick, shown in Petitioner's Exhibit 2. During the hearing, following clarification of some of the ambiguities, the AHCA physical therapist declared it was now likely there was sufficient justification for authorization of a power wheelchair in the home. This would relate to need for power equipment to complete activities of daily living. However, she continued to conclude that authorization of the specific custom model requested was not justified because that model was more costly than other models which should achieve medical necessity and would be Medicaid compensable. AHCA declared there was an agency obligation to authorize the least costly equipment that would achieve medical necessity. She noted that it was a family obligation to keep the battery charged and to adequately maintain the power equipment such that escape from the home could occur using the motorized wheelchair, if household electric power failed and escape were necessary.

While agreeing that a power wheelchair was justified, AHCA declared that there were at least two less costly alternatives, i.e., a power folding unit or a small power unit, which would be covered by Medicaid. The requested customized power option wheelchair would have a rechargeable power pack and joystick for one-handed operation and had more convertibility options. The agency reviewer noted that the less costly options needed to be explored and investigated, before approval of the more expensive equipment could be authorized.

The agency position set forth in the Statement of Matters, Respondent's Exhibit 2, reflected that "Medicaid may reimburse for a customized wheelchair that is specially constructed. Prior authorization is required, which must include documentation of medical necessity..." Prior Authorization standards were submitted in Respondent's Exhibit 4, Medicaid Provider Reimbursement Handbook, excerpts.

Related to concerns of the petitioner, and the new June 30 – July 18, 2006 information, AHCA explained that a new and more sufficient prior authorization request could be submitted by the provider to AHCA and would be reviewed by AHCA staff as quickly as possible. Approval was not guaranteed, but an amended request would be considered carefully and timely by the agency.

CONCLUSIONS OF LAW

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

Florida Statute 409.913 addresses **Oversight of the integrity of the Medicaid program**, with (1)(d) describing "medical necessity or medically necessary" standards and saying in relevant part that: "...For purposes of determining Medicaid reimbursement, the agency is the final arbiter of medical necessity." Consistent with statute, Fla. Admin. Code 59G-1.010 (166) defines "medically necessary," informing that such services must:

> (a) Meet the following conditions:
> 1. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;

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

Fla. Admin. Code 59G-4.070 addresses **Durable Medical Equipment and Supplies.** In relevant part, it informs:

(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.
(3) All DME providers and their billing agents must comply with the provisions of the Florida Medicaid Provider Reimbursement Handbook, Non-Institutional 081, November 1996, which is incorporated by reference and available from the Medicaid fiscal agent.
(4) Durable Medical Equipment and Supplies. All DME/Medical Supply providers must comply with the provisions of the Florida Medicaid DME/Medical Supply Services Coverage and Limitations Handbook January 2000, which is incorporated by reference and available from the Medicaid fiscal agent.

The DME/Medical Supply Services Coverage and Limitations Handbook, page 2-57 and 58, informs as follows:

Medicaid may reimburse for a customized wheelchair that is specially constructed (K0008, K0013, K0014). Prior authorization is required.

> Medicaid will not approve a customized wheelchair or wheelchair upgrade where no medical necessity to accomplish basic ADLs within the home has been established. ...
> Medicaid will not approve a motorized wheelchair or wheelchair upgrade where no medical necessity to accomplish basic ADLs within the home has been established. When a motorized wheelchair is prescribed the documentation must establish that the device is a safe method of mobility. The recipient must meet all of the following conditions:
> • documented, severe abnormal upper extremity dysfunction or weakness
> ...
> • an environment conducive to the use of a motorized wheelchair ...
> • documentation of home accessibility is required in a prior authorization request for an oversized, heavy-duty or power customized wheelchair.

The Medicaid Provider Reimbursement Handbook, page 2-2 et seq. establishes the ***Prior Authorization Requirements*** and identifies "Durable Medical Equipment" as one of the "Programs with Services that Require Prior Authorization. " Thus, in order to achieve Medicaid coverage of the special wheelchair (durable medical equipment or DME) expense, a prior authorization must occur and the customized or special wheelchair must meet agency standards for the specific circumstance.

After careful review of facts and governing regulations, the hearing officer concurs with the revised agency determination that a power wheelchair is justified for use in the home as related to completion of activities of daily living. However, the customized wheelchair requested by the provider was not the most cost effective equipment necessary to protect life, to prevent significant illness or disability, or to alleviate severe pain as required by the definition of medical necessity. At least two less costly alternatives exist, according to the agency reviewing expert. One option is a folding power wheelchair. Another option is a small power wheelchair.

The goal in this situation is to achieve Medicaid payment for an appropriate and cost effective piece of equipment effective to the medical needs of the petitioner. At this

point in the process, such has not occurred. It may occur in near future as discussed at the hearing. AHCA denial of the specific customized model of equipment that was requested has been justified. However, the provider shall have an additional opportunity to submit a request for a less costly power wheelchair alternative and the review shall proceed. AHCA shall review the new material submitted at the hearing which was from the physical therapist and doctors dated in June and July 2006. The parties may continue their dialogue. Further review shall proceed and the appeal is remanded to achieve that purpose. Following that review, further notice shall be issued to the petitioner and would be appealable in customary procedure of the agency.

DECISION

The appeal is granted in that medical necessity for power wheelchair has been adequately established. The appeal is denied in that the specific requested power accessory model is not authorized. Remand to achieve further review is directed.

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 3rd day of October, 2006, in Tallahassee, Florida.

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

Copies Furnished To:

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

APPEAL NO. 06F-05100

PETITIONER,

Vs.

AGENCY FOR HEALTH
CARE ADMINISTRATION
DISTRICT: 15 St. Lucie
UNIT: AHCA

RESPONDENT.
_____/

ORDER OF DISMISSAL

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on September 12, 2006, at 2:05 p.m., in Fort Pierce, Florida. The petitioner appeared by telephone at her request, and represented herself. Dave King, management analyst, Area 9 Medicaid, represented the Agency for Health Care Administration (AHCA). Dr. Amy Tunanidas, medical director, Keypro; Theresa Ashey, review operations supervisor; Susan Ziebell, review operations specialist and Deanne Weller, contract manager, appeared telephonically as witnesses for AHCA.

At issue is the action taken by the agency to deny one day of inpatient services for the petitioner's hospital stay. Medicaid paid for her stay from June 26, 2006 through July 2, 2006, but denied July 3, 2006, because she did not meet the requirements for Medicaid reimbursement for acute medical care for that day.

According to the Florida Medicaid Provider General Handbook (the Handbook), page 1-5, "A provider who bills Medicaid for reimbursement of a Medicaid-covered

service must accept payment from Medicaid as payment in full. This does not include Medicaid copayments and coinsurance. A provider who fails to bill Medicaid correctly and in a timely manner may not bill the recipient...Prior to rendering a service, a provider must inform the recipient of his responsibility for the payment of any services received that are not covered by Medicaid. The provider must discuss this with the recipient for each service and must document this discussion in writing in the recipient's medical record. Only those procedures that are not listed on the provider's Medicaid fee schedule (procedure code table) in the service-specific Coverage and Limitations Handbook are non-covered services. Other than copayments and coinsurance, the provider cannot seek payment from a recipient for a compensable service for which a claim has been submitted, regardless of whether the claim has been approved, partially approved or denied except under the following circumstances:• The recipient is not eligible to receive Medicaid services on the date of service..."

On July 19, 2006, the petitioner received a notice that payment for one day of her in-patient services was denied payment because medical necessity for the service was not established. Receiving medication orally does not constitute medical necessity for acute care. This was the first notification received by the petitioner of the inpatient denial. The hospital was also notified and did not request reconsideration (Respondent's Exhibit 2).

The agency explained that the petitioner would not be responsible for the portion of the bill denied by Medicaid because of the requirement quoted above from the Handbook. The agency instructed the petitioner to contact Mr. King if she received a bill from the hospital concerning the denied charges. Because the petitioner will not be

held responsible for the cost of the Medicaid denied inpatient day, the issue is moot.

There is no corrective action to be ordered by the undersigned. Therefore, the appeal is

hereby dismissed.

JUDICIAL REVIEW

This decision is final and binding on the part of the agency. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Agency Clerk, 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 2nd day of November 2006,

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

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

APPEAL NO. 06F-04755

PETITIONER,

Vs.

AGENCY FOR PERSONS
WITH DISABILITIES
DISTRICT: 15 St. Lucie
UNIT: APD

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on August 29, 2006, at 10:15 a.m., in Fort Pierce, Florida. The petitioner was not present. [redacted] owner of group home and Mario Price, waiver support coordinator, had written permission from the petitioner's mother to represent him at the hearing. Jeff Mahl, attorney, Office of the Attorney General, represented the Agency for Persons with Disabilities (ADP). Steve Stoltz, program administrator, was present as a witness for the respondent. Dr. Emma Guilarte, consultant reviewer, Maximus, appeared telephonically as a witness for the agency. Cheryl Starkgraf, notary, was present as Dr. Guilarte took her oath.

ISSUE

At issue is whether the agency was correct to approve with changes the petitioner's request for adult day training (hourly) services and to terminate behavior analysis services. The agency has the burden of proof.

FINDINGS OF FACT

The petitioner is 31 years old and receives services through the Agency for Persons with Disabilities Medicaid Waiver Program, formerly known as the Developmental Disabilities Home and Community Based Services Medicaid Waiver Program. He resides in a group home. As part of the eligibility determination process, the support coordinator must submit a care and support plan for annual review. The agency conducted a prior service authorization review of a request for behavior analysis service (level 1) for 192 quarter hours to address "repeated vocals". No behavior analysis services were approved and the service was terminated. Adult Day training (ADT) was requested for 5760 quarter hours of 1:5 ratio of staff to participant to provide a meaningful day activity and to manage behavior problems. ADT at a ratio of one to 6-10 was approved for the remainder of the cost plan.

Maximus, a contracted agency that performs prior service authorizations (PSA) for the agency, determined that the services were reduced or terminated because the requests exceed medical necessity or there is no determination that the service(s) is medically necessary. Adult dental, medication review, nonresidential support services (hourly), residential habilitation standard, support coordination, and transportation (one way), was approved as requested (Respondent's Exhibit 1).

The reviewer at Maximus determined that there were documents missing necessary to conduct a review, so the consultant issued Form #2a. They requested a behavior intervention plan and data displays for services from the preceding 12 months, including the data and phase lines, among other information. They received a "service request" for continuation of services and an outline of a fading plan. Without the behavior intervention plan and requested information, medical necessity for behavior analysis services could not be determined and the service was terminated (Respondent's Exhibit 3).

The documentation needed to review ADT training at a 1:5 ratio for medical necessity includes a current behavior analysis services plan that will be implemented in the ADT, a plan for fading services, and an annual report. The information was not sent with the support plan for review. A Form 2A was sent requesting the information, and the requested information was not received by the respondent.

A reconsideration request was received by Maximus on August 17, 2006. A Form 2A was sent on August 24, 2006, again requesting the same missing information from the original request.

The support coordinator believes that he sent a behavior plan dated April 17, 2003. Mr. [illegible]l asserts that the petitioner is exhibiting old behaviors of soiling himself for task avoidance. The petitioner's representatives explain that they will get together with Ms. Mafera, the petitioner's certified behavior analyst, to get the proper documents since his behavior plan is outdated.

CONCLUSIONS OF LAW

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

> (1) Purpose. Under authority of section 2176 of Public Law 97-35, Florida obtained waivers of federal Medicaid requirements to enable the provision of specified home and community-based (HCB) services to persons at risk of institutionalization. Through the administration of several different federal waivers, Medicaid reimburses enrolled providers for services that eligible recipients may need to avoid institutionalization. Waiver program participants must meet institutional level of care requirements. The HCB waiver services are designed to allow the recipients to remain at home or in a home-like setting. To meet federal requirements, Medicaid must demonstrate each waiver's cost-effectiveness...
> (5) Service Limitations – General. The following general limitations and restrictions apply to all home and community-based services waiver programs: (a) Covered services are available to eligible waiver program participants only if the services are part of a waiver plan of care ("care plan", "individual support plan", or "family support plan"). Care plan requirements are outlined in subsections (6) and (8) of this rule. (b) The agency or its designee shall approve plans of care based on budgetary restrictions, the recipient's necessity for the services, and appropriateness of the service in relation to the recipient, prior to their implementation for any waiver recipient...(6) Program Requirements- General. All HCB services waiver providers and their billing agents must comply with the provisions of the Florida Medicaid Provider Reimbursement Handbook. Non-Institutional 081, October 2003, which is incorporated by reference and available from the Medicaid fiscal agent. The following requirements are applicable to all HCB services waiver programs:...(f) The plan of care will identify the type of services to be provided, the amount, frequency, and duration of each service, and the type provider to furnish service...
> (12) Developmental Services Waiver – General. This rule applies to all Developmental Services Waiver Services providers enrolled in the Medicaid program. All Developmental Services Waiver Services providers enrolled in the Medicaid program must comply with the Developmental Services Waiver Services Florida Medicaid Coverage and Limitations Handbook, October 2003, incorporated by reference, and the Florida Medicaid Provider Reimbursement Handbook, Non-Institutional 081, October 2003. Both handbooks are available from the Medicaid fiscal agent. The Developmental Disabilities Waiver Services Provider Rate Table, November 2003, is incorporated by reference. The Developmental

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

The Developmental Services Waiver Services Florida Medicaid Coverage and Limitations Handbook, June 2005, ch. 2 states in relevant part:

> Day training programs for adults are training services intended to support the participation of recipients in daily, meaningful, valued routines of the community, which for adults may include work-like settings that do not meet the definition of supported employment.
> Adult day training services stress training in the activities of daily living, selfadvocacy, adaptive and social skills and are age and culturally appropriate.
> The service expectation is to achieve the outcomes (goals) defined by each recipient; and, to attain and support participation in less restrictive settings.
> The training, activities and routine established by the adult day training program shall be meaningful to the recipient and provide an appropriate level of variation and interest. This training is provided in accordance with a formal implementation plan, developed under the direction of the recipient, reflecting their goal(s) from the current support plan.
> Special Considerations:
> Indicators of a one staff to five recipient staffing rate ratio level include:
> • Recipients who have a moderate level of support for personal care services on the Department approved assessment may receive the rate level identified as moderate for the service. The moderate rate is paid when a recipient routinely requires prompts, supervision and physical assistance to complete the basic personal care areas of eating, bathing, toileting, grooming, and personal hygiene; or
> • A recipient who is on a behavioral services plan that is implemented by the adult day training provider, and who requires visual supervision during all waking hours and occasional intervention as determined by a Certified Behavioral Analyst. The recipient does not have to live in a licensed residential facility.

The Developmental Services Waiver Services Florida Medicaid Coverage and Limitations Handbook, June 2005, at page 2-22 states in relevant part:

> Description Behavior analysis services are provided to assist a person or persons to learn new behavior that are directly related to existing challenging behaviors or functionally equivalent replacement behaviors for identified challenging behaviors. Services may also be provided to increase existing behavior, to reduce existing behavior, and to emit

behavior under precise environmental conditions. The term "behavior analysis services" includes the terms "behavior programming" and "behavioral programs." Behavior analysis includes the design, implementation and evaluation of systematic environmental modifications for the purposes of producing socially significant improvements in and understanding of human behavior based on the principles of behavior identified through the experimental analysis of behavior.
It includes the identification of functional relationships between behavior and environment. It uses direct observation and measurement of behavior and environment. Contextual factors, establishing operations, antecedent stimuli, positive reinforcement and other consequences are used, based on identified functional relationships between behavior and environment, in order to produce practical behavior change.
Behavioral services must include procedures to insure generalization and maintenance of behaviors. The services are designed to engineer environmental modifications including ongoing styles of interactions, and contingencies maintained by significant others in the recipient's life. Training for parents, caregivers and staff is also part of the services when these persons are integral to the implementation or monitoring of a behavior analysis services plan. Services should be provided for a limited time and discontinued as the significant others gain skills and abilities to assist the recipient to function in more independent and less challenging ways.
Behavior analysis does not rely on cognitive therapies and expressly excludes psychological testing, neuropsychology, psychotherapy, sex therapy, psychoanalysis, hypnotherapy and long-term counseling as treatment modalities. Provision of behavioral services must comply with Chapter 65B- 4.030(9)(10), F.A.C. Services provided by behavior analysts with limited experience in the problem area or by behavior analysts who are not Board Certified Behavior Analysts with three years of experience or licensure under Chapter 490 or 491, F.S., should receive oversight and approval of services with a more experienced behavior analyst or with the above described highest level of certification.

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

(a) "Medically necessary" or "medical necessity" means that the medical or allied care, goods, or services furnished or ordered must meet the following conditions:
1. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;

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

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

The Developmental Services Waiver Services and Limitations Handbook includes definitions of services, specific requirements, and limitations on those services. The support plan must provide a clear explanation of need for the services. Maximus made the determination on medical necessity based on the information provided with the support plan and cost plan, and determined that medical necessity was not established for the requested ratio of staff to consumer of1:5 at ADT or behavior analysis services. The basis for the respondent's decision was the lack of a behavior plan and data sets for behavior analysis services and ADT at the requested level. The petitioner does not receive personal care assistance and would be required to have a behavior services plan to have 1:5 ratio of staff at ADT.

The hearing officer has considered the evidence and testimony and concludes there was not sufficient medical necessity evidence to rebut the agency's expert testimony and qualified professionals who made the medical necessity decision on the services at issue. It cannot be concluded that the behavior analysis services and 1:5

staff ratio at ADT, are necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain.

In summary, the hearing officer finds that the agency's action to approve with changes the petitioner's request for ADT and the action to terminate behavior analysis services is justified.

DECISION

The appeal is denied.

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 19th day of October, 2006,

in Tallahassee, Florida.

Margaret Poplin

Margaret Poplin
Hearing Officer
Building 5, Room 203
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
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Gail Scott Hill
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M. Catherine Lannon, Sr. Assistant Attorney General

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

APPEAL NO. 06F-04181

PETITIONER,

Vs.

CASE NO.

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

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on September 7, 2006, at 1:06 p.m., in Ft. Myers, Florida. The petitioner was present. He was represented by his mother and father, [redacted]. The agency was represented by Allison Becker, assistant attorney general. Present as witnesses for the petitioner were Mary Provencher, president of [redacted] Inc. residential facility; Lisa Longo, waiver support coordinator; and Nell Knott, president of Knottsville Farm Inc. President as a witness for the agency was Beverly Benkhatar, operations management consultant. Present as a witness for the agency telephonically was Dr. Emma Guilarte, consultant reviewer with Maximus.

ISSUE

At issue is the April 20, 2006 action by the agency reducing the Non-residential Support Service from one provider and the termination the Non-residential Support Service from another provider.

FINDINGS OF FACT

The petitioner is an adult who receives benefits through the Developmental Disabilities Home and Community-Based Services Waiver Program (DD/HCBS). His cost plan for the period of April 1, 2006 through March 31, 2007 was submitted for approval. The Department contracts with Maximus to perform Prior Service Authorization (PSA) reviews on certain requested services, or when the cost on a support plan exceeds certain levels. The PSA unit reviews these requests to determine if the service(s) meets the established criteria for medical necessity.

On April 4, 2006, Maximus determined that the petitioner's request for services was approved with changes. Among other services, the petitioner requested hours of Non-Residential Support Services (NRSS) with two different providers. The petitioner requested 3536 quarter hours of NRSS for [redacted] Inc. The hours would be used on Tuesday, Friday, Saturday, and Sunday. The activities listed for the hours included "sits outside or go to a quiet pace as desired table top activities...makes choices in the community: safe travel skills, going directly to locations, social interaction with staff and other individuals in the community." The activities performed resembled an Adult Day Training Program. Maximus found that there was no indication of what skills the petitioner has

acquired with this service. The schedule intermingled Residential Habilitation with NRSS and the scope and purpose of NRSS could not be determined.

Non-residential support services are individualized training activities provided in integrated, non-residential settings. They are training activities provided in accordance with a specific outcome on the support plan and are not merely recreational or a diversion. Maximus determined that medical necessity was not met for the requested number of hours. They did approve 590 quarter hours of NRSS hours for this provider to allow the petitioner a meaningful day activity and to prepare the information that is required for this service.

The petitioner requested 3744 quarter hours of NRSS for use at I m, Inc. The hours would be provided with a 1 to 3 staff ratio. Information provided by the petitioner indicated that I n completes contract work, crafts, money skills, writing skills both on and off site at a farm. Maximus determined that the service appeared to be provided in a segregated environment and its description was more like an Adult Day Training Program. They cited the requirement in the Developmental Coverage and Limitations Handbook that the services are training activities provided in accordance with a specific outcome on the support plan and are not merely recreational or a diversion. The information provided by the petitioner indicated that at least four of six goals were recreational in nature and provided in a segregated setting. Maximus denied the requested hours as "medical necessity" was not established to support allowing the service.

The petitioner requested a reconsideration of both denials of NRSS services. On May 11, 2006, the reconsideration of the Inc. quarter hours (3536) was denied upholding the original denial. Maximus found that the additional information provided still did not establish medical necessity number of NRSS hours requested. The summary of the petitioner's progress toward his NRSS goal of demonstrating restaurant skills with 95% accuracy for two months showed that the petitioner's demonstration of restaurant skills improved from 57% in February 2006 to 89% in March 2006. Therefore, the reconsideration reviewer upheld the approval on 590 quarter hours of NRSS services provided by Shalimar Inc.

On May 11, 2006, the reconsideration of the [illegible] quarter hours (3744) was denied upholding the original denial. Maximus found that the additional information provided still did not establish the medical necessity of the service. The information provided as documentation did not identify the progress made while the petitioner performed community activities. He volunteered at the Kiwanis club, landscaped at the Methodist church, attended plays in the community, and worked on craft projects, and learned safety skills. While the activities were listed, the documentation was not clear regarding the specific training to accomplish and outcomes to measure effectiveness. Since the documentation did not provide data monitoring his progress in learning these skills, the original denial was upheld.

CONCLUSIONS OF LAW

The Florida Administrative Code at 59G-8.200 Home and Community-Based Services Waivers states in relevant part:

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

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

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

The Developmental Disabilities Waiver Services Coverage and Limitations Handbook states in relevant part on page 2-69 regarding NRSS:

> **NON-RESIDENTIAL SUPPORT SERVICES**
> **Definition: Non-residential support services** are training activities provided to adult individuals in community-integrated

> settings, individually or may include groups not to exceed three (3) individuals9. These services support the individual in valued roles in the community, are age and culturally appropriate, increase the individual's ability to control the environment, encourage the development of friendships with people who reside in the community and emphasize community-inclusive qualities. These activities are not merely diversional in nature but are related to a specific outcome(s) or goal(s) of the individual. This training is provided in accordance with a formal implementation plan, developed with direction from the individual and reflects the individual's goal(s) from the current support plan.
> The primary functions of **non-residential support services** are:
> 1. Development of communication and social skills to assist the individual to function with maximum independence in the community;
> 2. Development of skills needed to increase independent living in the community setting; and,
> 3. Development of the skills required to assist the individual to maintain a living environment, use community resources and conduct activities of daily living.

The Findings of Fact show that the petitioner receives services through the Developmental Disabilities Home and Community-Based Services Waiver Program. His support and cost plan were submitted to Maximus for prior authorization review. One of the services requested was NRSS. The agency determined that medical necessity was not established for this service, and the activity did not meet the specific training activity in the community criteria. The activities appeared recreational in nature. The training goals were not clear with measurable outcomes. According to the above-cited laws and handbook passages, this was a correct decision. After reviewing the evidence and testimony, the petitioner could not establish the justification for NRSS hours.

DECISION

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

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the 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 20th day of October, 2006,

in Tallahassee, Florida.

Terry Oberhausen

Terry Oberhausen
Hearing Officer
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Gail Scott Hill, Esq.
M. Catherine Lannon, Sr. Assistant Attorney General
Jennifer Lima, Esq.

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

APPEAL NO. 06F-04936

PETITIONER,

Vs.

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

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on September 26, 2006 at 3:04 p.m., in Jacksonville, Florida. The petitioner was present and represented by Pete and Earnestine Brewer, Medicaid Waiver Support Coordinators with P.M. Support Services. Also present as a witness was Daniel Mokuwa, D.E.M Support Services Provider. The agency was represented by Ann Cocheu, attorney with the Attorney General's Office. Present for the agency was Ora Way, Agency for Persons with Disabilities (APD) Medicaid Waiver Liason and Gary Reavis, R.N. consultant with Maximus, who testified by speakerphone.

ISSUE

At issue is the agency's action of July 18, 2006 to terminate skilled nursing under the Agency for Persons with Disabilities Home and Community Based Services Medicaid Waiver Program (hereinafter referred to as "the waiver"). The agency holds the burden of proof.

FINDINGS OF FACT

The petitioner is 33 years old and is a recipient of services under the Agency for Persons with Disabilities Home and Community Based Services Medicaid Waiver Program. He lives in a supported living arrangement with a roommate. He has a provider with him for 24 hour supervision, due to a court order and receives supported living coaching and in-home support services under the waiver.

The agency contracts with Maximus to review high cost plans or residential habilitation services under the Waiver. These are called prior service authorization (PSA) reviews. A PSA review is a review of paper documents submitted by the Waiver Support Coordinator. The PSA review determines if the requested services meet the criteria as set forth in the Developmental Disabilities Waiver Services Coverage and Limitations Handbook (hereinafter referred to as "the handbook"), the Medicaid State Plan Handbook and the Home Health and Durable Medical Equipment Handbook.

Maximus received an eight page support plan to begin April 7, 2006. The identified nursing treatment in the Home Health Certification and Plan of Care indicated that the service was requested for the purpose of monitoring blood glucose levels and administering insulin injections two times per day. The information provided by the Waiver Support Coordinator stated that the service was requested under the Waiver

due to the Home Health Agency not billing State Plan Medicaid. Maximus had no indication that nursing services had been sought through State Plan Medicaid. Because the State Plan Medicaid covers home health skilled nursing services for an individual needing insulin injections and residing in a supported living arrangement, skilled nursing services under the waiver were terminated. The termination was due to a service limitation of the waiver.

An additional letter was submitted to Maximus from the Waiver Support Coordinator for reconsideration. The letter did not offer any new evidence; only that the petitioner was having difficulty finding a provider that would bill State Plan Medicaid for the nursing services (Petitioner's Exhibit 1). The reconsideration determination was completed by Mary Seay, M.D. who determined that this was a provider issue and should be resolved by the area APD office and the Agency for Health Care Administration (Medicaid office). Dr. Seay advised that because a provider is not enrolled in the Medicaid program does not change the fact that the service is provided through the State Plan Medicaid Home Health Program and therefore, cannot be provided under the waiver (Respondent's Composite Exhibit 4).

The previous PSA review for the cost plan year of May 2, 2005 through April 30, 2006 reduced the skilled nursing to one hour per day for 240 days to administer insulin injection at the Adult Day Training program. At that time, the Maximus reviewer recommended that the petitioner's waiver support coordinator and the home health agency contact the home health analyst in the Area Medicaid office to facilitate the coordination with the home health agency in obtaining authorization under State Plan Medicaid (Respondent Exhibit 5).

Testimony from the Waiver Support Coordinators was that no provider has been located that will provide the service and bill State Plan Medicaid.

CONCLUSIONS OF LAW

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

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

The Developmental Services Waiver Services Florida Medicaid Coverage and Limitations Handbook, June 2005, defines skilled nursing and states on part:

> Description - Skilled nursing is a service prescribed by a physician and consists of part-time or intermittent nursing care provided by registered or licensed practical nurses, within the scope of Florida's Nurse Practice Act. Limitations - This service supplements nursing services available through the Medicaid State Plan. Skilled nursing services are available to children under the age of 21 with complex medical needs. Licensed nursing is available to children and adults when determined medically necessary by the Medicaid program and related to the care of a medical condition. Refer

to the Florida Medicaid Home Health Services Coverage and Limitations Handbook for additional information on Medicaid State Plan coverage. Limitations continued - Nursing services not available to recipient's under the Medicaid State Plan, or which are insufficient in quantity to meet their needs, may be paid for by the DD Waiver, if the appropriate, qualified professional determines, on behalf of the Department, that the standards for medical necessity set forth in Chapter 59G-1.010(166)(a), F.A.C., are met. The DD Waiver may pay only for those medically necessary services not covered by the Medicaid State Plan.

The Developmental Services Waiver Services Florida Medicaid Coverage and Limitations Handbook, June 2005, Requirements to Receive Services, states in part:

Availability of Other Coverage Sources, continued
When a service must be purchased, those available under the Medicaid State Plan must be utilized before accessing services through the waiver. The waiver cannot supplant or replace a benefit available through Medicaid State Plan services. It is a federal requirement to access state plan coverage before the provision of waiver services. As stated in section 4442.3, State Medicaid Manual:
'No service may be provided under the waiver if it is already provided under the State plan unless the nature or the amount of the service, when provided under the waiver, would not be covered if provided under the State plan. For example, if the waiver provides for coverage of home health aide services, the maximum number of visits allowed under the waiver could be greater than the limit contained under the State plan. The amount chargeable for waiver services is that amount incurred after any limits in State plan services have been reached. Similarly, if the State proposed to provide home health aide services, which were defined more broadly than those available under the State plan, these could be included as waiver services.'

The State Plan Medicaid Home Health Services Coverage and Limitations Handbook, October 2003, states in relevant part:

Covered, Limited and Excluded Services
Covered Services For Adults
Medicaid reimburses the following services provided to eligible recipients age 21 years or older:
- Licensed nurse and home health aide visits;
- Limited durable medical equipment and supplies; and
- Limited therapy evaluations.

The Findings of Fact show that the petitioner was receiving skilled nursing services under the waiver program. This service was reduced at the prior year's PSA review and the waiver support coordinators were advised to begin facilitating the coordination in obtaining authorization for this service under the State Medicaid Plan. According to the above authorities, no service may be provided under the waiver if it is already provided under the State plan unless the nature or the amount of the service, when provided under the waiver, would not be covered if provided under the State plan. These authorities also state that the waiver cannot supplant or replace a benefit available through Medicaid State Plan services. There was no evidence that the petitioner fit the exception stated in the authorities. No provision could be found to allow an exception due to the lack of providers who will not bill Medicaid. Therefore, the undersigned concludes that the agency was correct in its termination of skilled nursing under the waiver.

DECISION

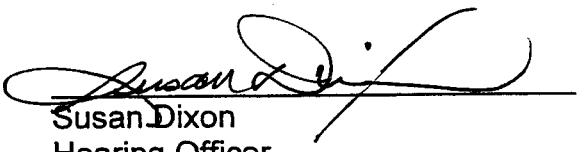
The appeal is denied. The agency's action is affirmed.

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 23rd day of October, 2006,

in Tallahassee, Florida.



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Ernestine Brewer
M. Catherine Lannon, Sr. Assistant Attorney General

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

PETITIONER, APPEAL NO. 06F-05199

Vs.

AGENCY FOR PERSONS
WITH DISABILITIES (APD)
DISTRICT: 07 Seminole
RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer at 3:17 p.m. on September 8, 2006 in Sanford, Florida. The petitioner was not present but was duly represented by her guardian, [redacted] while the respondent was represented by Gerald Siebens, Esq. Present to testify on behalf of the petitioner were: Donna Strickland, board certified behavior analyst with Developmental Services Inc, (DSI); Roger Zhuang, clinical director and board certified behavior analyst of [illegible] Group Homes ([illegible], with DSI; Renee Goehring, board certified associate behavior analyst with [illegible]; Deloris Battle with Bridge Builders, waiver support coordinator director; and Malika Brown, waiver support coordinator with Bridge Builders. Present to testify on behalf of APD were Joan Schneider, program specialist; and by telephone, Kelli Michaels, the MAXIMUS original prior service authorization reviewer; and Emma Guilarte, EdD (special education), reconsideration reviewer with MAXIMUS prior service authorization unit. By agreement

and with Notice of Filing, Respondent's Exhibit 5, the Published Rates and Billing Code Matrix, was submitted to the petitioner and hearing officer following the hearing.

ISSUE

At issue was whether or not APD correctly denied a request to increase residential habilitation service hours at the behavior focus level, on the basis of lack of medical necessity. The petitioner had the burden of proof.

FINDINGS OF FACT

The petitioner, with date of birth [redacted], has developmental and behavioral impairments such that she is undisputedly eligible for assistance under the Medicaid Waiver in the APD Home and Community Based Services (HCBS) Program. As a recipient of HCBS Medicaid Waiver services, she resides with other young women at a group home, professionally supervised around the clock, by Group Homes, DSI. As part of ongoing care and eligibility assessment, the waiver support coordinator developed a support plan update during March 2006, to be effective April 1, 2006 (Petitioner's Exhibit 2). Additionally, a behavior program (Petitioner's Exhibit 3) had been approved by the APD senior psychologist on February 15, 2006.

MAXIMUS is the contract agent which performs Prior Service Authorization (PSA) reviews for APD.

Following PSA review of the waiver support plan submission, on April 3, 2006, MAXIMUS informed the petitioner (guardian) that adult day training, behavior analysis, and behavior assistant services were approved as requested, but request to increase residential habilitation – behavior focus hours from seven to ten a day was not authorized, with a determination "(h)ave not been determined to be medically

necessary." Respondent's Exhibits 1 and 2 were issued to the guardian informing of such.

On behalf of the petitioner a hearing was requested (Petitioner's Exhibit 1). Reconsideration (Respondent's Exhibit 3) by Dr. Guilarte of MAXIMUS occurred during June 2006, but level of approval remained at seven hours daily. That reconsideration also included materials in Petitioner's Exhibit 3.

Services as authorized by APD included Adult Day Training of six hours daily, plus transportation, with behavior analysis services for about nine hours per month and behavior assistant services for eight hours weekly. According to the behavior program in Petitioner's Exhibit 3, the plan was to reduce behavior analysis "when target behaviors are zero for 16 weeks...." That has not yet occurred and the behavior services remain in place and have not been reduced by an agency action.

The petitioner is able to walk, talk, eat, drink, toilet herself, sleep through the night, and complete personal care tasks independently with verbal prompts and assistance to encourage personal hygiene focus. She initiates and completes household chores, attends to her own laundry and assists other residents, but requires constant supervision and some prompting. She also has a history of maladaptive behavior such as physical and verbal aggression, inappropriate touching, property destruction and self injurious behavior. On at least one occasion this year, inappropriate sexual behavior occurred. According to Ms. Goehring's March 1, 2006 progress report in Petitioner's Exhibit 2, the petitioner "is making stable progress at both the group home and day program." The report informs:

> ...continues to make steady progress on reducing her frequency of dangerous behaviors, however, the intensity continues to remain very intense and has caused injuries to others in the past year. She continues to exhibit incidents of physical aggression as well as other behaviors that are preventing her from living in a less restrictive environment. We anticipate (the petitioner) will continue to make progress on reducing her target behaviors with the recommended services in place at the group home...
> Due to the potential danger of (the petitioner's) problematic behaviors and lack of safety skills, at this time [illegible] Group Homes, L.L.C remains the most appropriate placement to provide on-going behavioral supports, training in daily living skills, and 24-hour supervision.

Historically, the petitioner has been at the group home for seven or eight years, was doing rather well after a time, left to return to the family home for a few months, deteriorated, and returned to the facility. According to the director, his organization serves approximately 85 clients with some commonalities, and the petitioner is one of the 10 most restricted. He described her as not on a one way trajectory, and in need of 24 hour a day supervision. Need for 24 hour per day supervision is undisputed. He further noted that there can be behavior incidents which require 3-4 staff members. Such incidents were not discernible from available evidence.

June 2006 reconsideration review of the request for ten hours daily of residential habilitation service at the behavior focus level, resulted in affirmation to continue the seven hours instead, and noted the following:

> The initial determination approved the service at the intensity of seven hours of direct care staff per day. ... The graphic displays indicate a recent increase in some target behaviors...does not provide an analysis of these events or any refinement, indications of the Behavior Analysis provider's attention to this increase or possible monitoring of the circumstances leading to this increase. There appears to be no consideration to a recommendation to increase the use of time limited Behavior Assistant Services. The graphic displays do not make it clear if these incidences are specific to the Adult Day Training service or the home...may need

additional Behavior Analysis supports, there does not appear to be efforts to gather those specialized resources...

CONCLUSIONS OF LAW

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

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

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

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

(6) Program Requirements – General. All HCB services waiver providers and their billing agents must comply with the provisions of the Florida Medicaid Provider Reimbursement Handbook, Non-Institutional 081, October 2003, which is incorporated by reference and available from the Medicaid fiscal agent. The following requirements are applicable to all HCB services waiver programs: ...

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

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

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.

(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.

In accord with the rules, Florida Medicaid **Developmental Disabilities Waiver Services Coverage and Limitations Handbook** October 2003, revised June 23, 2005, Chapter 2, **Covered Services, Limitations, and Exclusions** establishes the following standards:

Residential Habilitation Services
Description
Residential habilitation provides supervision and specific training activities that assist the recipient to acquire, maintain or improve skills related to activities of daily living. The service focuses on personal hygiene skills related to activities of daily living. The service focuses on personal

> hygiene skills such as bathing and oral hygiene; homemaking skills such as food preparation, vacuuming and laundry; and on social and adaptive skills that enable the recipient to reside in the community. This training is provided in accordance with a formal implementation plan, developed with direction from the recipient and reflects the recipient's goals(s) from their current support plan.
> Recipients with challenging behavioral disorders may require more intense levels of residential habilitation services described as behavioral residential habilitation, or intensive behavioral residential habilitation. The necessity for these services is determined by specific recipient behavioral characteristics that impact the immediate safety, health, progress and quality of life for the recipient, and the determination that less intensive services have not been sufficient to alter these behaviors. The need for more intense levels of residential habilitation, behavioral residential or intensive behavioral residential habilitation will be verified by the Developmental Disabilities Program Office.
> Note: Refer to special considerations under behavioral analysis and behavioral assistant services for additional requirements. ...
> **Limitations**
> Children or adults whose primary problem is behavioral in nature, should receive services through the behavior assistant services. ...
> **Special Consideration** ...
> Residential Habilitation with a Behavioral Focus ...
> The service provides for comprehensive monitoring of staff skills and their implementation of required procedures...
> Provides for the eventual transitioning of behavioral improvement of the recipient, to a less intense service alternative, through formalized procedures incorporated into implementation plans. ...
> The provider must document evidence of continued need as well as evidence that the services are assisting the service provider in meeting the needs of the recipient so that transition to less restrictive services may be possible.

Arguing on behalf of the petitioner, the group home director opined that the original requests and residential habilitation approvals (prior to the 2006 reviews) had been too low at only seven hours, and staff did not concur with that level. The MAXIMUS reconsideration reviewer noted that service authorization for the petitioner inherently included around the clock supervision at the facility, the question was really about how much additional one-on-one service is needed, and the materials presented

for review did not support need for an additional three hours over and above the already authorized seven hours daily. She noted that behavior issues were thoroughly considered along with information submitted. MAXIMUS staff found there had been steady progress, the petitioner's situation had not worsened, and information did not support approval of greater number of hours. Further, she opined that more behavior assistance could be requested, and if need were adequately shown, such a service might be approved at greater level.

Complete review of the materials submitted by both the petitioner and respondent has occurred, along with careful consideration of the arguments offered. Evidence established the petitioner has severe limitations and her behavior poses problems, but she has made significant progress under the care received at the supervised group home. There has been significant progress and there are significant other services in place, such as adult day training, behavior analysis/assistance, and around the clock supervision. It should be possible to meet needs of the petitioner with continuation of seven hours per day residential habilitation with a behavior focus. Medical necessity for a greater number of hours has not been established by substantive evidence.

Based upon evidence and in light of regulatory guidelines, it cannot be concluded that residential habilitation with behavior focus increase to ten hours per day has been justified.

DECISION

The appeal is denied and the agency action is affirmed.

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 30th day of October, 2006, in Tallahassee, Florida.

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

Copies Furnished To:

M. Catherine Lannon, Sr. Assistant Attorney OAG
Shane DeBoard, Esq, 7DLC

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

APPEAL NO. 06F-05520

PETITIONER,

Vs.

AGENCY FOR PERSONS WITH DISABILITIES
DISTRICT: 10 Broward
UNIT: APD

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on September 12, 2006, at 11:10 a.m., in Plantation, Florida. The petitioner was present with Patricia Ealy-Stewart, Medicaid Waiver support coordinator, and Tiara Baker, supported living coach. The agency was represented by Anne Blanford and James Murdock, attorneys from the Office of the Attorney General. Present from the Agency For Persons With Disabilities was David Gillis, human services counselor. Present on the telephone was Kim Watson, consultant reviewer from the Prior Service Authorization (PSA) Unit from APS.

ISSUE

At issue is the agency's July 21, 2006 action of denying the petitioner's request of supported employment services. The petitioner has the burden of proof.

FINDINGS OF FACT

The petitioner, who is 30 years old, date of birth [redacted] receives services from the Agency for Persons with Disabilities Home and Community Based Services Medicaid Waiver Program. There was a request for supported employment services for him. A notice was provided, dated July 21, 2006, informing the petitioner of the request for supported employment services was denied.

APS is a private firm that is contracted by the agency to evaluate services for eligible recipients of the Medicaid Waiver Program. APS completes Prior Service Authorization reviews (PSA). APS's process for completing the reviews is to have a consultant reviewer make a preliminary decision for each review. A peer reviewer reviews this decision, and agrees or not. Then a physician reviews this action, and makes a decision if the action being reviewed is correct or not. This process occurred for this case.

Supported employment services provides training and assistance in a variety of activities to support recipients in sustaining paid employment at or above minimum wage. Included in the evidence is a copy of a Developmental Services Support Plan update form dated June 12, 2006, requesting a supported employment coach for the petitioner to assist him with locating a job.

Included in the evidence is a copy of a Determination of Prior Authorization Review form #3b for the cost plan year effective June 27, 2006. It states that supported employment services are requested for the petitioner for an allotted amount of $1,600.00. According to the Developmental Disabilities Waiver Services Coverage and Limitations Handbook on page 2-103, it states that supported employment services furnished under the waiver are not available through programs funded by the Rehabilitation Act of 1973.

Vocational Rehabilitation services provides phase 1 of supported employment services to eligible individuals with disabilities. It was not shown that supported employment services was requested through Vocational Rehabilitation, therefore the request for these services was denied because it is available through a funding source other than the Developmental Disabilities waiver.

CONCLUSIONS OF LAW

Fla. Statutes at 393.063 defines supported employment, and states:

> (37) "Supported employment" means employment located or provided in an integrated work setting, with earnings paid on a commensurate wage basis, and for which continued support is needed for job maintenance.

The Developmental Services Waiver Services, Medicaid Coverage and Limitations Handbook, starting on page 2-98 explain supported employment, and special considerations states in part:

> Supported employment services provided training and assistance in a variety of activities to support recipients in sustaining paid employment at or above minimum wage...Supported employment services furnished under the waiver are not available through programs funded by the Rehabilitation Act of 1973.

It was determined that supported employment services from the Agency For Persons With Disabilities Medicaid Waiver Program was denied for the petitioner. These services are provided by Vocational Rehabilitation, and it was not shown that the petitioner requested these services from them before requesting it through the waiver. After careful consideration, it is concluded that the denial of the supported employment services, is upheld.

DECISION

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

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 2nd day of October, 2006,

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 T

Patricia Lary-Stewart
Gail Scott Hill
M. Catherine Lannon, Sr. Assistant Attorney General
Jean Costa, Esq.

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

APPEAL NO. 06F-05531

PETITIONER,

Vs.

AGENCY FOR PERSONS WITH DISABILITIES
DISTRICT: 10 Broward
UNIT: APD

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on September 12, 2006, at 10:00 a.m., in Plantation, Florida. The petitioner was present with Nancy Leslie, Medicaid Waiver support coordinator, and Rose Marie Hector, director of . Inc. The agency was represented by Anne Blanford, attorney from the Office of the Attorney General. Also present was James Murdock, attorney from the Office of the Attorney General. Present from the Agency For Persons With Disabilities was David Gillis, human services counselor. Present on the telephone was Jane Siskind, consultant reviewer from the Prior Service Authorization (PSA) Unit from Maximus.

ISSUE

At issue is the agency's July 25, 2006 action of denying the petitioner's request of ten hours of daily residential habilitation services, and approving her for five hours daily. The petitioner has the burden of proof.

FINDINGS OF FACT

The petitioner, who is 27 years old, date of birth [illegible] receives services from the Agency for Persons with Disabilities Home and Community Based Services Medicaid Waiver Program. She resides at the [illegible] Group Home, and she was approved for five hours of daily residential habilitation services. A notice was provided, dated July 25, 2006, informing the petitioner of the approval, and of a denial of her request for ten hours of daily residential habilitation services.

Maximus is a private firm that is contracted by the agency to evaluate services for eligible recipients of the Medicaid Waiver Program. Maximus completes Prior Service Authorization reviews (PSA). Maximus' process for completing the reviews is to have a consultant reviewer make a preliminary decision for each review. A peer reviewer reviews this decision, and agrees or not. Then a physician reviews this action, and makes a decision if the action being reviewed is correct or not. This process occurred for this case. Maximus determined that the petitioner requires residential habilitation services.

According to the Maximus witness, five hours of daily residential habilitation services are the amount of services that the petitioner requires within the Medicaid definition of medically necessity. In the Determination of Prior Authorization Review form #3b, it states that the petitioner has been approved in this cost plan for behavior analysis, and it is recommended that she has behavior assistance services, based on the

information provided. It also states that the petitioner is independent in all of her activities of daily living, and that according to the information provided, a total of four hours of daily residential habilitation tasks are noted in the report of her activities.

A hearing was previously held with the petitioner under appeal number 06F-2311. The petitioner requested the same ten hours of daily residential rehabilitation, and the agency approved her for five hours of daily residential habilitation. The decision on the Final Order dated June 6, 2006, upheld the agency's action. In addition to residential habilitation services, the petitioner has been approved for dental services, dietician services, and support coordination.

CONCLUSIONS OF LAW

Fla. Admin. Code 59G-1.010 defines medically necessary, and states in part:

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

> goods or services medically necessary or a medical necessity or a covered service.

In making a determination of what a word means, the normal and ordinary meaning for the word is used. However, by rule the term "medically necessity" has special meaning. The Rule specifically defines matters that have to be taken into consideration in determining medically necessary. The Developmental Services, Waiver Services, Florida Medicaid Coverage And Limitations Handbook starting on page 2-5 addresses medically necessary determinations, and states in part:

> An appropriate, qualified, professional shall make the determination that the standards for medical necessity set forth in 59G-1.010(166)(a)(c), F.A.C., are met, and that the requested item meets the service definition of medically necessary.

This recognizes that it takes a qualified professional to apply the concepts included in the rule definition of medically necessary. The agency's reason for the decision for services was on the basis that the amount of hours that was requested for residential habilitation exceeds medical necessity, and that there is no determination that the amount of hours of services that were requested are medically necessary.

The Developmental Services Waiver Services, Medicaid Coverage and Limitations Handbook, starting on page 2-57 explains residential habilitation, and states in part:

> **Residential habilitation** provides specific training activities that assist the beneficiary to acquire, maintain or improve skills related to activities of daily living...When this service is provided in a beneficiary's own home, the service must be directly related to a training goal(s) on the beneficiaries support plan and cannot be used solely for the supervision of the beneficiary... When residential habilitation is provided in a beneficiary's family home, the beneficiary shall have an outcome (goal) for supported living on the support plan.

The findings show that Maximus determined that residential habilitation services from the Agency For Persons With Disabilities Medicaid Waiver Program was approved for the petitioner for five hours a day. It was determined that the request for ten hours of daily residential habilitation services exceeds medically necessity, and there is no determination that the services requested are medically necessary. After considering the evidence, Fla. Admin. Code Rule, and all of the appropriate authorities, it is concluded that the determination that five hours of daily residential habilitation services are medically necessary for the petitioner, is upheld.

DECISION

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

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 2nd day of October, 2006,

in Tallahassee, Florida.

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

Copies Furnished 1

Gail Scott Hill
M. Catherine Lannon, Sr. Assistant Attorney General
Jean Costa, Esq.

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

PETITIONER,

Vs.

APPEAL NO. 06F-04153

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

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned-hearing officer on September 7, 2006, at 3:45 p.m., in Gainesville, Florida. The petitioner was not present. Present representing the petitioner was his mother, [redacted] Present as witnesses for the petitioner were Chris LaBelle, PhD, behavior analyst and Michael McLean, waiver support coordinator. The respondent was represented by Lucy Goddard-Teel, District 3 legal counsel. Present testifying by telephone on behalf of the respondent was Dr. Emma Guilarte of MAXIMUS.

The hearing was scheduled for August 18, 2006. However, at the request of the petitioner a continuance was granted.

ISSUE

The petitioner is appealing the respondent's action of June 16, 2006, to decrease the number of hours of behavior assistant services and personal care assistance (PCA)

that he was receiving through the Developmental Disabilities Home and Community-Based Medicaid Waiver Program.

FINDINGS OF FACT

The petitioner is developmentally disabled and is eligible to receive services from the respondent's Developmental Services Home and Community-Based Services Waiver Program. The petitioner was 16 years old. He attends school on a regular basis and resides with his mother. Prior to living with his mother, the petitioner was in a residential habilitation intensive behavior program. The petitioner has been diagnosed with mental retardation and Autism. The petitioner receives the following services through the Developmental Services Home and Community-Based Services Waiver Program. Behavior analysis, behavior assistant services, personal care assistance, respite, medication review and support coordination.

The respondent's Developmental Disabilities Program has contracted with Maximus to perform Prior Service Authorization (PSA) reviews on certain requested services or when costs of a support plan exceed certain levels. The petitioner through his waiver support coordinator requested 13,940 quarter hours of behavior assistant services and 9,600 quarter hours of personal care assistance which he had been previously receiving.

Documentation received by Maximus indicated that the petitioner's behavior intervention plan was primarily focused on the development of basic communication skills to replace target behaviors. There was no indication of how the communication system was used with the petitioner in the school he attended. There was no indication that personal care and activities of daily living were included in any formal skill

development or replacement program. The information received by Maximus indicated that the behavior assistant service was paired with the personal care assistance to go on community activities and there was no documentation to indicate that family members were being trained to support the work of the behavior assistant. Maximus approved 11,120 quarter hours of behavior assistant services to carry out the training of other caregivers in the behavior intervention plan, coordinate the implementation of school designed communication program for replacement of target behaviors and other procedures to acquire independence with personal care and activities of daily living. The 11,120 quarter hours approved was based on an average of 12 hours on non-school days (165 days) and four hours on 200 school days. Maximus determined that the petitioner's request for 13,940 quarter hours of behavior assistant service which included an average of six hours on school days was not medically necessary and in excess of the petitioner's needs. The petitioner requested a reconsideration of the reduction in behavior assistant services. The reconsideration was denied and the Maximus reviewer upheld the original determination to approve 11,120 quarter hours of behavior assistant services.

The information received by Maximus related to the request for 9,600 quarter hours of personal care assistance indicated that the service was used to accompany the petitioner and the behavior assistant services provider on walks, community outings, work on puzzles, read books, accompanying him to therapy session, playing in the back yard, cooking for him and giving the petitioner free time. The personal care assistance provider also assisted the petitioner's family with his personal care routines. Maximus approved 6,820 quarter hours or approximately five and one half hours per day of

personal care assistance and determined that 9,600 quarter hours or approximately six and one half hours per day was not medically necessary and in excess of the petitioner's needs. Maximus' determination was based on the fact that personal care assistance for children is required to be provided in the family home only to assist the parent of primary caregiver of children in meeting the personal care needs of the child and that there was a misuse of the service and an overlap with other services.

CONCLUSIONS OF LAW

Fla. Admin. Code 59.G-8.200, Home and Community-Based Services Waivers, states in part:

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

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

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

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

Behavior Assistant Services include the performance of one-on-one activities related to the delivery of behavior analysis services, as defined under Behavior Analysis Services and Assessment, and are designated in and required by a behavior analysis service plan. Activities include monitoring of behavior analysis services, the implementation of behavioral procedures, data collection and display (e.g., graphics) as authorized by a beneficiary's behavior analysis service plan and training for caregivers. The behavior analysis service plan must be designed, implemented and monitored in accordance with Chapter 65B-4.030, F.A.C., and approved in accordance with Chapter 65B-4.029, F.A.C. Behavior assistant services are designed for beneficiaries for whom

traditional residential habilitation services have been documented unsuccessful.

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

> Personal care assistance is a service that assists a beneficiary with eating and meal preparation, bathing, dressing, personal hygiene, and activities of daily living. The service also includes activities such as assistance with meal preparation, bed making and vacuuming when these activities are essential to the health and welfare of the beneficiary and when no one else is available to perform them. This service is provided on a one-on-one basis...
>
> Special Considerations...Personal care assistance in the family home should be provided only to assist the parent or primary caregiver of children in meeting the personal care needs of the child. Beneficiaries who live in their own home or adults that live in a family home may require personal care assistance to assist them with meeting their own personal care needs.
>
> Things to consider when approving this service for children include: 1) physical limitations or abilities of the parent or caregiver; 2) number of other beneficiaries the parent or caregiver is attempting to provide assistance to; 3) gender of beneficiary, compared to that of the parent or caregiver; and 4) complexity of the beneficiary's personal care routine.
>
> For beneficiaries living in their own home, consider their own physical limitations or abilities to meet their own daily personal care assistance needs.

The Findings of Fact show that the respondent approved 11,120 quarter hours of behavior assistant services which was an average of 12 hours on non-school days (165 days) and four hours on 200 school days. The evidence presented did not show that the petitioner required additional hours of behavior assistant services. Based on the above, the petitioner's request for 13,940 quarter hours of behavior assistant service was not medically necessary and in excess of the petitioner needs. Therefore, it is

determined that the respondent correctly reduced the petitioner's behavior assistant services.

Personal care assistance for children is a service that assists a beneficiary with activities that include eating, bathing, dressing, personal hygiene, and activities of daily living. Personal care assistance in the family home should be provided only to assist the parent or primary caregiver of children in meeting the personal care needs of the child. The evidence presented showed that the personal care assistance that was previously approved was being used to provide the petitioner with his personal care needs and was also being used to take the petitioner on walks, community outings, work on puzzles, read books, accompanying him to therapy session and playing in the back yard. Based on the above, it is concluded that the 9,600 quarter hours or approximately six and one half hours per day of personal care assistance requested was not justified by the evidence presented and that 6,820 quarter hours or approximately five and one half hours per day would be considered to be medically necessary. Therefore, it is determined that the respondent correctly reduced the petitioner's personal care assistance.

DECISION

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

NOTICE OF RIGHT TO APPEAL

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

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

DONE and ORDERED this 10th day of October, 2006,

in Tallahassee, Florida.

Morris Zamboca

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

Copies Furnished To:

M. Catherine Lannon, Sr. Assistant Attorney General
Lucy Goddard-Teel

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

APPEAL NO. 06F-05779

PETITIONER,

Vs.

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

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on October 4, 2006, at 9:57 a.m., in Largo, Florida. The petitioner was present. The petitioner was represented by Shelly Law, residential home director. The respondent was represented by Sabrina Redd, assistant attorney general, and Gerald Siebens, assistant attorney general. Witnesses for the respondent were Gary Reavis, registered nurse consultant reviewer with APS Incorporated, and Holly Campbell, Developmental Services Waiver Services liaison. Present on behalf of the petitioner and called as a witness by the respondent was Jolynn Zufelt, adult day trainer.

ISSUE

The petitioner is appealing for the respondent's actions in the notice of August 25, 2006 to terminate skilled nursing services, on the basis that the

services is not Developmental Disability Waiver covered services as it is a service that is provided under the Medicaid State Plan. The respondent has the burden of proof.

FINDINGS OF FACT

The petitioner is a 73 year old eligible Developmental Disability Waiver participant. The petitioner is insulin dependent and unable to administer his own injections.

A request was made for payment by the Developmental Disability Waiver for services including skilled nursing two and one quarter hours a day for the service period. The respondent reviewed the requests and referred the case to APS Healthcare Incorporated.

APS Healthcare Incorporated is the contract provider for the respondent that reviews Developmental Disabilities Waiver service requests and performs prior service authorizations.

APS Healthcare Incorporated reviewed the Developmental Services Waiver Services Florida Medicaid Coverage and Limitations Handbook (June 23, 2005). The handbook on page 2-6 described "Availability of Other Coverage Sources". Skilled nursing service, in this case, should be provided by the Medicaid State Plan as set for Home Health Services Coverage and limitation Handbook (October 2003) on page 2-12 and 2-13. The Notice of Denial for the requested service of skilled nursing was sent on August 25, 2006.

CONCLUSIONS OF LAW

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. The Agency for Persons with Disabilities determines recipient eligibility for the Developmental Disabilities Waiver Program. Florida Statutes at 393.066 sets forth:

> (9) The department may adopt rules to ensure compliance with federal laws or regulations that apply to services provided pursuant to this section.

Florida Administrative Code 59.G-8.200, "Home and Community-Based Services Waivers", states in part for covered services:

> (1)Purpose. Under authority of section 2176 of Public Law 97-35, Florida obtained waivers of federal Medicaid requirements to enable the provision of specified home and community-based (HCB) services to persons at risk of institutionalization. Through the administration of several different federal waivers, Medicaid reimburses enrolled providers for services that eligible recipients may need to avoid institutionalization...
> (4) Covered Services — General. Services provided under the HCB services waivers include those described in subsections (3)(a) through (ff). The availability of these services to waiver program participants is subject to approval by the Medicaid office and is subject to the availability of the services under the specific waiver program for which a recipient has been determined eligible...
> (5) Service Limitations — General. The following general limitations and restrictions apply to all home and community-based services waiver programs:
> (a) Covered services are available to eligible waiver program participants only if the services are part of a waiver plan of care ("care plan", "individual support plan", or "family support plan")...
> (9) Home and Community-Based Services Waiver Programs. The following are authorized HCB services waivers...
> (c) Developmental Services Waiver...

Home health visit limitations and skilled nursing service under the Medicaid State Plan is set forth in the Home Health Services Coverage and limitation Handbook, October 2003, (page 2-12 and 2-13). The Developmental Services Waiver Services Florida Medicaid Coverage and Limitations Handbook, June 23, 2005 (page 2-6) sets forth that the Waiver may not provide a State Plan covered service:

> When a service must be purchased, those available under the Medicaid State Plan must be utilized before accessing services through the waiver. The waiver cannot supplant or replace a benefit available through Medicaid State Plan services. It is a federal requirement to access state plan coverage before the provision of waiver services. As stated in section 4442.3, State Medicaid Manual:
>
> No service may be provided under the waiver if it is already provided under the State plan unless the nature or the amount of the service, when provided under the waiver, would not be covered if provided under the State plan. For example, if the waiver provides for the coverage of home health aide services, the maximum number of visits allowed under the waiver could be greater than the limit contained under the State plan. The amount chargeable for waiver services is that amount incurred after any limits in State plan services have been reached. Similarly, if the State proposed to provide home health aide services, which were defined more broadly than those available under the State plan, these could be included as waiver services.

Skilled nursing service is covered by the State Plan and services covered by the State Plan cannot be provided by the Developmental Disability Waiver. Services provided through the Medicaid State Plan cannot be services paid by the Developmental Disability Waiver. Based upon the above cited authorities, the respondent's action, to terminate skilled nursing service, on the basis that the service was not a waiver covered services, was within the rules of the Program.

DECISION

This appeal is denied.

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 10th day of October, 2006,

in Tallahassee, Florida.

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

Copies Furnished T

)r respondent

Gail Scott Hill
M. Catherine Lannon
Jennifer Lima, Esquire

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

APPEAL NO. 06F-04684

PETITIONER,

Vs.

AGENCY FOR PERSONS
WITH DISABILITIES (APD)
DISTRICT: 07 Seminole

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice and following the petitioner's good cause rescheduling request, an administrative hearing was convened before the undersigned hearing officer at 11:00 a.m. on September 14, 2006 in Sanford, Florida. The petitioner was present with her mother, [redacted] and waiver support coordinator, Anna Actisdano. The respondent was represented by Diana Esposito, Esq, Office of the Attorney General, with testimony available from Leslie Varhol, APD human service analyst, and telephone testimony available from Kim Watson, consultant reviewer with APS Healthcare.

ISSUE

At issue was whether or not APD funding authorization of respite care service at level of thirty days per year was correct. Burden of proof is on the agency. Another issue of behavioral therapy service termination was resolved in favor of the petitioner and was not further addressed at hearing.

FINDINGS OF FACT

The petitioner is a recipient of Home and Community Based Services (HCBS) Medicaid Waiver Program with the Agency for Persons with Disabilities (APD). Eligibility for such is undisputed. With date of birth as [redacted] she has many physical and mental challenges along with cerebral palsy, and lives with her family in the community while also attending school. She needs assistance for personal hygiene, cannot walk or talk, and occasionally exhibits behavioral aggression.

Her mother is a significant part of her care giving team and personal care assistance (PCA) service is received under the HCBS. Her mother works. Her mother has lost jobs due to attention required for the petitioner. Her mother's life has been severely limited by care, attention and appointments required for the petitioner. On occasion, her mother may "need a break."

In the past, respite care was authorized at a level of 52 days a year under the HCBS waiver program. In March 2006, a support plan update was submitted, requesting respite care at a level of more than ninety days, so that the mother could achieve respite for about eight days per month. APS prior authorization review occurred by the contract agent and APD waiver funding authorization occurred at level of thirty days only under Prior Service Authorization (PSA) number 22887. The support plan was included in Respondent's Exhibit 2 and the June 13, 2006 APS notification was Respondent's Exhibit 1, as under challenge.

The reviewer noted there was a new manual policy limitation in place, such that respite authorization currently was limited to no more than thirty days annually. APD staff explained that it was generally a waiver support coordinator responsibility to review

policy and make requests consistent with limitations. APD staff further noted that personal care assistance could be authorized at a higher level if situations warranted, such as after surgery, and there might be funding available for nonresidential support services also, if requested with appropriate documentation. Also, staff noted that when the petitioner reaches age 18, companion service is an option.

As a practical matter, the petitioner's care requires intense attention and her behavior poses serious challenges. She cannot eat or drink or dress or toilet or walk on her own. All areas of personal hygiene require assistance.

CONCLUSIONS OF LAW

Fla. Admin. Code 59G-13.080 addresses **Home and Community-Based Services Waivers** in relevant part, informing:

> (5) Service Limitations – General. The following general limitations and restrictions apply to all home and community-based services waiver programs:
> (a) Covered services are available to eligible waiver program participants only if the services are part of a waiver plan of care ("care plan", "individual support plan", or "family support plan"). Care plan requirements are outlined in subsections (6) and (8) of this rule.
> (b) The agency or its designee shall approve plans of care based on budgetary restrictions, the recipient's necessity for the services, and appropriateness of the service in relation to the recipient, prior to their implementation for any waiver recipient. ...
>
> (6) Program Requirements – General. All HCB services waiver providers and their billing agents must comply with the provisions of the Florida Medicaid Provider Reimbursement Handbook, Non-Institutional 081, October 2003, which is incorporated by reference and available from the Medicaid fiscal agent. The following requirements are applicable to all HCB services waiver programs: ...
> (f) The plan of care will identify the type of services to be provided, the amount, frequency, and duration of each service, and the type provider to furnish each service. ...
>
> (12) Developmental Services Waiver – General. This rule applies to all Developmental Services Waiver Services providers enrolled in the

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

The Developmental Services Waiver Services Florida Medicaid Coverage and Limitations Handbook of October 2003 was further updated with an "implementation date of June 23, 2005," as shown in the Florida Medicaid transmittal correspondence from the Deputy Secretary for Medicaid, dated June 14, 2005. Page 2-79 of the updated handbook informs:

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

Fla. Admin. Code 59G-13.080 (2)(w) defines respite care as:

> ...the provision of supervisory, supportive, and short-term emergency care necessary to maintain the health and safety of a recipient when the primary caregiver is not available to provide such care or requires relief from the stress and demands associated with daily care.

Medical Services covered under Medicaid are defined as being "medically necessary" and are described in the Florida Administrative Code 59G-1.010(166)(a)(c), as follows:

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

Arguing in support of the request for greater respite than thirty days annually, the mother noted how tremendously limited her own life had become while attending to her daughter's needs. APD staff and APS reviewer noted that additional services might be available, and that other options for care may be explored under other descriptions and definitions of assistance, such as greater hours of personal care assistance or nonresidential support service, and that additional relief might occur in such a manner, rather than through direct authorization for respite. However, APD argued that under current procedural requirements, it is not currently permissible to authorize respite services for greater than 30 days per year.

After careful review of the facts and applicable regulatory guidelines, it is concluded that denial of additional respite hours was justified under the current plan which must be followed by the administrative agency. In view of the unique adverse

circumstances in the case at hand, it is understandable the petitioner would prefer higher level of service. Need for assistance is evident. However, the agency simply cannot authorize the additional respite coverage. The current limit is 2880 quarter hours, or 720 hours, or 30 days. The respite service is intended to provide a brief period of planned support and supervision for a recipient, during planned or emergency intervals, when the primary caregiver is unavailable. Therefore, it must be concluded that denial of additional hours was justified.

DECISION

The appeal is denied and the agency action is affirmed as to respite care authorization.

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 9th day of November 2006, in Tallahassee, Florida.

J.W. Alper

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

Copies Furnished To

Gail Scott Hill
Diana Esposito, Esq. OAG
M. Catherine Lannon, Sr. Assistant Attorney General

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

APPEAL NO. 06F-04827

PETITIONER,

Vs.

CASE NO. 1243237350

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

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on August 23, 2006, at 10:12 a.m., in Port Charlotte, Florida. The petitioner was not present. He was represented by his spouse, [redacted] The department was represented by Mary Norman, senior eligibility specialist.

ISSUE

At issue is the July 26, 2006 action by the department approving the petitioner for benefits through the Institutional Care Program and establishing his monthly patient responsibility as $3,301.87.

FINDINGS OF FACT

The petitioner resides in a nursing facility. On May 25, 2006, he filed a Request for Assistance to apply for benefits through the Institutional Care

Program. His spouse resides in the community and is referred to as the community spouse. The petitioner formed an income trust in order to qualify for the program on income. It was formed and funded in June 2006.

The petitioner has gross monthly income of $3336.87 from his social security benefit and a pension. His spouse has gross monthly income of $1,823.03 from a pension, her social security benefit, stock interest, and bank account interest. The community spouse has shelter expenses of $195.52. She was allowed a standard utility allowance of $198.

To determine if the community spouse was eligible for an income diversion from her spouse, the department considered her income and allowable expenses. Her shelter/utility expense totaled $393.53. The department compared this expense to 30% of the Minimum Monthly Maintenance Income Allowance (MMMIA) or $495. Since the petitioner's expenses did not exceed this amount, she was not entitled to an excess shelter expense. The petitioner has gross monthly income of $1,823.03. The MMMIA is $1650. Since the petitioner's income after allowable deductions exceeds the MMMIA, she was not entitled to any diversion from her spouse's income.

The department considered the petitioner's gross monthly income as $3336.87. They subtracted a personal need allowance of $35 resulting in a patient responsibility of $3,301.87. This is the amount that the petitioner must pay the nursing facility each month from his funds.

The petitioner lists her monthly expenses as the following:

Water and trash	100.00

Electricity	160.00
Phone	51.00
Cell phones	80.00
Cable	58.00
Medical expenses	100.00
Personal Loan	221.46
House insurance	100.00
Life insurance	47.92
Gas	50.00
Food	450.00
Yard, Pest, AC maintenance	67.00
Car payment	464.44
Car insurance	94.17
House and land taxes	33.33
Total	2077.32

CONCLUSIONS OF LAW

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

(c) Spousal Impoverishment Standards

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

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

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

4. Food Stamp Standard Utility Allowance: $198.

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

The Fla. Admin. Code at 65A-1.714 explains 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.
> (b) Single veterans or surviving spouses with no dependents residing in medical institutions who receive a reduced VA Improved Pension of $90, or less, are entitled to keep their reduced VA pension payment and shall have $35 of their income protected for their personal need allowance.
> (c) If the individual earns therapeutic wages an additional amount of income equal to one-half of the monthly therapeutic wages, up to $111, shall be protected for personal need. This protection is in addition to the $35 personal need allowance.
> (d) Individuals who elect hospice services have an amount of their monthly income equal to the federal poverty level protected as their personal need allowance unless they are a resident of a medical institution, in which case $35 of their income is protected for their personal need.
> (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.
> (f) For community hospice cases, a spousal allowance equal to the SSI FBR minus the spouse's own monthly income shall be deducted from the individual's income...

The Department's budgeting methodology as outlined in the Findings of Fact correctly reflect the budgeting methodology set forth in the above Florida Administrative Code Rule in calculating the amount Ms. ⁻ can retain of Mr.

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

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

The language of the preceding rule indicates that a couple must prove the existence of exceptional circumstances which result in significant inadequacy of the income allowance to meet their needs, before such income allowance can be upwardly revised. In examining the relative nature of what may be defined as an individual's "needs", it is necessary to define a standard of such "needs" that is consistent with the intent of public assistance programs in general, and more specifically with the ICP Program. Since the ICP Program sets the Minimum Monthly Maximum Income Allowance (MMMIA) to equal 150 percent of the Federally defined Poverty Level, it is evident that the intent of the ICP program is confined to address an individual's basic needs of food, shelter, medical costs, and work-related expenses. Therefore, any other indicated expenses would potentially be beyond the scope of this basic need definition of the ICP Program and thus, is not included or allowable in determining such basic needs.

Consistent with the above interpretative conclusion on the definition of basic needs, the community spouse would be allowed all of the expenses listed in the Findings of Fact with the exception of cable ($58), the charges for the cell

phone ($80), the personal loan payment ($221.46), and the payment for life insurance ($47.92). The community spouse may only receive the benefit of an expense for insurance when it is for health or dental. Life insurance and other such policies are considered beyond the scope of basic needs.

The United States Department of Agriculture, Food and Nutrition Services defines a one person "Thrifty Food Plan" to be $155 monthly. Therefore, the community spouse's listed $450 monthly expense for food expenses cannot be considered reasonable. The standard food stamp benefit level of $155 for one person was allowed.

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

Water and trash	100.00
Electricity	160.00
Phone	51.00
Medical expenses	100.00
House insurance	100.00
Gas	50.00
Food	155.00
Yard, Pest, AC maintenance	67.00
Car payment	464.44
Car insurance	94.17
House and land taxes	33.33
Total	1374.94

Ms. . . monthly income is established as $1,823.03. Her allowable monthly expenses of $1374.94 does not exceed her monthly income of $1,823.03. The facts establish that the community spouse is not eligible for a diversion of her spouse's income either using the department's standard procedures or the procedures permitted under a hearing officer's review.

The hearing officer reviewed the calculations used by the Department in determining the petitioner's patient responsibility for the Institutional Care Program. No mathematical of any other error was found. The calculations showed that the community spouse is not eligible for a diversion of his income. The Department computed the petitioner's benefits in the most favorable manner allowed by the above-cited laws.

DECISION

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

NOTICE OF RIGHT TO APPEAL

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

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

in Tallahassee, Florida.

Terry Oberhausen

Terry Oberhausen
Hearing Officer
Building 5, Room 203
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Tallahassee, FL 32399-0700
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Copies Furnished To

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

APPEAL NO. 06F-03512

PETITIONER,

Vs.

CASE NO. 1049667409

AGENCY FOR HEALTH CARE ADMINISTRATION
DISTRICT: 23 Hillsborough
UNIT: 88155

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was initially convened before the undersigned hearing officer on August 26, 2006, at 2:48 p.m., in Plant City, Florida, and then reconvened at the same location October 20, 2006, at 1:57 p.m. The hearing had been previously continued with the parties' concurrence, and then continued again after August 26, 2006 to allow sufficient time to explore possible settlement. The minor petitioner was not present at either convened hearing date, but was represented by her grand-father and guardian, [redacted] who also testified.

The agency was represented at both convened hearing dates by Harold D. Daniels, senior human services program specialist with the Agency for Health

Care Administration (AHCA), who also testified. Dr. William D. Layman, treating orthodontist, testified by telephone at the first convened hearing date. Dr. Heath Burch, contracted orthodontic consultant with the Agency for Health Care Administration, testified by phone at the second convened hearing date. Mary Cerasoli, program analyst with AHCA, appeared as a potential witness by telephone only at the second convened hearing date.

ISSUE

The petitioner is seeking reimbursement for the approximate $1,500 cost of orthodontic braces and treatment the petitioner received beginning September 21, 2005 through June 1, 2006. The respondent decision to deny funding for the then proposed treatment was on June 24, 2005. Prior to reviewing appeal merits, it is necessary to determine if the appeal was timely requested.

FINDINGS OF FACT

On July 7, 2005, the petitioner's grand-father and guardian, was verbally advised that his request for Medicaid coverage of proposed orthodontic services for the petitioner had been denied. No notice was sent the petitioner to advise of this denial determination. AHCA does not customarily generate such type of written notice when a this type of service is denied, per AHCA testimony. AHCA did not send any other type of written notice to the petitioner to advise of the timeframe to request an appeal. Even though the petitioner's representative testified that he spoke with several persons to

request this appeal, the hearing record establishes that the petitioner verbally requested this instant appeal to the Office of Appeal Hearings on May 23, 2006.

The petitioner is 15 years old and was born on [redacted]. The petitioner is approved to receive eligible services under the Florida Medicaid Program. The petitioner presently lives with her paternal grandfather and guardian, [redacted]. W[redacted]k and her grandmother are her present caretakers.

The petitioner began to receive orthodontic treatment on September 21, 2005, and this treatment ended on June 1, 2006. This treatment was performed by Dr. William D. Layman, orthodontist, while he was employed with a prior clinic, Sunshine Orthodontics. Dr. Layman is a Medicaid provider of orthodontic treatment.

Dr. Layman testified on the petitioner's orthodontic treatment based on his recollection alone, as he did not have access to the petitioner's medical records at the time of his telephone testimony. The petitioner had deterioration in the wear patterns in her teeth, increased crown fractures, and needed corrective measures to prevent future dental diseases, per Dr. Layman's testimony. Based on Dr. Layman's evaluation, the petitioner had a graded score of 12, per the asserted "old" Medicaid criteria. This graded number 12 is asserted as the minimum number necessary to warrant a referral to Medicaid for evaluation. Based on this number 12 grading, the petitioner's orthodontic treatment was referred to AHCA for evaluation.

After the petitioner's orthodontic medical information was sent to AHCA for evaluation, it which was forwarded to the contracted orthodontic consultant for a final decision. The AHCA contracted original consultant denied this request based on a determination of not being medically necessary. However, on July 13, 2006, Sunshine Orthodontics advised AHCA that medical records were being sent again to Medicaid headquarters to request a reconsideration review by a newly contracted orthodontic consultant. The hearing was continued for a period of at least 45 days to allow for completion of this reconsideration review. The hearing was reconvened on October 20, 2006.

A second orthodontist named Dr. Broussard removed the petitioner's braces and continued treatment after the treatment performed by Dr. Layman. In Dr. Broussard's opinion, the petitioner's orthodontic treatment warranted a score of 23 points under newly revised criteria reflected on the Medicaid Orthodontic Initial Assessment Form labeled Respondent Exhibit 3. Based on AHCA's reconsideration review of new medical evidence, the AHCA orthodontic consultant downwardly revised the treatment score to 17 points, per Dr. Heath Burch's testimony and as reflected on Respondent Exhibit 3. The AHCA representative asserts that a 26 point score is necessary to meet the defined medical necessity criteria and be eligible for Medicaid funding.

The second contracted AHCA orthodontic reviewer, Dr. Heath Burch, opined the petitioner to have had a deep overbite with severe maxillary crowding and very severe Class II malocclusion. However, Dr. Burch opined the

petitioner's orthodontic condition does not meet defined criteria of a severe handicapping malocclusion, and warranted a scoring of 17 points.

CONCLUSIONS OF LAW

Prior to reviewing the specific merit of the decision at issue, it is necessary to determine if the appeal was timely requested. The Findings of Fact show that the petitioner's representative was verbally advised on July 7, 2005 that the then proposed orthodontic services had been denied. Findings further establish that the appeal was requested on May 23, 2006. The language of the Florida Administrative Code (F.A.C.) Rule 65-2.046(1) sets forth a normal 90-day maximum time period from the date of the action at issue to request an appeal. Findings show the appeal was requested on May 23, 2006, which is more than this defined 90-day period.

However, findings also show that the petitioner did not receive any written notice that advised of the right and timeframe to request an appeal. Such requisite notice is necessary before constraining an appeal request to the ninety-day timeframe per F.A.C. Rule 65-2.046(2), as follows:

> (2) The time limitation does not apply when the Department fails to send a required notification, fails to take action of a specific request or denies a request without informing the appellant. If the notice is not mailed on the day it is dated, the time period commences on the date it is mailed.

Therefore, the appeal is not dismissed or denied as being untimely requested. Thus, the appeal proceeds to review the merit of the specific reimbursement denial determination at issue.

The Florida Administrative Code Rule 59G-1.010(166) addresses relevant definitions within the Medicaid Program, which are also applicable to this specific Medicaid decision regarding the request for orthodontic treatment reimbursement at issue. Subsection (166) of the Florida Administrative Code Rule defines what constitutes "medically necessary" care, goods or services, as follows:

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

The defined medical necessity criteria in paragraph 1. of the above-cited Administrative Code Rule indicates that services must be at the level to "protect life, prevent significant illness or significant disability, or to alleviate severe pain."

The "Dental Services Coverage and Limitations Handbook" on pages 2-15 sets forth specific limitations to Medicaid compensable orthodontic services for recipients under age 21. The beginning statement of this limitation is as follows:

> "Orthodontic services are limited to recipients under age 21 whose malocclusion creates a disability and is impairment to their physical development."

One of the listed criteria for approval of such orthodontic services is based on the following condition:

> "Correction of severe handicapping malocclusion as measured in the Initial Assessment Form. A minimum score of 26 points should be required for full banding."

The Findings of Fact do not show that the petitioner's orthodontic condition was severe enough to be at the level of a "severe handicapping malocclusion" based on the opinions of either of the treating orthodontists or the opinions of the reviewing AHCA orthodontists. Further, both the treating orthodontist Dr. Broussard and the second AHCA reviewing orthodontist, Dr. Burch, graded the petitioner's orthodontic condition to be less than the 26 points needed to meet the described medical necessity criteria.

In conclusion, the petitioner's orthodontic condition did not meet the level of medical necessity criteria described by the above authorities. Therefore, this treatment is not eligible for Medicaid funding. Since this treatment is not Medicaid compensable, it is moot to explore the potential reimbursement of this paid orthodontic treatment to the petitioner's representative.

DECISION

This appeal is denied and the agency action affirmed.

NOTICE OF RIGHT TO APPEAL

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

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

DONE and ORDERED this 16th day of November, 2006,

in Tallahassee, Florida.

Jim Travis
Hearing Officer
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1317 Winewood Boulevard
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STATE OF FLORIDA
DEPARTMENT OF CHILDREN AND FAMILIES
OFFICE OF APPEAL HEARINGS

APPEAL NO. 06F-04671

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 August 11, 2006, at 10:32 a.m., in Miami, Florida. The petitioner was present and represented herself. The agency was represented by Oscar Quintero, senior human service program specialist, Agency for Health Care Administration. Present via the telephone, as witnesses for the agency, were: Dr. Marcelino Oliva, medical director for KePRO; Judy Cox, RN supervisor for KePRO; and Diane Weller, KePRO contract manager at the Agency for Health Care Administration. Hector Gutierrez, served as an interpreter.

ISSUE

At issue is the agency's denial to pay for inpatient hospital medical services provided to the petitioner from May 17 through May 22, 2006, because the medical care as described to them does not appear to require inpatient services. The authorization request was denied pursuant to rule 59G-4.150. The petitioner has the burden of proof.

FINDINGS OF FACT

The petitioner, [redacted] is an adult female, 57 years of age, who was admitted via emergency room for generalized weakness, low blood pressure and bloody diarrhea at Tenet Hialeah Health Systems on May 15, 2006.

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

On May 16, 2006, KePRO received a request from the provider (Tenet Hialeah Health systems) for authorization for an admission review for five inpatient days 05/15/06-05/20/06. The nurse reviewers performed an initial screening review at the direction of AHCA using Interqual criteria to determine necessity for acute inpatient care and concluded that the clinical information sent did not meet Interqual criteria under Surgery/Trauma. The case was referred to a board-certified internal medicine physician who recommended approval for one day, from 05/15/06-05/16/06. The physician concluded that there was limited data to support five day LOS stay.

On June 12, 2006, the provider submitted a request to KePRO for authorization for retrospective review for six inpatient days 05/16/06-05/22/06, and provided additional information.

The nurse reviewers determined that the clinical information submitted did not meet Interqual criteria under GI criteria. The case was referred to a physician consultant board-certified in internal medicine who approved one more day. On June 20, 2006, the nurse

reviewer processed the split decision and approved one day 05/16/06-05/17/06 and denied five days 05/17/06-05/22/06.

On July 7, 2006, a reconsideration determination was completed, and the agency upheld its original decision.

At the hearing Ms. Weller explained that according to the Medicaid Provider General Handbook, the hospital cannot, and will not bill the petitioner for the denied inpatient services. Ms. Weller noted that Ms. Gonzalez has no financial responsibility for the denied days.

CONCLUSIONS OF LAW

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

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

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

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

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

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

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

These rules established guidelines for the definition and authorization of inpatient hospital services. The agency has reviewed the petitioner's eligibility for this service from May 15, 2006 through May 22, 2006, and determined that the service does not meet the conditions of medical necessity from May 17, 2006 through May 22, 2006.

Based on the evidence, testimony and above authorities, the hearing officer concludes that the agency was correct in its denial to pay for inpatient hospital medical services provided to the petitioner from May 17, 2006 through May 22, 2006.

DECISION

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

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 11th day of October, 2006,

in Tallahassee, Florida.

Alfredo Fernandez Jr

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

Copies Furnished T

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

APPEAL NO. 06F-04480

PETITIONER,

Vs.

AGENCY FOR HEALTH CARE
ADMINISTRATION (AHCA)
DISTRICT: 07 Brevard
UNIT: CMAT

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, and the petitioner's good cause for rescheduling, an administrative hearing was convened before the undersigned hearing officer in Cocoa, Florida at 2:38 p.m. on September 6, 2006. The petitioner was represented by her grandmother, [redacted] with Debra Fulton, RN from PSA testifying. The respondent was represented by Kathy Popp, RN with AHCA. Testimony was presented on behalf of AHCA by: Sandra DeVeaux, Children's Medical Assessment Team (CMAT) social worker; Lisa Wilson, CMAT RN; and Margaret Meunier, CMAT supervisor.

ISSUE

At issue was whether or not termination of full time Prescribed Pediatric Extended Care (PPEC) authorization was correct. Burden of proof is on the agency.

FINDINGS OF FACT

The petitioner was born November 17, 2004 with multiple health problems related to chromosome 18q deletion. She lives with her grandmother in the community. Prior to the action under challenge she received PPEC day care services under Medicaid, based upon CMAT determinations of medical necessity.

CMAT staffing occurred on June 27, 2006 (Respondent's Exhibits 3 and 4). The team determined there was no longer medical necessity for PPEC as the petitioner's condition(s) no longer justified such intense care, and needs could be met at a less costly nonmedical day care facility. Using the PPEC eligibility guide (Respondent's Exhibit 6) along with other administrative guides, CMAT determined the situation was not medically complex or fragile enough, nor was there sufficient instability, to justify continuation of PPEC. Notice of the adverse agency determination was Respondent's Exhibit 1, as under challenge. Further memorandum of explanation was Respondent's Exhibit 2.

The petitioner has a cleft palate, along with other anomalies such as gross motor skill deficiencies, and tubes were placed in ears during August 2006. Seizures occurred on August 13, 2006, EEG appeared to be normal, and no further seizure activity has been documented. Subsequent follow up CMAT reconsideration occurred before the hearing (Respondent's Exhibit 5), but the CMAT determination to terminate PPEC remained. Cleft palate repair is not anticipated until medical authorization occurs from the pediatrician when weight is "at least 20 pounds" (Respondent's Exhibit 3, page 3).

One of the biggest problems faced in the petitioner's situation is the length of time required for feeding. She eats regular table food by mouth (can feed herself finger

foods) and drinks Pediasure in a cross cut nippled bottle. She has reflux and is on medication and it takes approximately 15-20 minutes for the formula feedings. She can sit up, roll from side to side, use a walker and bouncy seat. Petitioner's Exhibits 1-3 included a physician statement recommending "she remain (in PPEC) to monitor her seizure activity as well as her poor weight gain." The doctor's statement had not been presented to CMAT staff until the hearing. Her grandmother described "problems eating and drinking and sometimes with breathing." Her grandmother does not believe adequate care could occur at another facility and fears relapse.

Another problem is the availability of adequate alternative placement in the community.

CONCLUSIONS OF LAW

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

Florida Statute 409.913 addresses **Oversight of the integrity of the Medicaid program**, with (1)(d) describing "medical necessity or medically necessary" standards and saying in relevant part that: "...For purposes of determining Medicaid reimbursement, the agency is the final arbiter of medical necessity..." Consistent with statute, Fla. Admin. Code 59G-1.010 (166) defines "medically necessary," informing that such services must:

> (a) Meet the following conditions:
> 1. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;

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

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

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

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

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

Purpose
The purpose of the Florida Medicaid Prescribed Pediatric Extended Care (PPEC) Program is to enable children with medically-complex conditions or the need for acute medical care to receive medical care at a non-residential pediatric center. ...
...
Description
A PPEC is a rehabilitative facility that serves three or more children under the age of 21 who require short or long-term continual medical care due to medically-complex conditions or the need for acute medical care. A PPEC

offers services that meet the child's physiological, developmental, physical, nutritional, and social needs.

...

Who Can Receive Services
To receive PPEC services, a recipient must meet the following criteria:
- Be Medicaid eligible;
- Be medically fragile or technologically dependent;
- Be age 20 or under;
- Be medically stable; and
- Must require short or long-term health care supervision due to medically-complex condition or the need for acute care.

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

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

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

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

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

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

grandmother argued that it was difficult, if not impossible to locate a satisfactory community day care alternative and that sustaining the current PPEC level would provide prudent prevention of further deterioration, substantive evidence did not support such a contention. Other than possible monitoring for seizures which have not recurred, and weight concerns which could be addressed by unskilled feeding, no skilled nursing services were evident from testimony or evidence. The physician's support for continuation of service is not controlling without solid and substantive evidence to confirm such a position, and such was not available. A nonmedical day care facility should be able to handle needs as they have been described and documented for the petitioner. Evidence submitted did support the agency determination as to appropriateness of transition to an equally effective, less restrictive and more conservative or less costly alternative.

Based upon the evidence and the governing guidelines, it is concluded that the plan, to cease Medicaid authorization of PPEC, is a reasonable determination. Thus, it is concluded the agency action has been justified. The agency will continue to assist in exploring other day care options as desired by the grandmother.

DECISION

The appeal is denied and the agency action is upheld.

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the agency. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Agency Clerk, Agency for Health Care Administration, 2727 Mahan Drive, Tallahassee, FL 32308-5403. The petitioner must also file another copy of the "Notice of Appeal" with the 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 25th day of October 2006, in Tallahassee, Florida.

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

Copies Furnished To

William Roberts, [illegible]

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

APPEAL NO. 06F-04949

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 October 6, 2006, at 8:15 a.m., in Fort Lauderdale, Florida. The hearing was rescheduled from September 8, 2006 and October 5, 2006, at the petitioner's request. The petitioner was not present. He was represented by his mother [redacted] The agency was represented by Jim Machonis, senior human services program specialist. Present on the telephone from the agency was Mary Cerasoli, program analyst, and Dr. Heather Burch, orthodontic specialist consultant.

ISSUE

At issue is the agency's May 16, 2006 action of denying a request for the Medicaid Program to pay for orthodontic services by providing the petitioner with braces. The petitioner has the burden of proof.

FINDINGS OF FACT

The petitioner, date of birth [redacted] is a recipient of Medicaid benefits in Broward County, Florida. Included in the evidence is a copy of a Prior Authorization Notice, dated May 16, 2006, stating that the request for Medicaid Services on behalf of the petitioner, was denied. It was determined that the request for the Medicaid Program to pay for orthodontic services by providing the petitioner with braces, is not medically necessary. The petitioner, through his representative, is appealing this denial.

Included in the evidence is a copy of a Medicaid Orthodontic Initial Assessment Form (IAF), dated March 7, 2006, from Edward R. Walters, D.D.S., P.A., in Coral Springs, Florida. Listed on the form are conditions observed, and points are assigned to the conditions. The petitioner achieved the following scores for the following conditions: Anterior Crowding- 5, and Labio-Lingual Spread- 2. The total score of the conditions on the form for the petitioner is 7.

According to Dr. Burch at the hearing, in this case, in order for the Medicaid Program to pay for orthodontic services by providing the petitioner with braces, he would have to achieve a minimum score of 26 on the IAF form. Since he did not achieve at least that score, the agency determined that braces for the petitioner is not medically necessary, therefore the request for the Medicaid Program to pay for orthodontic services by providing the petitioner with braces, was denied.

CONCLUSIONS OF LAW

Fla. Admin. Code at 59G-1.010 defines medically necessary, and states in part:

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

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

The Dental Services Coverage and Limitation Handbook, dated January 2006, starting at page 2-17 explains Orthodontic Services, and states in part:

> Orthodontic services must be authorized by Medicaid prior to the services being rendered.
>
> A score of less than 26 indicates that treatment of the recipient's condition may not qualify for Medicaid reimbursement, and request for prior authorization would probably be denied.
>
> This does not say that such cases do not represent some degree of malocclusion, but simply that the severity of the malocclusion does not qualify for coverage under the Florida Medicaid Orthodontic Program.

It was determined by the agency that the request for the Medicaid Program to pay for orthodontic services by providing the petitioner with braces, was denied because it was not medically necessary. At the hearing, Dr. Burch explained the agency's action. According to the Initial Assessment Form referred to in the above cite, the petitioner

achieved a score of 7, and the criteria to qualify is a minimum score of 26. The petitioner did not meet any of the other criteria to qualify for the orthodontic services. After careful consideration, it is determined that the agency's action to deny the request for the Medicaid Program to pay for orthodontic services by providing the petitioner with braces, 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 12th day of October, 2006,

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

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

APPEAL NO. 06F-04950

PETITIONER,

Vs.

AGENCY FOR HEALTH
CARE ADMINISTRATION
DISTRICT: 15 St. Lucie
UNIT: AHCA

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on September 22, 2006, at 3:30 p.m., in Fort Pierce, Florida. The petitioner was present and was represented by his maternal aunt, [redacted] and uncle, [redacted] Dave King, management analyst, Area 9 Medicaid, Agency for Health Care Administration (AHCA), represented the agency. Mary Cerasoli, program analyst, was present as a witness for AHCA. Dr. Heather Burch, orthodontic consultant, Medicaid, appeared by telephone as a witness for the respondent. Notary, Eleanor Dann, was present as she took her oath.

Two continuances were granted to the respondent for prior scheduled hearings.

ISSUE

At issue is the agency's denial of orthodontics for the petitioner. The petitioner holds the burden of proof in this matter.

FINDINGS OF FACT

Prior to hearing the merits of this case, jurisdiction had to be established. AHCA sent a Prior Service Authorization Notice on April 14, 2006. The agency shows July 28, 2006 as the date of the hearing request. As a result, AHCA moved to dismiss the appeal because they believed that the petitioner did not request a hearing within the allowable timeframe of 90 days. The petitioner's aunt wrote a letter to AHCA on July 10, 2006 disputing the reasons for denial and requested a reconsideration. The hearing officer finds that although the letter was sent to an incorrect address for reconsideration, that this was the petitioner's attempt at a request for a hearing (Petitioner's Exhibit 1). The motion for dismissal was denied. Jurisdiction was established and the hearing moved forward.

The petitioner is a thirteen year old boy, date of birth for whom orthodontic coverage was requested. His Medicaid eligibility is undisputed.

In consideration of the request for Medicaid reimbursement for orthodontic coverage, the agency's orthodontic evaluators conducted a prior authorization review of materials submitted by the attending dentist. The Initial Assessment Form (IAF) submitted by the attending Medicaid dentist, Dr. Edward Walters, is the Respondent's Exhibit 5. It reflects a dental examination date on February 20, 2006, showing a diagnosis of Class I Malocclusion and a tongue habit. A fixed appliance, a tongue rake was requested as treatment. Dr. Walters did not submit a request for braces for the

petitioner. The attending dentist used a point evaluation system, and assigned two points, shown in Respondent's Exhibit 5.

The agency determined that medical necessity standards for Medicaid reimbursement coverage were not met due to the level of points assigned by the attending dentist. The agency's Florida Medicaid Dental Services Coverage and Limitations Handbook is incorporated in the Florida Administrative Code. The agency did not say that braces for the petitioner are not medically necessary, just that the need is not severe enough for Medicaid to pay the cost. The level of severity is determined by the scoring on the AIF. To be eligible, the score must be at least a 26.

Mrs. [redacted] believes that the petitioner has an abnormal overbite that will worsen over time. She does not want his side teeth to wear down. She disagreed with Dr. Walter's evaluation and took the petitioner to Dr. Legler for a second opinion. He is not a Medicaid provider. He was not present at the hearing. He saw the petitioner on July 20, 2006, for an orthodontic evaluation. He believes that the petitioner does not bite correctly because his front teeth protrude about 6mm beyond his lower teeth forcing him to slide his jaw forward excessively. He recommended full fixed braces on both upper and lower teeth for alignment of his teeth (Petitioner's Exhibit 2).

When AHCA made the decision on medical necessity, they did not have the evaluation completed by Dr. Legler. Dr. Burch opined that it would not have made a difference in the decision because Medicaid only pays for the most severe cases.

CONCLUSIONS OF LAW

By agreement between the Agency for Health Care Administration and the Department of Families and Children, the Agency for Health Care Administration has

conveyed jurisdiction to the Office of Appeal Hearings to conduct this hearing pursuant to Chapter 120.80 F.S.

Florida Statute 409.913 addresses **Oversight of the integrity of the Medicaid program**, with (1)(d) describing "medical necessity or medically necessary" standards and saying in relevant part that: "...For purposes of determining Medicaid reimbursement, the agency is the final arbiter of medical necessity." Consistent with statute, Fla. Admin. Code 59G-1.010 (166) defines "medically necessary," informing that such services must:

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

Fla. Admin. Code 59G-4.060 addresses **Dental Services** with subsection (2) informing:

> All dental services providers enrolled in the Medicaid program must be in compliance with the Florida Medicaid Dental Services Coverage and Limitations Handbook, January 2006, and the Florida Medicaid Provider Reimbursement Handbook, Dental 111, October 2003, which are incorporated by reference, and the Florida Medicaid Provider Reimbursement Handbook, CMS-1500, which is incorporated by

reference in Rule 59G-4.001, F.A.C. All handbooks are available from the Medicaid fiscal agent's website at http://floridamedicaid.acs-inc.com. Click on Provider Support, and then on Handbooks. Paper copies of the handbooks may be obtained by calling Provider Inquiry at (800)377-8216.

Page 2-17 of the **Dental Services Coverage and Limitations Handbook,** ***Orthodontic Services,*** addresses the required point evaluation system, **Index Score of 26 or Greater,** and says the following:

> A score of 26 or greater may indicate that treatment of the recipient's condition could qualify for Medicaid reimbursement, and the orthodontic provider should submit a prior authorization request for approval of orthodontic services to the orthodontic consultant. A score of 26 or greater on the IAF is not a guarantee of approval. It is used to determine whether diagnostic records should or should not be sent to the orthodontic consultant.

The Handbook continues, and addresses **Index Score of Less than 26**, saying:

> A score of less than 26 indicates that treatment of the recipient's condition may not qualify for Medicaid reimbursement, and request for prior authorization would probably be denied
> This does not say that such cases do not represent some degree of malocclusion, but simply that the severity of the malocclusion does not qualify for coverage under the Florida Medicaid Orthodontic Program.

In accord with processing standards, a prior authorization review must occur before Medicaid reimbursement may be authorized. In the case at hand, while the petitioner has occlusion problems, the situation does not rise to an approvable level under Medicaid standards, for purpose of Medicaid reimbursement. Occlusion difficulties are the determining factor and in the case at hand, the standard required for Medicaid reimbursement was not demonstrated. Therefore, denial was justified.

DECISION

The appeal is denied and the agency action is upheld.

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 17th day of November 2006,

in Tallahassee, Florida.

Margaret Poplin

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

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

APPEAL NO. 06F-04521

PETITIONER,

Vs.

CASE NO. 1003944051

AGENCY FOR HEALTH
CARE ADMINISTRATION
DISTRICT: 04 Duval
UNIT: AHCA

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on October 31, 2006, at 3:05 p.m., in Jacksonville, Florida. The petitioner participated in the hearing by telephone. The agency was represented by Brevin Brown, attorney, who participated in the hearing by telephone. Jody Winter, Physical Therapist and Dan Gabric, Program Analyst appeared as witnesses for the agency and also participated in the hearing by telephone. Michelle Manor, Program Operations Administrator, Jill Hricz, Karen Belkot, Program Administrator and Ron Dixon, Medicaid Program Integrity, all of the Agency for Health Care Administration (AHCA), appeared at the hearing as witnesses for the agency.

ISSUE

The petitioner disagrees with the type of wheelchair paid for by Medicaid.

FINDINGS OF FACT

In April 2005, the Medicaid Program approved a request for a Pride Jet 2 wheelchair for the petitioner. The Medicaid authorization request showed Medicaid would pay $369.97 for 10 months for a total of $3699.70. The Provider name listed on the request form was First Coast Medical. The agency submitted a doctor's statement dated February 22, 2006 showing the petitioner weighed 295.6 pounds. It was unclear whether or not the petitioner actually received a Jet 2 or Jet 3 wheelchair. The capacity documentation submitted at the hearing showed the weight capacity for a Jet 2 and a Jet 3 wheelchair was 300 pounds.

Since receiving the wheelchair there have been several service calls for repair. The batteries and motors have been replaced several times since the chair was purchased in April of 2005. The petitioner believes the provider gave him the wrong chair for his size. The petitioner also believes that the amount of repair work done on the wheelchair confirms that the wheelchair is not able to meet his needs. The agency initiated an investigation of the medical equipment provider. The agency investigator testified that he found no evidence of fraud or abuse on the part of the provider.

The petitioner did not have an issue with Medicaid. The record did not show that Medicaid had denied a request for services or equipment made by the petitioner. The petitioner turned 65 in April 2006 making him dually eligible for Medicare and Medicaid. The AHCA representatives submitted policy to show that Medicaid can only pay for a motorized wheelchair once every five years. It was also noted that since Medicaid is a payer of last resort, the petitioner would need to process a request for a new wheelchair through the Medicare Program before sending a claim to Medicaid. The policy to

confirm this process was submitted into evidence. This policy is found in the Florida Medicaid Provider Reimbursement Handbook CMS-1500 page 1-4 February 2006.

CONCLUSIONS OF LAW

Florida Administrative Code 65-2.056, **Basis of Hearings**, states in relevant part:

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

Florida Administrative Code 65-2.047, **Rejection of Hearing Request**, states:

> "A hearing request may only be rejected or dismissed by the hearing officer."

The Findings of Fact show that the agency approved a request for a wheelchair for the petitioner in April 2005. The petitioner believes the wheelchair he was provided does not have the capacity to meet his needs. All parties acknowledged that this is an issue that needs to be addressed with the wheelchair provider. The petitioner has no issue with any action taken by the Medicaid Program. Therefore, the Hearing Officer concludes that there is no basis for the appeal and is therefore dismissed in accordance with the above cited rule.

DECISION

This appeal is dismissed as there is no issue to review.

NOTICE OF RIGHT TO APPEAL

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

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

in Tallahassee, Florida.

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

Copies Furnished 1

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

APPEAL NO. 06F-05557

PETITIONER,

Vs.

AGENCY FOR HEALTH
CARE ADMINISTRATION
DISTRICT: 15 Martin
UNIT: AHCA

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on October 12, 2006, at 9:10 a.m., in Stuart, Florida. The petitioner was not present. She was represented by her mother, [redacted] Jean Blank, physical therapist, assistive technology practitioner, was present as a witness. Dave King, management analyst, Agency for Health Care Administration (AHCA), Area 9, represented the respondent. Maria De Pick, registered nurse specialist, AHCA, was present as a witness for the respondent. Jody Winter, physical therapy consultant, AHCA, appeared by telephone as a witness for the respondent.

ISSUE

At issue is the action taken by the agency to deny modifications to a custom wheelchair, specifically, a powered tilt.

FINDINGS OF FACT

Custom Mobility, the petitioner's durable medical equipment provider, submitted a request for custom wheelchair modifications, power tilt. Attached to the request was a doctor's prescription, a letter of medical necessity from Jean Blank, the petitioner's school physical therapist, and a quote confirmation from Sunrise Medical (Respondent's Exhibit 2). The original packet requesting powered mobility with appropriate seating and head array controls was approved for $13,451.00. The current request of $6,445 was for modifications (Respondent's Exhibits 1&2).

The request for a power tilt was forwarded to AHCA's physical therapist for review. The respondent reviewed the documentation and guidelines in the DME/Medical Supply Service Coverage and Limitations Handbook. The handbook at "Customized Wheelchair Documentation", at page 2-57 states, "...Medicaid will not approve a customized wheelchair or wheelchair upgrade where no medical necessity to accomplish basic ADL's within the home has been established (Respondent's Composite Exhibit 1).

Ms. Winters, of AHCA, expressed several concerns as she reviewed the prior service authorization request. She determined that there was insufficient justification for a powered tilt and there was no discussion of less costly alternative equipment in the packet she reviewed. She opined that using adjustable hardware to have a fixed tilt of the requested tilt of 10-15 degrees for postural control was a viable plan, but not addressed why it was not feasible. She is concerned that the petitioner lacks the judgment for the rigid protocol in pressure management. She believes that when the original wheelchair was delivered, it was never properly adjusted to meet the petitioner's

needs and did not provide a safe means of mobility. It was unclear if the petitioner had the hardware to adjust the seating system into a fixed tilt, and if she had the adjusting hardware, it was unclear why it wasn't tilted at delivery.

The petitioner has no skin breakdowns. She was using foam padding over a solid seat to maintain her skin. She received a high quality pressure relieving cushion. No information on pressure mapping was provided to justify the need for additional methods of pressure management such as a powered tilt. Clear and objective examples to support statements of the petitioner's abilities were lacking in the justification she reviewed (Respondent's Composite Exhibit 1). She found no specific protocol for frequency, degree, and duration of tilt to justify medical necessity in the home.

The petitioner is almost ten years old. She uses a computer from switches attached in her head array. She has limited motor control. She uses her entire body to try to stay upright. Using a plastizote vest helps her by acting as a sensory block, but does not result in full postural control. Ms. Blank believes that the petitioner's problem of limited trunk and pelvic control can be corrected by moving the petitioner's shoulders forward over her hips. A slight posterior tilt of 10-15 degrees added to her wheelchair could help maintain that position without her falling forward. She believes she would be able to use her head to drive her chair if her arms, legs, and trunk are more effectively controlled. She opines that if 20-30 degrees of posterior tilt is added to the petitioner's seating system, her trunk would relax when she is resting in her chair or not actively engaged in an activity. Her chest harness would be used for safety support then, not compromising her swallowing ability and inhibiting her full lung expansion. She further

believes that if the petitioner had a power tilt, she could determine when a tilt is needed, act on it, and have less risk for medical complications (Respondent's Exhibit 2).

CONCLUSIONS OF LAW

The Florida Administrative Code 59.G-4.070 set forth the rules for durable medical equipment:

> (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.
> (3) All DME providers and their billing agents must comply with the provisions of the Florida Medicaid Provider Reimbursement Handbook, Non-Institutional 081, November 1996, which is incorporated by reference and available from the Medicaid fiscal agent.
> (4) Durable Medical Equipment and Supplies. All DME/Medical Supply providers must comply with the provisions of the Florida Medicaid DME/Medical Supply Services Coverage and Limitations Handbook January 2000, which is incorporated by reference and available from the Medicaid fiscal agent.

The Florida Administrative Code 59.G-1.010 defines 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 DME/Medical Supply Services Coverage and Limitations Handbook, April 2001, ch. 2-57 Wheelchair Documentation states:

Medicaid may reimburse for a customized wheelchair that is specially constructed (K0008, K0013, K0014). Prior authorization is required. Medicaid will not approve a customized wheelchair or wheelchair upgrade where no medical necessity to accomplish basic ADLs within the home has been established.
For a customized wheelchair, the following information must be submitted with the prior authorization request:
- medical necessity;
- written documentation describing the physical status of the recipient with regard to mobility, self-care status, strength, cognitive abilities, coordination, and activity limitations;
- wheelchair evaluations performed by either a registered physical or occupational therapist or a certified physiatrist;
- what physical improvement(s) can be anticipated;
- what physical deterioration can be prevented;
- a list of each customized feature required for unique physical status;
- specify the medical benefit of each customized feature;
- identify the principle places of use;
- an itemized invoice listing actual costs for parts and labor;
- list the source(s) of purchased accessories and modifications; and
- documentation of home accessibility is required for an oversized, heavy duty, or manual customized wheelchair.

Motorized Wheelchairs Documentation

Medicaid will not approve a motorized wheelchair or wheelchair upgrade where no medical necessity to accomplish basic ADLs within the home has been established. When a motorized wheelchair is prescribed the documentation must establish that the device is a safe method of mobility. The recipient must meet all of the following conditions:

- documented, severe abnormal upper extremity dysfunction or weakness;
- sufficient eye/hand perceptual capabilities to operate the chair and the cognitive skill to guide it independently;
- capable of some activity to which the motorized chair will provide access;
- an environment conducive to the use of a motorized wheelchair;
- clinical documentation of a power wheelchair trial must accompany any first request for a power wheelchair; and
- documentation of home accessibility is required in a prior authorization request for an oversized, heavy-duty or power customized wheelchair.

The petitioner's mother argues that the petitioner needs all of the tilt functions, not one fixed position. She believes that titled at 10-15 degrees she would slump over after a prolonged period of time affecting her swallowing, lung capacity, and posture.

The agency argued that the basis for the chair is to address the petitioner's needs at home, not school, and that the request does not meet the definition of medical necessity because a fixed tilt provided by attaching hardware to the seating system could provide the 10-15 degrees of posterior tilt in a less costly manner. She believes that a powered tilt could meet her needs, but is in excess of it because it has not been established that a fixed tilt would not be sufficient.

After considering all testimony and specifically the testimony of both therapists, and the rules stated above, the undersigned finds that the agency's action to deny the petitioner a power tilt is justified. No evidence was presented that a fixed tilt would not work as it has not been tried, and it is a less costly alternative to the power tilt.

DECISION

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

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 9th day of November, 2006,

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

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

APPEAL NO. 06F-05126

PETITIONER,

Vs.

CASE NO. 1226286836

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

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on October 13, 2006, at 10:10 a.m., in Jacksonville, Florida. The petitioner was not present. However, she was represented by her power of attorney, [redacted]. Robert Pritchard, appeared as a witness for the petitioner. The department was represented by Rycha Redden, economic services self-sufficiency specialist supervisor and Sarah Malone, economic services self-sufficiency specialist.

ISSUE

At issue is the department's action of January 23, 2006 to deny Institutional Care Program (ICP) Medicaid benefits for January, February, March and April 2006, due to excess assets. The petitioner has the burden of proof.

FINDINGS OF FACT

The petitioner applied for ICP Medicaid on October 25, 2005. The petitioner owned a long term care insurance policy. The department needed verification of who would receive the proceeds from the policy before the ICP Medicaid eligibility determination could be completed. On November 21, 2005, the department requested that verification of the long term care insurance policy be submitted by December 1, 2005. The application was denied on January 23, 2006 because the petitioner did not provide the requested information. In March 2006, the petitioner's representatives called the insurance company and requested that the petitioner's claim reimbursement checks go directly to the nursing home. On April 3, 2006, the Insurance Company sent a letter to the petitioner confirming that the reimbursement checks would be paid to the nursing home.

The petitioner reapplied for ICP Medicaid on April 24, 2006. The case was approved on June 7, 2006. The effective date of the approval was May 1, 2006. ICP Medicaid eligibility was denied for the months of January, February, March, and April 2006 because during these months the department determined that the petitioner's bank account balances exceeded the $2000 asset limit.

The petitioner's representative related that she did not know that assets greater than $2000 affected ICP Medicaid eligibility. The petitioner's representative explained that she could have easily spent the money on a variety of expenses if she had known the bank balances would negatively impact the ICP Medicaid eligibility. There was no dispute that the petitioner's bank account balances exceeded the $2000 asset limit during the months of January through April 2006. The account information submitted

into evidence showed the following balance information: $7334.54 on April 21, 2006, $6090.85 on March 23, 2006, $5092.42 on February 21, 2006, and $4016.19 on January 24, 2006. The petitioner's income consisted of approximately $1293 from Social Security benefits which is direct deposited into her bank account.

The petitioner's representative inquired about the $2500 burial exclusion at the hearing since information regarding this policy was not provided at the eligibility interview. The department's representatives explained the policy and provided material from the Integrated Manual to support its position.

CONCLUSIONS OF LAW

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

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

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

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

The Integrated Public Assistance Manual paragraph **1640.0514 Burial Exclusion Policy (MSSI, SFP)**, states in part:

> "An individual and the individual's spouse may set aside funds of up to $2,500 each for burial expenses. These funds are excluded as assets as long as the individual shows that they are clearly designated as being set aside for burial. This is true even if the case has been closed as long as

the funds continue to be designated for burial. The funds must be separately identifiable (not commingled with other funds) unless the asset cannot be separated or it is unreasonable to require it. The individual (or deemed individual) must provide a written statement defining:
1. the amount of funds set aside,
2. for whose burial the funds are set aside, and
3. the form in which the funds are held.
The individual and the individual's spouse must be given the opportunity to designate funds for burial at the time of application and at review if the maximum amount is not already designated. These funds may be excluded regardless of whether the exclusion is needed to allow eligibility. The $2,500 limit is not reduced by the value of excluded life insurance policies or irrevocable burial contracts. If the funds are not clearly designated for burial at the time of the application, the funds may be excluded if the individual:
1. provides a written statement that the funds are intended for the individual's burial, and
2. agrees to submit evidence that the funds are separately identifiable and designated for burial within 10 days of signing the statement.
Note: If the evidence is not provided in 10 days, the funds cannot be excluded until the information is provided. Assets may be designated as burial funds for any month, including the three months prior to the month of application. (Burial fund accounts for prior months may be commingled with non-burial funds.)"

The findings show the petitioner applied for ICP Medicaid in April 2006 and benefits were approved for May 2006. ICP Medicaid benefits for January through April 2006 was denied due to excess assets. The petitioner's bank records showed the account balances were $7334.54 on April 21, 2006, $6090.85 on March 23, 2006, $5092.42 on February 21, 2006, and $4016.19 on January 24, 2006. The department determined that since the bank balances exceeded the $2000 asset limit, ICP Medicaid was denied for those months due to excess assets.

Based on the above cited policy, the petitioner could designate up to $2500 for burial even though the funds in the bank account would be commingled with non burial funds. In this case, the petitioner was not previously been given this opportunity. In

addition, the petitioner's direct deposited income of approximately $1293 can be subtracted from the bank account balances. When the petitioner's income and the burial designation amounts are subtracted from the bank account balances, the petitioner is potentially eligible for the months previously denied by the department. It is noted that the Integrated Manual policy at paragraph 1640.0405 requires that the lowest bank account balance amount in any month be used for the asset determination.

Based on a careful review of the evidence submitted at the hearing, the hearing officer concludes that the department's action to deny ICP Medicaid for January through April 2006 was premature. The asset value of the bank account balances should be determined by subtracting the petitioner's direct deposited income from the bank account balances and by allowing the petitioner to designate up to $2500 for burial costs. This case is remanded to the department for evaluation under the above policies.

DECISION

This appeal is granted. The case is remanded as stated in the above conclusions. A written notice, to include appeal rights, is to be issued subsequent to this determination.

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 3rd day of November, 2006,

in Tallahassee, Florida.

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

Copies Furnished

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. 06F-04817

CASE NO. 1026716543

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on October 13, 2006, at 11:20 a.m., in Jacksonville, Florida. The petitioner was not present. However, she was represented by her son and power of attorney, [redacted] The department was represented by Rycha Redden, economic services self-sufficiency specialist supervisor and Euzera Foster, economic services self-sufficiency specialist.

ISSUE

At issue is the department's action of June 8, 2006 to deny Institutional Care Program (ICP) Medicaid benefits for December 2005, January, February, March, April and May 2006, due to excess assets. The petitioner has the burden of proof.

FINDINGS OF FACT

The petitioner applied for ICP Medicaid on March 13, 2006 and the department conducted an interview with the petitioner's son and daughter on March 27, 2006. At that time, it was reported that the petitioner owned a policy with New York Life Insurance Company. The details regarding this policy were unclear. As such, the petitioner's representatives were asked to verify the cash value and verify whether any payment from the policy would go to the nursing home or the petitioner.

On April 26, 2006, in an effort to assist the petitioner, the department faxed a request to New York Life asking that the policy information be provided. On May 10, 2006, New York Life sent a response to the department indicating the petitioner's policy had a face value of $5000 and a cash value of $4938.18. Since the cash value exceeded the ICP asset limit of $2000, the worker contacted the petitioner's representative and informed him of the cash value of the policy. On May 12, 2006, the petitioner's representatives wrote a letter to New York Life to request that the policy be surrendered immediately. The insurance company authorized a check for $4938.18 on May 23, 2006. The money was in turn paid to the facility in the same month.

On June 8, 2006, the department approved ICP Medicaid eligibility for June 2006 and ongoing and denied ICP Medicaid for December 2005 through May 2006 due to excess assets. At the hearing, the department's representative stipulated to approve ICP Medicaid for May 2006, as the asset limit was met.

The petitioner's income consisted of a pension of $171.12 and Social Security benefits of around $1240. The petitioner's income was not disputed. The petitioner disagreed with the department's action to deny ICP Medicaid due to excess assets

because he was not aware that the New York life insurance policy had any cash value until he was informed by the department's representative in May 2006. He argued that eligibility could have been established earlier had the department informed him of the cash value earlier in the process. The department explained that the petitioner was primarily responsible for providing the cash value and as a courtesy the department faxed the request form to the life insurance company on April 26, 2006. The department requested it be returned within 10 days; however, it was not returned until May 10, 2006.

CONCLUSIONS OF LAW

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

> (1) Resource Limits. If an individual's total resources are equal to or below the prescribed resource limits at any time during the month the individual is eligible on the factor of resources for that month. The resource limit is the SSI limit specified in Rule 65A-1.716, F.A.C...(2) The department follows SSI policy prescribed in 20 C.F.R. Part 416 in determining what is counted as a resource...(2) Exclusions...(c) The cash surrender value of life insurance policies is excluded as resources if the combined face value of the policies is $2,500 or less. (d) The individual, and their spouse, may designate up to $2,500 each of their resources for burial funds for any month, including the three months prior to the month of application. The designated funds may be excluded regardless of whether the exclusion is needed to allow eligibility. The $2,500 is not reduced by the value of excluded life insurance policies or irrevocable burial contracts. The funds may be commingled in the retroactive period.

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

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

The Integrated Public Assistance Manual paragraph **1640.0554 Life Insurance (MSSI, SFP),** states in part:

> A life insurance policy is considered only to the extent of its cash surrender value. However, if the face value of all life insurance policies on any one individual totals $2,500 or less, no part of the cash surrender value of any such policy or policies will be taken into account. Life insurance having no cash surrender value (for example, term insurance or burial insurance) is not considered in determining the face value of insurance and is excluded from all computations.
> The policy must be owned by the individual or the person whose assets are deemed to the individual to be considered a countable asset to the individual.
> When the total face value of all life insurance policies on an eligible individual, or an eligible/ineligible spouse whose assets are deemed to the eligible individual exceed $2,500, the cash surrender values of all such policies must be counted as assets. When the cash surrender values of such policies exceed the asset limitation, an individual may adjust his insurance holdings to policies of a reduced face value. If an adjustment is made, the life insurance policies (and any cash adjustments) are reconsidered in determining eligibility.

The department's Integrated Manual 165-22, section 1640.0514 Burial Exclusion Policy (MSSI, SFP), states in part:

> An individual and the individual's spouse may set aside funds of up to $2,500 each for burial expenses. These funds are excluded as assets as long as the individual shows that they are clearly designated as being set aside for burial. This is true even if the case has been closed as long as the funds continue to be designated for burial. The funds must be separately identifiable (not commingled with other funds) unless the asset cannot be separated or it is unreasonable to require it. The individual (or deemed individual) must provide a written statement defining:
> 1. the amount of funds set aside,
> 2. for whose burial the funds are set aside, and
> 3. the form in which the funds are held.
> The individual and the individual's spouse must be given the opportunity to designate funds for burial at the time of application and at review if the maximum amount is not already designated. These funds may be excluded regardless of whether the exclusion is needed to allow eligibility. The $2,500 limit is not reduced by the value of excluded life insurance policies or irrevocable burial contracts.

The findings show the petitioner applied for ICP Medicaid in March 2006 and benefits were approved for June 2006 and ongoing, with an approval for May 2006, being stipulated to at the hearing. During the period from December 2005 through April 2006, the petitioner owned an insurance policy with a face value of $5000 and a cash value of $4938. Because this exceeded the $2000 asset limit, ICP was denied for these months. The above cited policy requires that the cash value of an insurance policy be counted as an asset when the face value of the policy is greater than $2500. The above policy also allows for a $2500 burial fund exclusion. The hearing officer has considered this policy and concludes that even with this deduction, the petitioner's cash value would still have exceeded the $2000 asset limit.

The findings show the department denied ICP Medicaid for December 2005 through May 2006 because the cash value of the insurance policy exceeded the $2000 asset limit. The asset limit was met in May 2006. The petitioner's representative was not aware of the cash value of the policy until he was informed by the department's representative in May 2006. It was undisputed that the petitioner's assets exceeded the $2000 asset limit for December 2005 through April 2006. The undersigned considered the petitioner's argument, however, was unable to locate any authority to allow ICP eligibility for months that assets exceeded the limit, when the family is unaware of the value.

Since the petitioner's assets exceeded the $2000 asset limit the department's action to deny ICP Medicaid for December 2005 through April 2006 is a correct action that is consistent with the above cited authority. However, because the petitioner

reduced the assets to within the $2000 asset limit for May 2006, the department is to authorize ICP eligibility for May 2006, as stipulated in the hearing.

DECISION

This appeal is both granted and denied. The appeal is granted in that the department is to authorize ICP Medicaid for May 2006. The appeal is denied in that the department's action to deny ICP Medicaid for December 2005, January, February, March and April 2006 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 30th day of October, 2006,

in Tallahassee, Florida.

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

Copies Furnished 1

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

APPEAL NO. 06F-05190

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 September 22, 2006, at 9:50 a.m., in Miami, Florida. The petitioner was present and represented herself. The agency was represented by Oscar Quintero, senior human service program specialist, Agency for Health Care Administration. Present as witnesses for the agency, via the telephone, were Dr. Amelia Tunanidas, medical director for KePRO, Susan Labelle, review operations specialist at KePRO and Diane Weller, registered nursing consultant, Agency for Health Care Administration. Hector Gutierrez served as an interpreter. This hearing was originally scheduled for September 1, 2006, but was continued at the request of the petitioner.

ISSUE

At issue is the agency's denial to pay for inpatient hospital medical services provided to the petitioner from February 27 through March 3, 2006, because the medical

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

FINDINGS OF FACT

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

On June 22, 2006, KePRO received a request from the provider (South Miami Hospital) for an admission review for four (4) inpatient days, February 27, 2006 through March 3, 2006. The provider provided the following information: "This is a 44yo female who has very strong family hx of both breast and ovarian cancer. Her risk factors for breast cancer are so high that we did not think inappropriate to offer her bilateral prophylactic mastectomies...2/27 surgery: Bilateral total mastectomies, immediate reconstruction with transverse abdominis myocutaneous flaps..."

Initial screening review performed by KePRO nurse reviewers at the direction of AHCA using InterQual criteria to determine necessity for acute inpatient care. KePRO determined that the clinical information sent by the provider did not meet Interqual criteria under Mastectomy, Total criteria.

On June 27, 2006, the case was referred to a physician consultant Board-Certified in surgery who recommended denial due to insufficient documentation.

On July 12, 2006, the provider requested a reconsideration. The case was referred for reconsideration to a physician consultant Board-Certified in surgery who had not issued the first denial to determine whether the initial decision was correct. The reconsideration physician agreed with the original determination, and the original decision was therefore upheld. The petitioner was notified on July 7, 2006 of the agency's decision.

The petitioner expressed that she does not have the financial resources to pay the bills that she has received related to her Mastectomy.

The agency explained to the petitioner that according to the Medicaid Provider General Handbook page on page 1-6, the petitioner may not be billed for any denied services unless the provider notifies her prior to rendering the services of her responsibility for the payment of any services received that are not covered by Medicaid, and documents in her medical record that she understands and agrees to this service.

CONCLUSIONS OF LAW

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

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

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

> (1) This rule applies to all hospital providers enrolled in the Medicaid program.
> (2) All hospital providers enrolled in the Medicaid program must comply with the Florida Medicaid Hospital Coverage and Limitations Handbook and the Florida Medicaid Provider Reimbursement Handbook, UB-92, both

incorporated by reference in Rule 59G-4.160, F.A.C. Both handbooks are available from the fiscal agent contractor.

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

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

These rules established guidelines for the definition and authorization of Inpatient Hospital Services. The agency has reviewed the petitioner's eligibility for this service from February 27 through March 3, 2006, and determined that based on the information provided, the medical care as described to them does not appear to require inpatient services.

Based on the evidence, testimony and above authorities, the hearing officer concludes that the agency was correct in its denial to pay for inpatient hospital medical services provided to the petitioner from February 27 through March 3, 2006.

DECISION

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

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 11th day of October, 2006,

in Tallahassee, Florida.

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

Copies Furnished To

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

PETITIONER,

Vs.

FLORIDA DEPARTMENT OF CHILDREN AND FAMILIES
DISTRICT: 13 Citrus
UNIT: 88083

RESPONDENT.
_____/

APPEAL NO. 06F-05614

CASE NO. 1183560729

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned-hearing officer on September 27, 2006, at 11:05 a.m., in Inverness, Florida. The petitioner was not present. Present representing the petitioner was her daughter [redacted]. Present as a witness for the petitioner was her son-in-law, [redacted]. The respondent was represented by Sandra Maxwell, economic self-sufficiency specialist supervisor.

ISSUE

The petitioner is appealing the department's action of August 9, 2006, to terminate her Institutional Care Program (ICP) benefits because she did not follow through in establishing her eligibility.

FINDINGS OF FACT

Prior to the action under appeal, the petitioner was receiving ICP Medicaid benefits through the department. On June 28, 2006, a redetermination of eligibility interview was held by telephone with the petitioner's daughter, [redacted], to determine the petitioner's continued eligibility for ICP benefits. At the time of the interview, the department discovered that on October 7, 2005, the petitioner sold her home for $41,666.91. On June 29, 2006, the department mailed [redacted] a Request For Information requesting verification of the fair market value of the petitioner's home, a copy of the sales document showing the selling price and net proceeds from the sale of the home and an accounting of the spenddown of the proceeds from the sale of the home. [redacted] was given until July 10, 2006, to provide the information. The case number for the petitioner that was listed on the Request For Information was 1196688681. This case number was not correct. The above information was requested in order to determine whether the petitioner's assets were under the ICP asset limit of $2,000.

On July 17, 2006, the department received a copy the settlement statement for the sale of the home, a copy of the petitioner's AmSouth Bank joint checking account statement that she had with her husband, [redacted] and a list of debts that [redacted] had when he passed away on May 8, 2005. [redacted] sent the department the above documents with a cover letter. On the cover letter [redacted] listed the petitioner's case number as 1196688681.

The department was not able to determine the amount of the spenddown from the net proceeds from the sale of the home with the information that they received from

Ms. [redacted] Therefore, on July 27, 2006, the department mailed [redacted] another Request For Information requesting documentation of the spenddown of the proceeds from the sale of the home, a copy of all of the AmSouth checking account statements from the date of the sale of the home and documentation of amounts owed to banks and financial institutions as the list of [redacted]'s debts included debts to banks and financial institutions. [redacted] was given until August 7, 2006, to provide the information. The case number for the petitioner that was listed on the July 27, 2006 Request For Information was 1183560729, which was the correct case number.

According to [redacted] she mailed the department all of the information requested, including copies of the AmSouth checking account statements and that the documents were mailed with a cover letter that listed the petitioner's case number as 1183560729 (Petitioner's Composite Exhibit 1). However, the department did not receive the information. On August 9, 2006, the department terminated the petitioner ICP benefits, as they did not receive the information requested and the petitioner's continued eligibility could not be determined. During the hearing, there was a question as to whether the information that was mailed to the department may have been filed in the wrong case file as the department had assigned two different case numbers to the petitioner's case. Therefore, at the hearing, the department agreed to review all of the documents presented and determine whether the petitioner was eligible to receive ICP benefits during the period at issue.

[redacted] stated that when [redacted] passed away, she contacted the department and reported that the petitioner was going to sell her home. However, she was not told that she had to report the sale of the home and provide documentation of

the net proceeds of the sale and verification of the spenddown of the proceeds from the sale.

CONCLUSIONS OF LAW

20 C.F.R. § 416.1201 in part states:

> Resources; general. (a) Resources; defined. For purposes of this subpart L, resources means cash or other liquid assets or any real or personal property that an individual (or spouse, if any) owns and could convert to cash to be used for his or her support and maintenance... (b) Liquid resources. Liquid resources are cash or other property which can be converted to cash within 20 days, excluding certain nonwork days as explained in §416.120(d). Examples of resources that are ordinarily liquid are ...life insurance policies, financial institution accounts (including savings, checking, and time deposits, also known as certificates of deposit)...

20 C.F.R. § 416.1205 sets forth the maximum asset limitation in the Institutional Care Program at $2,000.00 for an individual.

Fla. Admin. Code 65A-1.205(1)(d) in part states:

> If the eligibility specialist determines at the interview or at any time during the application process that additional information or verification is required, or that an assistance group member is required to register for employment services, the specialist must grant the assistance group 10 calendar days to furnish the required documentation or to comply with the requirements. For all programs, the verifications are due 10 calendar days from the date of request (i.e., the date the verification checklist is generated) or 30 days from the date of application whichever is later. In cases where medical information is requested the return due date is 30 calendar days following the request or 30 days from the date of application whichever is later. If the verification due date falls on a holiday or weekend, the deadline for the requested information is the next working day. If the verification or information is difficult for the person to obtain, the eligibility specialist must provide assistance in obtaining the verification or information when requested or when it appears necessary. If the required verifications and information are not provided by the deadline date, the application is denied, unless a request for extension is made by the applicant or there are extenuating circumstances justifying an

additional extension. The eligibility specialist makes the decision of whether to grant the request for extension based on extenuating circumstances beyond the control of the individual, such as sickness, lack of transportation, etc. When all required information is obtained, the eligibility specialist determines eligibility for the public assistance programs. If the eligibility criteria are met, benefits are authorized.

Fla. Integrated Pub. Policy Manual, 165-22, passage 1640.0409 in part states:

Conversion of Assets (MSSI, SFP)

Proceeds, including cash, from the sale of an asset or conversion of an asset from one form to another are considered assets rather than income. The proceeds of the item to which the asset is converted must be evaluated to determine if they affect eligibility, and if so, the value of the new asset.

Verification concerning the new asset must be obtained regardless of whether a liquid or nonliquid asset is involved. For example, an individual may have an automobile (nonliquid asset) which he sells for cash (liquid asset), or he may have cash, which he uses to purchase an automobile. In either case, the conversion or sale does not result in income to the individual. The newly acquired item is an asset subject to all asset valuation policy.

The Findings of Fact show that the department agreed to provide the petitioner with another opportunity to submit the information requested that was related to the sale of the petitioner's home and determine whether the petitioner was eligible to receive ICP benefits. Therefore, the action of August 9, 2006, to terminate the petitioner's ICP benefits is reversed. The department must provide the petitioner with an opportunity to provide the information necessary to determine her continued eligibility for ICP benefits. Upon receipt of the information, the department must notify the petitioner, in writing, of the decision and the right to appeal if she disagrees with the department's decision.

DECISION

The appeal is granted. The department's termination action is reversed as stated in the above conclusions.

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 15th day of November, 2006,

in Tallahassee, Florida.

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

Copies Furnished To:

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

APPEAL NO. 06F-04412

PETITIONER,

Vs.

AGENCY FOR HEALTH
CARE ADMINISTRATION
DISTRICT: 15 St. Lucie
UNIT: AHCA

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on August 17, 2006, at 10:40 a.m., in Fort Pierce, Florida. The petitioner was present, but was represented by her mother, [redacted] Mark Pickering, Field Office Manager, Area 9 Medicaid, represented the Agency for Health Care Administration (AHCA). Jody Winter, physical therapist, and Maria De Pick, RN specialist, appeared by telephone as witnesses for the respondent.

ISSUE

At issue is the agency's denial of a K0014 custom powered wheelchair for the petitioner. The agency approved a prior authorization for a power wheelchair. The petitioner will have the burden of proof in this matter.

FINDINGS OF FACT

On April 26, 2006, Custom Mobility, on the petitioner's behalf, submitted a Florida Medicaid Authorization Request for a custom power wheelchair. Attached to the request was the doctor's prescription, medical necessity documentation, and the manufacturer's price list. The total cost of the requested custom power wheelchair was $17,095.00 (Respondent's Composite Exhibit 4).

AHCA determined that there was enough justification to approve a request for a power wheelchair, but that some of the requested attachments did not meet Medicaid policy concerning medical necessity. The request was forwarded to AHCA's physical therapy consultant for review. The respondent reviewed the documentation and guidelines in the DME/Medical Supply Service Coverage and Limitations Handbook. The handbook at "Customized Wheelchair Documentation", at page 2-57 states,"...Medicaid will not approve a customized wheelchair or wheelchair upgrade where no medical necessity to accomplish basic ADL's within the home has been established (Respondent's Exhibit 2).

AHCA determined there was sufficient justification to authorize a power wheelchair, batteries, midline control mount, joystick, adaptive seat with growth hardware, pelvis positioning support, removable lateral trunk supports, head support and hardware, and foot ankle positioners. They also approved a power wheelchair drive wheel flat free insert, lateral trunk or hip support including fixed hardware, and a shoulder harness straps or chest strap, including mounting hardware. The cost of the power wheelchair minus frame depreciation is $7395.13. They denied a lap tray, powered tilt and upgraded electronics, custom cushions with additional positioning

components, and a light touch buckle upgrade (Respondent's Composite Exhibit 4). Ms. Winters determined that the physical therapy evaluation did not have objective clinical findings. She further explained that a power tilt would be in excess of the petitioner's needs if there is no history of pressure problems. Without an indication of the petitioner's cognitive abilities to follow medical protocol, the power tilt was not justified (Respondent's Exhibit 3).

The respondent sent notice on June 20, 2006, that the wheelchair requested was denied because it was not the least costly alternative that could meet the petitioner's needs. There was insufficient justification provided for a powered tilt component and contoured cushions with secondary positioning pads (Respondent's Exhibit 1). The agency determined that a power chair with a manual tilt would be the least costly alternative wheelchair. The physical therapist did not supply justification why a wheelchair other than the one requested would not meet the petitioner's needs.

The petitioner's mother explains that her daughter's posture is dependent on the structure of the wheelchair. She believes that her daughter needs a lap tray at home because the table is too high for her to eat from, and that she needs a lap tray for class work and to mount her keyboard to. She believes that it is medically necessary for her to have a tilt for her head, a harness to keep her posture up, and because her leg shifts to the right, she needs a wedge between them.

CONCLUSIONS OF LAW

The Florida Administrative Code 59.G-4.070 sets forth the rules for durable medical equipment:

make such care, goods or services medically necessary or a medical necessity or a covered service.

The DME/Medical Supply Services Coverage and Limitations Handbook, April 2001, chapter 2, establishes the guidelines for wheelchair reimbursement as:

Wheelchairs
Medicaid may reimburse for a standard wheelchair if the recipient is confined to a bed or chair. Reimbursement may be made for the following:
- a narrow wheelchair required due to narrow doorways in the home;
- a lightweight wheelchair required when the recipient cannot propel a standard wheelchair;
- a motorized wheelchair required when medical needs cannot be met by a less costly alternative;
- other models if the features and accessories are medically necessary;
- a customized wheelchair that is specially constructed and not available from manufacturers.

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

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

> Motorized Wheelchairs Documentation
> Medicaid will not approve a motorized wheelchair or wheelchair upgrade where no medical necessity to accomplish basic ADLs within the home has been established. When a motorized wheelchair is prescribed the documentation must establish that the device is a safe method of mobility.

The petitioner's mother argues that it is medically necessary for her daughter to have a wheelchair with a tilt, head support, lap trays, and custom cushions. She has not had any follow up with Custom Mobility concerning the proposed wheelchair.

The agency believes that the requested chair is not medically necessary and in excess of the petitioner's needs based on the justification submitted with the wheelchair proposal. They believe that a lap tray for school should be furnished at school, and documentation for one at home was not supplied.

Based on the testimony given and the above cited authorities, the hearing officer finds that AHCA's denial of the petitioner's proposed customized wheelchair is justified. Medical necessity was not established for all of the proposed components.

DECISION

The appeal is denied.

NOTICE OF RIGHT TO APPEAL

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

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

in Tallahassee, Florida.

Margaret Poplin

Margaret Poplin
Hearing Officer
Building 5, Room 203
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
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STATE OF FLORIDA
DEPARTMENT OF CHILDREN AND FAMILIES
OFFICE OF APPEAL HEARINGS

APPEAL NO. 06F-04294

PETITIONER,

Vs.

CASE NO. 1243237481

FLORIDA DEPARTMENT OF
CHILDREN AND FAMILIES
DISTRICT: 09 Palm Beach
UNIT: 88322

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on August 8, 2006 at 10:35 a.m., in Riviera Beach, Florida. The petitioner was not present. She was represented by attorney, Noreen Wiscovitch. Doris Gibbs, legal assistant and Pat McCarthy, RN, ... s Nursing and Rehab Center, were present as witnesses for the petitioner. Mildred Talbert, economic specialist II, represented the department.

The department requested a continuance after finding out the petitioner had legal counsel. A continuance was granted to the respondent to seek advice of district legal counsel. The hearing was reconvened on September 9, 2006, at the same time, with the same members in attendance.

ISSUE

The petitioner is appealing the department's action to deny her Institutional Care Program Medicaid benefits on the basis that she did not meet the disability criteria. The petitioner will have the burden of proof in this matter.

FINDINGS OF FACT

On May 23, 2006, an application for Institutional Care Program (ICP) Medicaid was filed on the petitioner's behalf. Retroactive Medicaid was requested for February, March, and April 2006. The petitioner's date of birth is [redacted]. At the time of the application she was under 65 years old and alleging a disability. As the petitioner was under 65 years old, she did not meet the aged criteria for Medicaid. Medical information was collected and sent to the District Medical Review Team (DMRT) for review. On June 22, 2006, the department received notice from DMRT that the petitioner was determined not disabled. DMRT cited the reason for denial as code N34, "impairment was not disabling for 12 full months" (Respondent's Exhibit 3). With DMRT's decision, the department denied the petitioners' application for ICP benefits (Respondent's Exhibit 1).

The petitioner alleges a disability from psychosis, dementia, alcohol dependence and hypertension. In June 2005, the petitioner was admitted to Columbia Hospital. On June 24, 2005, the petitioner had a psychiatric medical consultation by Dr. Marcus Allen, while in the hospital. The chief complaint was psychosis. His diagnosis was confirmed, along with alcohol dependence, chronic obstructive pulmonary disease, and hypertension, after his examination (Petitioner's Exhibit 5).

On June 29, 2005, the petitioner left the hospital and was admitted to Palm Beach Shores, where she currently resides. Prior to that, she lived at her home. She has been declared incompetent since her admission to [redacted] According to the Form 3008, completed upon her admission to the facility, the petitioner's major mental illness or psychiatric diagnosis is controlled with medication. She required partial help in dressing, complete bed bath procedure, walked with supervision, transferred with supervision, required help with toileting, and minor assistance with setting up her tray for meals. The long range plan for her was for assisted living facility placement (Petitioner's Composite Exhibit 4).

Ms. McCarthy stated that the petitioner has no restriction with walking, sitting, standing, carrying or lifting. She believes that she needs a very structured environment, supervision and constant monitoring, or she will return to her previous condition. She asserts that while she requires prompting with most of her activities of daily living, she will never recover her memory loss. She was delusional upon her admittance to the facility, but is not now because of the medication she takes. The petitioner's chart notes of April 7, 2006 show that the petitioner had a psychiatric evaluation on that day. It was conducted by Dr. Stoyanovich's registered nurse practitioner, Ann Marie Janice. She found [redacted] behavior stable, judgment and insight as good, and her mood or affect as unremarkable. She was not delusional and her medication would remain the same. She found that her immediate and remote memory was not impaired on that day, but that her recent memory was impaired (Petitioner's Composite Exhibit 4).

The petitioner was a practicing attorney in Palm Beach County. She was last employed in 2004.

The petitioner applied for Social Security Disability Income (SSDI) and Supplemental Security Income (SSI) in July 2005. She was denied SSDI for reasons other than not being determined disabled. Her SSI application is currently pending. An appointment was scheduled for June 20, 2006, with the Social Security Administration, to determine eligibility for SSI (Respondent's Exhibit 2).

CONCLUSIONS OF LAW

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

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

20 C.F.R. §416.909, **How long the impairment must last**, states in part:

> Unless your impairment is expected to result in death, it must have lasted or must be expected to last for a continuous period of at least 12 months. We call this the duration requirement.

20 C.F.R. §416.920, Evaluation of disability of adults, in general, states in part:

> (a) *Steps in evaluating disability.* We consider all evidence in your case record when we make a determination or decision whether you are disabled...Your impairment(s) must be severe and meet the duration requirement before we can find you to be disabled. We follow a set order to determine whether you are disabled...(c)

> *You must have a severe impairment.* If you do not have any impairment or combination of impairments which significantly limits your physical or mental ability to do basic work activities, we will find that you do not have a severe impairment and are, therefore, not disabled...

The DMRT uses the Social Security Administration's guidelines to determine a disability. An individual must have a condition or combination of conditions listed in the Federal Regulations that is expected to last for at least 12 full months, which prevents the ability to do any substantial gainful activity.

The hearing officer evaluated the petitioner's claim of disability using the sequential evaluation as set forth in 20 C.F.R. §416.920. The first step is to determine whether or not the individual is working. The petitioner is not working and therefore meets the first step.

The second step is to determine whether or not an individual has a severe impairment. In order to meet this definition of a severe impairment, an individual must have an impairment that is established by medical evidence consisting of signs, symptoms, and laboratory findings, and not only by the individual's statement of symptoms alone, as per 20 C.F.R. §404.1508. In addition, such impairment "must have lasted or must be expected to last for a continuous period of at least twelve months," in order to meet the duration requirement, as per 20 C.F.R. §404.1509. Thus, in summary, in order to meet this step, an individual must have a medically diagnosed impairment(s) that meets the duration requirement.

The petitioner was diagnosed with alcohol abuse, dementia, and psychosis in June 2005. According to the medical evidence submitted and reviewed, medication controls these conditions. By April 2006, medical evidence showed that the conditions

found in June 2005 were controlled by medication. The undersigned considered the fact that the petitioner is on psychotropic medications and found no evidence that it interfered with her functioning and it controls the originating problem. The evidence did not show that she has marked restrictions on activities of daily living. Based on the evidence, the hearing officer cannot conclude that the petitioner is unable to engage in any substantial gainful activity. Therefore, the petitioner does not meet the second step.

The action taken by the department to deny the petitioner's application for ICP Medicaid is justified.

DECISION

The appeal is denied for the reasons stated in the conclusions.

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 October, 2006,

in Tallahassee, Florida.

Margaret Poplin

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

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

PETITIONER,

Vs.
AGENCY FOR PERSONS
WITH DISABILITIES (APD)
DISTRICT: 12 Volusia
RESPONDENT.
_____/

APPEAL NO. 06F-05033

FINAL ORDER

Pursuant to notice, and the petitioner's good cause for rescheduling, an administrative hearing was convened before the undersigned hearing officer in Daytona Beach, Florida, at 2:45 p.m. on October 6, 2006. The petitioner was not present but was duly represented by his grandmother, [redacted] The respondent was represented by Ann Cocheu, attorney with the Office of the Attorney General and testimony was available from Leslie Richards and Cliff Robertson, senior human service specialists. Present to testify telephonically on behalf of APD, with APS Healthcare were Amy Brice, qualified mental retardation professional reviewer and Kim Watson reconsideration reviewer.

ISSUE

At issue was whether or not APD denial of funding for coverage of consumable medical supplies was correct due to not meeting Developmental Services Home and Community-Based Services (HCBS) Medicaid Waiver service limitations/exclusions or requirements.

FINDINGS OF FACT

With date of birth as [redacted], the petitioner is a young teenager who suffered profound injuries and is undisputedly eligible for APD HCBS under a Medicaid Waiver for the developmentally disabled. He lives in the community, staying with his grandmother, and they have engaged a waiver support coordinator to facilitate provision of services under the waiver. He is nonverbal, cannot ambulate, blink, toilet or feed himself, is totally reliant on others for all aspects of care, and receives tubal feedings.

On May 3, 2006, for support plan year April 1, 2006 to March 31, 2007, the waiver support coordinator submitted to APS Healthcare, prior services authorization request 33685, including support plan, Respondent's Exhibit 7. It requested annual consumable medical supplies as follows: 24 cases unscented wipes ($1582.32 total of federal match and general revenue), 48 cases of diapers ($3500.64 total of federal match and general revenue), 36 - 16 ounce bottles of acetaminophen, 144 – 4 ounce bottles of ibuprofen, 24 – 8 liter bottles of Pedialyte, 312 tubes of Lacrilube, and 9,000 catheters. The submission included physician prescriptions for large quantities of Pedialyte, catheters, ibuprofen, Lacrilube and acetaminophen, but description of medical necessity and reasoning was not included. The submissions did not include dietician assessment and did not reflect Medicaid State Plan requests, provision, exhaustion of limits or rejections. The support plan noted that the "physician (was) to supply documentation of medical necessity..."

APS, under contract with APD, reviewed request 33685, and did not authorize the requested quantities of medical supplies. On July 17, 2006, notice was issued by APS, informing that diapers and wipes were authorized in smaller quantities to allocated

amount of $138.86. Notice explained that authorization under the waiver would not occur until after coverage had been accessed under State Plan Medicaid. Notice explained there had been no indication that Medicaid State Plan was accessed for provision of catheters, there was no indication that dietician assessment had occurred as to Pedialyte; and acetaminophen liquid, ibuprofen liquid and Lacrilube were considered "general use available to the public at large..."

Reconsideration began, Respondent's Exhibit 6, and reflected March 2, 2006 physician correspondence further explaining the additional requests (page 10). This document was not evident in the original request. The reconsideration did not establish that State Plan Medicaid for the HCBS Medicaid Waiver - requested items had been accessed, provided, exhausted, denied, or that dietician assessment occurred. Reconsideration did not result in HCBS funding authorization.

CONCLUSIONS OF LAW

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

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

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

> (5) Service Limitations – General. The following general limitations and restrictions apply to all home and community-based services waiver programs:
> (a) Covered services are available to eligible waiver program participants only if the services are part of a waiver plan of care ("care plan", "individual support plan", or "family support plan"). Care plan requirements are outlined in subsections (6) and (8) of this rule.

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

(6) Program Requirements – General. All HCB services waiver providers and their billing agents must comply with the provisions of the Florida Medicaid Provider Reimbursement Handbook, Non-Institutional 081, October 2003, which is incorporated by reference and available from the Medicaid fiscal agent. The following requirements are applicable to all HCB services waiver programs...

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

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

Florida Medicaid **Developmental Disabilities Waiver Services Coverage and Limitations Handbook** October 2003, Revised June 23, 2005, Chapter 2, **Covered Services, Limitations, and Exclusions** states:

Description Consumable medical supplies are those non-durable supplies and items that enable recipients to increase their ability to perform activities of daily living. Consumable medical supplies are of limited usage and must be replaced on a frequent basis. Supplies covered under the Developmental Disabilities Home and Community-Based Services waiver must meet all of the following conditions: 1) be related to a recipient's specific medical condition, b) **not be provided by any other program** (emphasis added), c) be the most cost-beneficial means of meeting the recipient's need, and d) not primarily for the

convenience of the recipient, caregiver, or family. Consumable medical supplies covered by the DD waiver are listed under Limitations. ...

Limitations Consumable medical supplies **will not duplicate supplies provided by the Medicaid State Plan** (emphasis added). Refer to the Florida Medicaid Durable Medical Equipment-Medical Supplies Coverage and Limitations Handbook for additional information on Medicaid State Plan coverage. Supplies not available under the Medicaid State Plan, or available in insufficient quantity to meet the needs of the recipient, may be purchased by the waiver. ...

Consumable medical supplies covered by the DD waiver are listed below. Some items have specific requirements or limitations.

1. Diapers, including pull-ups, adult diapers...

2. Wipes. ...

6. Ensure, or other food supplements, when determined necessary by a licensed dietician. Recipients that require nutritional supplements must have a dietician's assessment documenting such need. The assessment shall include documentation of weight fluctuation. ...

Items not contained on this list, that meet the definition of consumable medical supplies, **may be** (emphasis added) approved through exception by the Department. To request an exception, a physician must prescribe the item. The statement from the physician, must delineate how the item is medically necessary, how it's directly related to the recipient's developmental disability, and without which the recipient can not continue to reside in the community or in his current placement. ...

Items of general use, such as: ... aspirin, Tylenol, Benadryl,...ointments...over-the-counter ... etc., are not covered.

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

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

(a) Meet the following conditions:
1. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs;

> 3. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;
> 4. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available; statewide; and
> 5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.
> ...
> (c) The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services does not, in itself, make such care, goods or services medically necessary or a medical necessity or a covered service.

The grandmother argued that the requested items had been authorized under the waiver in the past, they truly were necessary, basic State Plan Medicaid coverage was insufficient due to the highly unique circumstances, and that authorization should have occurred, because this was a predictable problem, existing for a long time. APD argued that State Plan Medicaid access had to be exhausted first, such was not demonstrated, and the case was complicated by concerns about residence along with documentation and supportive material problems. (As no notice of APD HCBS cancellation was issued on the basis of residence, such a concern will not be addressed at this time, in this forum.)

These rules establish mandatory guidelines for the definitions and authorization of services under the Waiver Services Program. The agency has reviewed the petitioner's eligibility for the requested consumable supplies. The Florida Medicaid Durable Medical Equipment-Medical Supplies Coverage and Limitations Handbook has been thoroughly explored and the determinations set forth by APD were supported therein. Catheters, including those that are non-urinary for suctioning, are a customarily covered service Medicaid service and special supplies may achieve waiver funding if

sufficiently medically justified and after exhaustion of State Plan coverage. The rules direct that coverage for the items must first be requested and provided where possible under the Medicaid State Plan. Because evidence did not establish that this was done, it is concluded the agency correctly denied the requests for HCBS Medicaid Waiver coverage and APD-APS denial of these items was justified.

While the grandmother's frustration is evident, and she has a long history of involvement with the HCBS waiver situation, the review process must be followed in full measure, and it cannot be concluded that APD funding authorization was justified in July 2006. Thus, the notice of July 17, 2006 is concluded to be proper.

DECISION

The appeal is denied and the agency action is upheld.

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 17th day of November 2006, in Tallahassee, Florida.

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

Copies Furnished To:

M. Catherine Lannon, Sr. Assistant Attorney General
George Beckwith, DLC

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

PETITIONER,

APPEAL NO. 06F-04743

Vs.

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

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on September 19, 2006, at 3:10 p.m., in Palatka, Florida. The petitioner was present and represented by her Waiver Support Coordinator, Shelley Schulz. Appearing as witnesses for the petitioner were [redacted], mother, John Townsend, ARC of Putnam County, Don Lee, supported living coach, and Cindy Burgoyne, ARC of Putnam County. The agency was represented by Lucy Goodard-Teel, Department of Children and Families' Attorney. Appearing as witnesses for the agency were Dorothy J. Rowe, consultant reviewer with APS Healthcare and Pamela Chamberlynn, consultant reviewer with APS Healthcare. Ms. Rowe and Ms. Chamberlynn participated in the hearing by telephone. Leigh Byrd, notary public did the swearing in of the telephone witnesses.

The record was left open to receive additional information. The petitioner submitted additional information after the record was closed. As such, the information will not be considered in the hearing officer's final decision.

ISSUE

The petitioner is appealing the agency's action of June 21, 2006, to reduce supported living coach services from 50 hours a month to 20 hours a month due to the lack of medical necessity, under the Developmental Services Home and Community Based Services Medicaid Waiver Program. The agency has the burden of proof.

FINDINGS OF FACT

The petitioner is a developmentally disabled adult who is approved to receive services in the Developmental Services Home and Community Based Services Medicaid Waiver Program. The petitioner is a high functioning individual who lives independently in her own home in the community. The petitioner's primary disability is mental retardation.

The petitioner is a competent adult who can legally make her own decisions. The petitioner excels in keeping her home clean and neat and she is able to manage activities of daily living without assistance. The petitioner has held several positions in the community and the annual report showed the petitioner is currently working under the Adult Day Training Program. In addition, the supported living coach testified at the hearing that the petitioner has another job as well. The support plan showed the petitioner has had some problems keeping jobs due to interpersonal relationship issues.

The petitioner sustained a closed head injury in a bicycle accident in 2002 and some of her behavior problems appear to have intensified since then. The petitioner's

parents are available for natural support and provide some financial assistance if needed.

A support plan with an effective date of July 1, 2006 and a cost plan were developed and submitted on behalf of the petitioner. The APS Unit performed a prior authorization review and approved adult dental services, support coordination services, Adult Day Training, transportation, 44 hours a month of companion services, supported employment, behavioral assessment services and behavior analysis services.

APS Healthcare is contracted by the Agency for Persons with Disabilities. The prior service authorization (PSA) is completed by APS is a paper document review which involves the Medicaid Waiver Support Coordinator submitting information to APS along with the requests for services to be paid for by the Medicaid Waiver Plan for the cost plan year. All reviewers employed by APS are approved by the Agency for Persons with Disabilities as qualified expert professionals to make the PSA determinations. Any services totaling $80,275 must be reviewed by a consultant physician and any service reduction must be reviewed by a consultant physician. APS is restricted from making contact with the petitioner's medical providers or the petitioner. The Waiver Support Coordinator collects the documentation. All contact must be in writing which is the reason for the form 2 when additional documentation is needed.

The APS unit determined that the request for 50 hours a month of supported living coach services was excessive and not medically necessary. The agency instead approved 20 hours monthly of supported living coach services. The rationale for the APS decision states in part:

"Continued Supported Living Coaching for CW is requested at a frequency of 50 hours a month with a unit rate of $8.29 in the allocated amount of $19,896.00, CW is 52 years old and lives alone at this time in a two bedroom home.
Supported Living Coach is a service to train a consumer how to live as independently as possible when they move into living on their own in the community and to assist a consumer who needs help with ongoing money and healthcare management to the degree that it is medically necessary. The support plan and the annual report for supported living coach were reviewed. The history of CW's use of supported living coaching in past cost plan years was reviewed. Supported Living Coach service appears to have begun in March 2004. The annual supported living report states that the Coach assists her [CW] in many areas. These areas include cooking, house cleaning, shopping, money management, making doctor's appointments and assisting in transporting CW to these appointments. CW also receives assistance in managing a diet. However, this same report states on the same page that 'CW keeps her home clean.' 'CW resists assistance with cooking. She understands how to cook some foods but needs to allow her coach to assist her in cooking healthy foods and a more variety of foods. CW purchases some frozen dinners that are healthy for her to eat,' The support plan adds that the supported living coach will assist CW with her laundry in addition to the items mentioned above. It does not appear CW has chosen in home supports or some other complimentary and available service to assist her living in her own home in the community. CW does receive 44 hours a month of companion services that are available to assist CW in many of these areas, particularly shopping.
Page 1-5, 6 of the Developmental Disabilities (DD) Waiver Service Coverage and Limitations Handbook defines the set of conditions for determining medical necessity for each requested service. Page 1-5, 6 states that services must 'Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment and not in excess of the patient's needs be furnished in a manner not primarily intended for the 'convenience' of the recipient or the provider.' Medical necessity has not been demonstrated for the amount of supported living coaching requested as evidenced by the types of household, money management shopping, cooking and medical needs documented. CW may consider a variety of more cost effective supported living services to provide ongoing assistance for successful living in her own home in addition to her supported living coaching if she so chooses and if medical necessity can be demonstrated. The recommendation is made to approve with changes 960 quarter hours, or 20 hours a month, of supported living coaching with a unit rate of $8.29 and a total allocated amount of $7958.40."

The petitioner was mailed notification of the agency's decision on June 21, 2006. The support plan indicated the supported living coach services was being used primarily for assistance with financial matters related to budgeting and paying bills and with purchasing and cooking foods that are compatible with the a healthy diet since the petitioner is a borderline diabetic. The supported living coach services was also used to assist with laundry skills, assistance with home safety, assistance with scheduling and accompanying the petitioner to medical, dental and counseling appointments. The petitioner has received supported living coach services since 2003.

The petitioner filed for a reconsideration and additional documentation submitted indicated this service was needed to make and take the petitioner to medical appointments, dental appointments, counseling appoints, training in safety issues, interpersonal issues, paying bills and banking. This information noted that the petitioner lives in a rural area so attending some of the medical appointments can take several hours. The reconsideration review also took into consideration the amount of supported living coach services requested in the previous cost plans. The reviewer noted that training for safety issues should have been maximized at this time and 50 hours of the service is greatly in excess of the needs of the petitioner. It was surmised that 50 hours of the service may have been requested for the convenience of the provider. In consideration of all of these factors the original APS decision was upheld. The APS reviewer noted that 50 hours a month of supported living coach services is a high level of service that is generally reserved for individuals that have serious limitations, legal problems, or are in transition.

The APS reviewer also explained that the supported living coach service is a service that is expected to be reduced over a period of time as the individual reaches a maximum trainable level. It was suggested that the 44 hours of the less expensive companion services could used to address some of the non professional activities such as choosing healthy foods that was being performed by the supported living coach. It was also noted that relationship issues/social conflicts, which take a considerable amount of time should be addressed by a trained professional and not the supported living coach.

CONCLUSIONS OF LAW

Pursuant to the Florida Administrative Code, Section 59G-1.010 **Definitions**, which states in part:

> "The following definitions are applicable to all sections of 59G, F.A.C., unless specifically stated otherwise in one of those sections. These definitions do not apply to any Medicaid program rules other than those in 59G, F.A.C.:. (164) 'Medically complex' means that a person has chronic debilitating diseases or conditions of one or more physiological or organ systems that generally make the person dependent upon 24-hour-per-day medical, nursing, or health supervision or intervention.
> (165) 'Medically fragile' means an individual who is medically complex and whose medical condition is of such a nature that he is technologically dependent, requiring medical apparatus or procedures to sustain life, e.g., requires total parenteral nutrition (TPN), is ventilator dependent, or is dependent on a heightened level of medical supervision to sustain life, and without such services is likely to expire without warning.
> (166) 'Medically necessary' or 'medical necessity' means that the medical or allied care, goods, or services furnished or ordered must:
> (a) Meet the following conditions:
> 1. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
> 2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs;

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

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

> "**Supported Living Coaching**
> **Description** Supported living coaching services provides training and assistance, in a variety of activities, to support recipient's who live in their own homes or apartments. These services may include assistance with locating appropriate housing; the acquisition, retention or improvement of skills related to activities of daily living such as personal hygiene and grooming; household chores; meal preparation; shopping; personal finances and the social and adaptive skills necessary to enable recipient's to reside on their own."

In the cost plan the petitioner requested 50 hours a month of supported living coach services. The agency instead approved 20 hours a month of the service, citing the lack of medical necessity as justification for its action. In evaluating the request for supported living coach services the agency noted that the petitioner is a high functioning individual who is able to live independently with minimal intervention. The petitioner is employed and is able to advocate for herself. The petitioner does not have any ongoing serious medical conditions and although, she has been diagnosed with borderline diabetes.

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

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

The agency notification states the reason for the reduction in services is "The request exceeds medical necessity or there is no determination that the service(s) is medically necessary." The petitioner's representatives did not present sufficient evidence to justify the medical necessity for 50 hours a month of supported living coach services. In the alternative, the respondent's expert witness offered testimony and evidence to show that 20 hours a month of supported living coach services is medically necessary and consistent with the needs of the petitioner.

Therefore, the hearing officer concludes after weighing all of the evidence that the agency met the burden of proof. As such, the action to approve 20 hours monthly of supported living coach services instead of the requested 50 hours monthly of the service due to the lack of medical necessity is an action that is consistent with the above cited authorities and is therefore, correct.

DECISION

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

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the 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 19th day of October, 2006,

in Tallahassee, Florida.

James Abdur-Rahman

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

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M. Catherine Lannon, Sr. Assistant Attorney General
Lucy Goddard-Teel

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

APPEAL NO. 06F-05059

PETITIONER,

Vs.

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

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned-hearing officer on September 19, 2006, at 1:19 p.m., at the Opa Locka Service Center, in Opa Locka, Florida. The petitioner was not present, but was represented at the hearing by Josefina Livingston, administrator, of the group home. Also present on behalf of the petitioner was Erica Diaz, support coordinator. Also present on behalf of the petitioner was Audrey Lawrence from the group home. The agency was represented by James Murdock, assistant attorney general, Attorney General Office. Also present on behalf of the agency, via the telephone, was Miranda Johnson, consultant reviewer, from Maximus. Maximus is located in Tallahassee, Florida.

ISSUE

At issue is the agency's action on June 22, 2006, to deny the (amended) request for ten hours a day of residential habilitation as a standard service as a Developmental

Disabilities Medicaid Waiver service for the petitioner, but provide seven hours a day on average, based on: "Have not been determined to be medically necessary." The petitioner has the burden of proof.

FINDINGS OF FACT

The petitioner is a recipient of the Medicaid Waiver Program under the Developmental Disabilities Program, is nineteen years of age; has a diagnosis of cerebral palsy and lives in a group home.

Maximus is the private agency that evaluates services for eligible recipients, for the agency, under the Medicaid Waiver Program. They also complete Prior Service Authorization reviews. The petitioner's representative had submitted an amended request for the residential habilitation service after an initial request for the service was approved.

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

Maximus or the agency determined as part of medical necessity and determining Medicaid Waiver services coverage and limitations that residential habilitation services were to be approved for seven hours a day on average. The petitioner was receiving seven hours a day on average and the petitioner's representatives had requested ten hours a day for this request.

The agency's reason for the above noted decision for services was based on: "Have not been determined to be medically necessary."

The information that was submitted to Maximus was in the form of a chart showing how the residential habilitation service is being provided by staff at the group home for the petitioner, Respondent Composite Exhibit 1. Maximus determined, that more specifically, based on the above information: "... [redacted] attends a meaningful day activity on a regular basis, she can eat and drink with verbal prompts, she can walk with the assistance of a walker, she requires assistance to bathe and does not exhibit any inappropriate behaviors at this time. In addition there is no information submitted to indicate that her health or current situation has changed to warrant an increase in service."

A reconsideration was requested by the petitioner's representatives and reviewed by Maximus and the agency upheld the above noted decision.

CONCLUSIONS OF LAW

In accordance with Fla. Admin. Code 59G-1.010:

(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 agency's Developmental Services Waiver Services Florida Medicaid Coverage and Limitations Handbook dated June 14, 2005, page 2-66, addresses residential habilitation services under description and states in part:

Residential habilitation provides supervision and specific training activities that assist the beneficiary to acquire, maintain or improve skills related to activities of daily living.

As shown in the Findings of Fact, Maximus determined, that residential habilitation as a standard service as a Developmental Disabilities Medicaid Waiver service for the petitioner, would be provided at seven hours a day, based on: "Have not been determined to be medically necessary."

The petitioner's representatives argued that as the petitioner gets older; her needs increase, thus the need for the additional residential habilitation hours. They also argued that the petitioner needs help with everything that she does, such as walking and thus the need for the additional hours of the service request. The respondent argued that the petitioner's representative had not provided information to indicate any major life changes

of the petitioner, thus seven hours of the residential habilitation service is appropriate for the petitioner.

After considering the evidence, the Florida Administrative Code Rule and all of the appropriate authorities set forth in the findings above, the hearing officer affirms the agency's action to deny the request for ten hours a day of residential habilitation as a standard service as a Developmental Disabilities Medicaid Waiver service for the petitioner, but provide seven hours a day on average, based on: "Have not been determined to be medically necessary."

DECISION

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

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 10th day of October, 2006,

in Tallahassee, Florida.

Robert Akel

Robert Akel
Hearing Officer
Building 5, Room 203
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
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Gail Scott Hill
M. Catherine Lannon, Sr. Assistant Attorney General
Hilda Fluriach

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

PETITIONER,

Vs.

APPEAL NO. 06F-05268

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

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned-hearing officer on September 28, 2006, at 3:45 p.m., in Gainesville, Florida. The petitioner was present. Present representing the petitioner was David Kanya, People Systems. Present as a witness for the petitioner was Nita Pierre, waiver support coordinator, People Systems. The respondent was represented by Lucy Goddard-Teel, District 3 legal counsel. Present testifying by telephone on behalf of the respondent was Kelli Michels of Maximus.

ISSUE

The petitioner is appealing the respondent's action of August 16, 2006, to reduce his residential habilitation behavior focus services from fourteen hours per day to seven hours per day and to deny his request for 192 quarter hours of behavior assistant services.

The petitioner was also originally appealing the reduction in his adult day training and the termination of his specialized mental health services and non residential support services. However, at the hearing, the petitioner withdrew his appeal related to those issues.

FINDINGS OF FACT

The petitioner is developmentally disabled and is eligible to receive services from the respondent's Developmental Services Home and Community-Based Services Medicaid Waiver Program. He is 45 years old and lives at the [redacted] Group Home.

The petitioner, through his waiver support coordinator, submitted a support plan which was to be effective September 1, 2006. In the support plan, the waiver support coordinator requested fourteen hours per day of residential habilitation at the behavior focus level. Additionally, the petitioner's waiver support coordinator requested 192 quarter hours of behavior assistant services.

The respondent's Developmental Disabilities Program has contracted with Maximus to perform Prior Service Authorization (PSA) reviews on certain requested services or when costs of a support plan exceed certain levels. Maximus reviewed the petitioner's request to continue his fourteen hours per day of residential habilitation services at the behavior focus level. The fourteen hours per day of residential habilitation services at the behavior focus level was previously approved on a temporary basis as the petitioner was going through a transition period and in need of additional support. Prior to the temporary approval, the petitioner was receiving seven hours of

residential habilitation at the behavior focus level. Maximus also reviewed the request for 192 quarter hours of behavior assistant services.

Information submitted to Maximus indicated that the petitioner had a period of regression last year after eloping from the group home. Since then, the petitioner has been more stable as the behavior data submitted showed a significant downward trend in all target behaviors. The documents submitted to Maximus did not show that the petitioner was continuing to experience instability. The petitioner has a history of sexual misconduct and he is receiving behavior analysis services and is also eligible to receive specialized mental health therapy to address his behavioral and mental health concerns. The petitioner is able to complete his personal care including toileting, dressing, and hygiene care with minimal prompts. He can prepare simple meals and can complete his laundry independently. Maximus determined that as the petitioner was in a more stable situation it would not be medically necessary for the continuation of fourteen hours per day of residential habilitation at the behavior focus level and that the fourteen hours would be in excess of his needs. Maximus determined that there was the medical necessity for seven hours per day of residential habilitation at the behavior focus level. Therefore, Maximus reduced the petitioner's residential habilitation at the behavior focus level to seven hours per day.

To determine the medial necessity for the petitioner's request for 192 quarter hours of behavior assistant services, Maximus requested that the petitioner through his waiver support coordinator provide a list of duties, a schedule of service and documented approval for a behavior assistant service by the LRC chairperson. The information requested was not submitted and Maximus could not determine the medical

necessity for the 192 quarter hours of behavior assistant services requested. Therefore, the petitioner's request for 192 quarter hours of behavior assistant services was denied.

On August 16, 2006, Maximus notified the petitioner that his residential habilitation services at the behavior focus level was being reduced to seven hours per day and his request for 192 quarter hours of behavior assistant services was being denied as medical necessity for the fourteen hours of residential habilitation services at the behavior focus level and the 192 quarter hours of behavior assistant services was not demonstrated.

CONCLUSIONS OF LAW

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

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

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

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

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

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

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

from the beneficiary and reflects the beneficiary's goal(s) from their current support plan.

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

Residential Habilitation with a Behavioral Focus

Service characteristics for residential habilitation with a behavioral focus include:

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

• Integration of behavioral services throughout residential and community programs,

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

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

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

procedures that are included in each recipient's behavior analysis services plan.

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

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

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

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

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

• Requires visual supervision during all waking hours and intervention as determined by a certified behavior analyst or licensed behavior analysis professional.

- Is being addressed through the use of behavior analysis services and reviewed by the Local Review Committee (LRC).
- Has lead to the use of restraint or emergency medications within the past year.

Has resulted in one or more of the following:

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

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

Behavior Assistant Services include the performance of one-on-one activities related to the delivery of behavior analysis services, as defined under Behavior Analysis Services and Assessment, and are designated in and required by a behavior analysis service plan. Activities include monitoring of behavior analysis services, the implementation of behavioral procedures, data collection and display (e.g., graphics) as authorized by a beneficiary's behavior analysis service plan and training for caregivers. The behavior analysis service plan must be designed, implemented and monitored in accordance with Chapter 65B-4.030, F.A.C., and approved in accordance with Chapter 65B-4.029, F.A.C. Behavior assistant services are designed for beneficiaries for whom traditional residential habilitation services have been documented unsuccessful.

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

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

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

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

Based on the evidence presented, it is determined that seven hours of residential habilitation at the behavioral focus level is sufficient to meet the petitioner's residential

habilitation needs and fourteen hours per day of residential habilitation is in excess of the petitioner's needs and is not considered to be medically necessary, as defined in the rule. Therefore, it is concluded that the respondent correctly reduced the petitioner's residential habilitation at the behavior focus level to seven hours per day.

The Findings of Fact showed that Maximus requested additional information to determine the medical necessity for the request for 192 quarter hours of behavior assistant services. However, the information requested was not provided. Therefore, it is determined that the medical necessity for 192 quarter hours of behavior assistant services was not demonstrated and the respondent correctly denied the petitioner's request for 192 quarter hours of behavior assistant services.

DECISION

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

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 2nd day of November, 2006,

in Tallahassee, Florida.

Morris Zamboca

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

Copies Furnished To:

M. Catherine Larrison, [illegible] General
Lucy Goddard-Teel

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

APPEAL NO. 06F-02802

PETITIONER,

Vs.

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

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on August 24, 2006, at 2:15 p.m. a.m., in Largo, Florida. The hearing was reconvened on September 26, 2006.

The petitioner was present. The petitioner was represented by Scott Orsini, Esq. Witnesses present on behalf of the petitioner were [redacted] the petitioner's mother, Jody Boone, support coordinator, Brook Levy, supported living coach. The respondent was represented by Gerald Siebens, assistant attorney general, attorney. Witnesses for the respondent were Cheryl Blackwell-Cox, supervisor, and Joyce Lang, Medicaid Waiver liaison. Present telephonically for the respondent from APS Healthcare Incorporated were Sandra Jensen, Ph.D., licensed clinical psychologist, and Pam Chamberlynn, M.A.,

clinical social worker and qualified mental retardation professional. Sandy Dormer, supported living coach supervisor, was observing.

ISSUE

The petitioner is appealing the notice of April 18, 2006 for the respondent's action to approve supported living coaching service with changes in approval of 960 quarter hours and denial of 720 quarter hours of the 1,680 quarter hours requested in the Support Plan for April 1, 2006 through March 31, 2007. As this is a reduction in service hours, the respondent has the burden of proof.

FINDINGS OF FACT

The petitioner is Medicaid eligible adult receiving services from Developmental Disability through the Home and Community-Based Services Waiver. The petitioner has received supported living coach services since the end of 2004. The petitioner had been receiving supported living coaching in the amount of 1,680 quarter hours for the April 1, 2005 through March 31, 2006 service period.

A Support Plan was submitted for services by the waiver support coordinator for the service period. One of the services, supported living coaching hours, was requested for 1,680 quarter hours. The documentation in the Support Plan indicated that the petitioner has experienced dramatic improvements in the last year, his health is stable and he has made great progress with becoming more self-sufficient and independent with personal care needs. The Annual Review indicated that the petitioner has worked with his supported living coach to

set up a budget, pay bills, handle medical appoints, medication refills, shopping needs and third party benefits. The petitioner's non-residential support service works with the petitioner on appropriate socialization, safety skills and choice-making when out in the community.

The respondent reviewed the request for services for the April 1, 2006 through March 31, 2007 service period. The respondent referred the request to APS Healthcare Incorporated. APS Healthcare Incorporated is the contract provider for the respondent that reviews Developmental Disabilities Waiver service requests and performs prior service authorizations.

APS Healthcare Incorporated reviewed the request for services including support living coach services. APS Healthcare Incorporated approved all other services except supported living coach service as requested. APS Healthcare Incorporated's rational indicated that the supported living coach service is to be provided for the services described in the Developmental Disabilities Waiver Services Coverage and Limitations Handbook. APS Healthcare Incorporated noted that according to the Annual Report by the supported living coach provider that in addition to the providing assistance with budgeting for monthly expenses, scheduling and transportation to doctor and dental appointment and maintaining Medicaid eligibility and food stamps, the support living coach was also providing household management, meal planning, shopping and community integration. The services of household management, meal planning, shopping and community integration were already being provided by the in-home support services staff and non-residential support staff. APS Healthcare Incorporated

determined based on documentation submitted that many activities the supported living coach was providing were not components of the supported living coach duties described in the handbook and were duplicating services provided by in-home support services staff and non-residential support staff. APS Healthcare Incorporated recommended that the supported living coach be reduced to 760 quarter hours for the Support Plan period April 1, 2006 through March 31, 2007. APS Healthcare Incorporated sent the petitioner a notice on April 18, 2006 reducing the supported living coach service. Forms 3a and 3b were attached to the notice.

A Reconsideration was requested. APS Healthcare Incorporated reviewed the Reconsideration request and documentation. The letter of April 24, 2006, indicated a detailed description of frequent medical appointments and frequent changes in the in-home support staff which required retraining and supervision by the supported living coach. APS Healthcare Incorporated reviewer recommended, based on the letter of April 24, 2006, that the support living coach hours be authorized in the amount of 960 quarter hours for the service period of April 1, 2006 through March 31, 2006. The remaining 720 quarter hours of the request of 1,680 quarter hours was denied.

The supported living coach testified that she is working with the petitioner 25 to 30 hours a month. Hours that the supported living coach is with the petitioner is spent in training, education, budgeting and monitoring his health issues. The supported living coach checks petitioner's blood sugar and catheter, monitors his medication and supervise and educates in home support staff. The

supported living coach is a licensed nurse. However, the agency that employs her as a supported living coach does not employ individuals to provide nursing service. The supported living coach submitted new information not considered by the respondent that the petitioner started to look for a new place to live in September 2006.

The respondent indicated that the petitioner could submit an amended Support Plan for any changes that occur.

CONCLUSIONS OF LAW

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

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

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

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

The Developmental Services Waiver Services Florida Medicaid Coverage and Limitations Handbook (June 23, 2005) is incorporated by reference in the

Florida Administrative Code at 59G-8.200 (12). The Florida Administrative Code at Fl. Admin. Code 59.G-1.010 defines medical necessity:

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

The Developmental Services Waiver Services Florida Medicaid Coverage and Limitations Handbook (June 23, 2005) at pages 2-104 through 108 set forth the description. limitations, place of service and special considerations for supported living coaching. The handbook states on for "Description" (page 2-104):

> Supported living coaching services provide training and assistance, in a variety of activities, to support beneficiaries who live in their own homes or apartments. These services may include assistance with locating appropriate housing, the acquisition, retention or improvement of skills related to activities of daily living such as personal hygiene and grooming, household chores, meal preparation, shopping, personal finances and the social and

adaptive skills necessary to enable beneficiaries to reside on their own.
Supported living services mean the provision of supports necessary for an adult who has a developmental disability to establish, live in and maintain a household of their choosing in the community. This includes supported living coaching and other supports.

Since this is a reduction of services, the respondent bears the burden of proof. The respondent must prove that the current level of supported living coaching of 1,680 quarter hours for the service period is not medically necessary, the reduction in service to 960 quarter hours for the service period is to an amount that is medically necessary and that a reduction is warranted.

The testimony revealed that the supported living coach is working with the petitioner 25 to 30 hours a month. This indicates service of between 1,200 and 1,645 quarter hours for the service period. The supported living coach did not demonstrate the services rendered for 1,680 quarter hours. Therefore, the request for the full 1,680 hours would not meet the definition of medical necessity.

Hours that the supported living coach is with the petitioner is spent in training, education, budgeting and monitoring his health issues. The supported living coach also checks petitioner's blood sugar and catheter, monitors his medication and supervises and educates in home support staff. Checking blood sugar and catheter and monitoring medication by a supported living coach is not a described service for a supported living coach in the handbook. These services could be provided by nursing service. As these services are more appropriately services by nursing or in-home support services, the request for the

full 1,680 hours would not meet the definition of medical necessity. As of the hearing date, the petitioner had not requested nursing services.

The support living coach was also providing household management, meal planning, shopping and community integration. The services of household management, meal planning, shopping and community integration were already being provided by the in-home support services staff and non-residential support staff. For the hours that the services that are duplicative, those service hours in the request for the full 1,680 hours would not meet the definition of medical necessity.

The supported living coach submitted new information not considered by the respondent that the petitioner started to look for a new place to live in September 2006. The petitioner was not looking for a new place to live when the Support Plan began on April 1, 2006. The supported living coach services may include assistance with locating appropriate housing. However, since this was not a request that made at the time of the submission of the support plan, the appropriate action would be to request modification of the current support plan.

In considering the authorities, evidence and arguments, the hearing officer concludes that the respondent was correct in their determination that a medical necessity did not exist for 1,680 hours of supported living coaching. Therefore, the action to approve 960 quarter hours and deny the 720 quarter hours of supported living coaching through the Developmental Disabilities Home and Community-Based Services Waiver Program was within the rules of the Program.

DECISION

This appeal is denied.

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 10th day of October, 2006,

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

Scott Sroka, counsel for the petitioner

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

APPEAL NO. 06F-03716

PETITIONER,

Vs.

CASE NO.

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

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on September 6, 2006, at 9:54 a.m., in Tampa, Florida. The petitioner was present as a witness, but was represented by Barbara Broadley, assistant director of supported living services with Suncoast New Options. Ms. Broadley also testified. Diana Esposito, attorney with the Office of the Attorney General (OAG), represented the Agency.

Denise Oetinger, senior human services program specialist, and Joyce Klein, liaison, both with the Agency For Persons with Disabilities (APD), observed. Dr. Sandra Jensen, forensic psychologist, and Pamela Chamberlynne, a mental health reviewer with APS, both appeared as witnesses by phone.

ISSUE

At issue is the respondent agency decision of May 17, 2006 to reduce the approved amount of Supported Living Coaching (SLC) services under the Home and Community Based Developmental Disabilities Medicaid Waiver Program from 30 hours monthly to 20 hours monthly. The respondent has the burden of proof.

FINDINGS OF FACT

The petitioner is a 28 year-old developmentally disabled adult, approved to receive various services through the HCBS Medicaid Waiver Program. In January 2006, the petitioner moved into a two bedroom apartment. The petitioner now lives in this apartment with an in-home support (IHS), paid for by the HCBS Medicaid waiver Program since she moved into her new apartment. The petitioner used to live by herself, but the petitioner then had difficulty maintaining her health and hygiene. The petitioner also had a roommate as of the hearing date, but the roommate was scheduled to move out on September 15, 2006.

The petitioner has been receiving supported living coaching services since approximately the year 2002 from the same provider/agency. The in-home support also provides natural support to the petitioner by taking her to church on weekends. The petitioner's grand-mother also provides some natural support.

The petitioner has diagnoses to include mental retardation, organic personality disorder, depression, sinus problems and cyclical anemia. The petitioner takes Risperdal, Lithium/Eskalith CR, and Lexapro for depression and

behavior management. The petitioner is able to self-medicate and her Supported Living Coach (SLC) and in-home support monitor medication management.

The petitioner has a high level of abilities and independence in consideration of her diagnoses. She is very independent and is described as "having come along way over the years" according to her supports. The petitioner is motivated, communicates verbally and fully, and is fully ambulatory. The petitioner prepares her own food with assistance from her in-home support staff. The petitioner is able to dress and bathe herself.

Pamela Chamberlynne is a qualified mental retardation professional with a Master's degree in clinical social work. Ms. Chamberlynne was the initial APS reviewer for the services at issue. Ms. Chamberlynne opines the petitioner to have a continued need for a maintenance level of SLC services in managing medical care and assisting with finances. Ms. Chamberlynne also opines that the SLC can provide a list to the in-home support to do shopping. Further, Ms. Chamberlynne opines that the SLC can do meal preparation, but the in-home support can assist with meal preparation. In summary, Ms. Chamberlynne opines that the less costly in-home support can perform certain functions that may have been provided by the SLC. Due to these factors, Ms. Chamberlynne opines that a reduced level of 20 hours monthly SLC services is the defined medically necessary amount. This expert opinion is factually established as further described in conclusions.

Barbara Broadley is the assistant director of the agency from which the petitioner receives supported living coaching services, Suncoast New Options.

Ms. Broadley opines the petitioner to lack sufficient self-preservation skills as she was found on Interstate 75 and has missed days of school at ADT. Dr. Sandra Jensen, forensic psychologist who was the contracted APS reconsideration reviewer, opines that a SLC would not identify and address behavior problems, and the petitioner should have been under the Baker Act for such incident. Dr. Jensen recommends a behavior assessment to address the need for behavior services. Ms. Broadley agrees that a behavior assessment is needed, and agrees that an SLC would assist in the implementation of a behavior plan, if such were approved.

By letter dated May 17, 2006, the Agency's contracted APS reviewer reduced the approved amount of supported coaching living services from 30 hours monthly to 20 hours monthly. Upon subsequent reconsideration, the Agency retained its original decision to reduce these approved services to the same amount. The Agency asserts that this level of service meets defined medical necessity criteria. The Agency asserts that the petitioner's in-home supports (services) are a more cost effective service to assist with some of the petitioner's needs.

CONCLUSIONS OF LAW

The Florida Administrative Code Rule 59G-1.010 addresses relevant definitions within the Medicaid Program, which are also applicable to the HCBS Medicaid Waiver Program and further iterated in the Agency's manual at page 1-5 and 1-6. Subsection (166) of the administrative code rule defines what constitutes "medically necessary" care, goods or services, as follows:

"...means that the medical or allied care, goods, or services furnished or ordered must:

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

Paragraph 2. of the above-cited administrative code rule indicates that services must not be "in excess of the individual's needs" in order to be determined "medically necessary," as per the above definition of such. The respondent Agency asserts that the requested amount of the SLC services at issue, 30 hours monthly, is in excess of the petitioner's needs. The Respondent asserts that 20 hours monthly of this requested service should be sufficient to meet the petitioner's needs. Further, the Respondent asserts and argues that some of the reduced amount of SLC hours could be served by the lower cost service, in-home support services, which the petitioner presently receives.

Supported Living Coaching services are defined on page 2-104 though 2-108 in the Developmental Services Waiver Services Florida Medicaid Coverage

and Limitations Manual, as labeled Respondent Exhibit 2. Pertinent excerpts of this definition include the first two paragraphs, as follows:

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

The Respondent argues that the reduction of SLC services at issue can be more appropriately served by the less costly In-Home Support Services. In-Home Support Services are defined on page 2-48 of the same referenced manual. The description of In-Home Support services is as follows:

> In-home support services are services that provide a recipient in a supported living situation with four to 24-hours-a-day assistance from a support worker or support workers. The support worker may live in the recipient's home or apartment and share living expenses (rent, utilities, phone, etc.) with the recipient. The support worker provides companionship and personal care, and may assist with or perform activities of daily living and other duties necessary to maintain the recipient in supported living. The in-home support services are separate and not a replacement for the services performed by a supported living coach. Some recipient's in supported living may need only the services of an in-home support worker, or only the services of a supported living coach. Other recipient's may need both services. When both services are used, the providers must coordinate their activities to avoid duplication.

The essential distinction in the definition of Supported Living Coaching services and In-Home Support Services is that Supported Living Coaching provides *training and assistance*, whereas In-home support services do not have a defined training component, but solely provide assistance with services. Findings show that the petitioner has made significant progress in performing life skills over the approximate four years she has received SLC services. Findings further establish that the petitioner retains the need for a maintenance level of defined SLC services for management of medical care, assisting with finances and perhaps with shopping and meal planning. Both of the Agency's expert witnesses opine that 20 hours monthly of SLC services should be sufficient to meet these needs. Further, the Agency psychologist witness recommends the petitioner to receive a behavior assessment to determine if behavior services are needed. The evidence is absent specific rebuttal evidence in dispute of these expert opinions. Upon cumulative review, the evidence as applied to the appropriate authorities shows that the Agency is correct to reduce the approved amount of SLC services to 20 hours monthly.

DECISION

This appeal is denied and the Agency action at issue is affirmed.

NOTICE OF RIGHT TO APPEAL

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

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

DONE AND ORDERED this 10th day of October, 2006,

in Tallahassee, Florida.

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

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

APPEAL NO. 06F-04754
-05057

PETITIONER,

Vs.

AGENCY FOR PERSONS
WITH DISABILITIES
DISTRICT: 15 St. Lucie
UNIT: APD

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on August 29, 2006, at 11:00 a.m., in Fort Pierce, Florida. The petitioner was not present. Ruben Cancel, owner, [redacted] Group Home, and Mario Price, support coordinator, had written permission from the petitioner's mother to represent him at the hearing. Jeff Mahl, Attorney, Office of the Attorney General, represented the Agency for Persons with Disabilities (APD). Steve Stoltz, program administrator, APD, was present as a witness for the respondent. Dr. Emma Guilarte, consultant reviewer with the prior service authorization unit, Maximus, appeared by telephone as a witness for the respondent. Cheryl Starkgraf, notary, was present as Dr. Guilarte took the oath.

ISSUE

At issue is whether the agency correctly approved with changes the petitioner's request for 10 hours direct care staff per day of residential habilitation (standard) services and terminated behavior analysis services. The agency holds the burden.

FINDINGS OF FACT

The petitioner is 20 years old and receives services through the Agency for Persons with Disabilities Medicaid Waiver Program, formerly known as the Developmental Disabilities Home and Community Based Services Medicaid Waiver Program. He resides in a group home. As part of the eligibility determination process, the support coordinator must submit a care and support plan for annual review. The agency conducted a prior service authorization review of a request for behavior analysis service (level 1) for 192 quarter hours to monitor his behavior plan. None were approved and the service was terminated. Residential Habilitation was requested for ten hours of direct care staff per day for 350 days. Eight hours of direct care staff per day for 350 days was approved.

Maximus, a contracted agency that performs prior service authorizations (PSA) for the agency, determined that the services were reduced or terminated because the requests exceed medical necessity or there is no determination that the service(s) is medically necessary. Medication review and support coordination were approved as requested (Respondent's Exhibit 1).

The reviewer at Maximus determined that there were documents missing necessary to conduct a review, so the consultant issued Form #2a. This form notifies the consumer that additional information is needed to process his request for behavior

analysis services. Along with this notice, Maximus included a listing of all required documentation needed for service requests. They requested a behavior intervention plan, including a plan for fading, data displays for services from the preceding 12 months, among other information. When they did not receive the requested information, they terminated behavior analysis services because they could not determine medical necessity (Respondent's Exhibit 2).

The petitioner attends school as his meaningful day activity. He eats and drinks on his own, ambulates unassisted, but needs considerable attention with daily hygiene. Residential habilitation (standard) services were requested for ten hours of direct care staff per day to assist the petitioner with personal care and activities of daily living. The reviewer at Maximus discovered there was no residential habilitation annual report included with the support plan. A Form 2A was issued and the report was never received. The support coordinator asserts that the annual summary was submitted with the support plan.

The consultant reviewer determined that the support plan had general statements indicating that the petitioner requires 10 hours of direct care staff to improve his social and daily living skills as well as receive redirection with social/safety skills and ongoing behaviors while in the home and community settings. The plan indicates that the petitioner has aggressive behaviors of hitting, scratching, kicking, and disturbing others while they sleep (Respondent's Composite Exhibit 4).

At reconsideration, Maximus received a summary of maladaptive behaviors, not an annual report or a behavior plan. Dr. Guilarte opined that the transition period is over and the petitioner should have appropriate services by now. She further believes

that the petitioner needs a behavior analyst to address his issues and train staff, and that more hours of residential habilitation is not the appropriate service to do that. She suggested that his IEP should include the services of a certified behavior analyst and a bus program, and recommended that the reduction of residential habilitation could be given to behavior analysis services. The reviewers determined that the petitioner receives adequate training, supervision, and assistance with activities of daily living for eight hours of direct care staff per day (Respondent's Exhibit 3).

CONCLUSIONS OF LAW

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

> (1) Purpose. Under authority of section 2176 of Public Law 97-35, Florida obtained waivers of federal Medicaid requirements to enable the provision of specified home and community-based (HCB) services to persons at risk of institutionalization. Through the administration of several different federal waivers, Medicaid reimburses enrolled providers for services that eligible recipients may need to avoid institutionalization. Waiver program participants must meet institutional level of care requirements. The HCB waiver services are designed to allow the recipients to remain at home or in a home-like setting. To meet federal requirements, Medicaid must demonstrate each waiver's cost-effectiveness...
> (5) Service Limitations – General. The following general limitations and restrictions apply to all home and community-based services waiver programs: (a) Covered services are available to eligible waiver program participants only if the services are part of a waiver plan of care ("care plan", "individual support plan", or "family support plan"). Care plan requirements are outlined in subsections (6) and (8) of this rule. (b) The agency or its designee shall approve plans of care based on budgetary restrictions, the recipient's necessity for the services, and appropriateness of the service in relation to the recipient, prior to their implementation for any waiver recipient...(6) Program Requirements- General. All HCB services waiver providers and their billing agents must comply with the provisions of the Florida Medicaid Provider Reimbursement Handbook. Non-Institutional 081, October 2003, which is incorporated by reference and available from the Medicaid fiscal agent. The following requirements

are applicable to all HCB services waiver programs:...(f) The plan of care will identify the type of services to be provided, the amount, frequency, and duration of each service, and the type provider to furnish service... (12) Developmental Services Waiver – General. This rule applies to all Developmental Services Waiver Services providers enrolled in the Medicaid program. All Developmental Services Waiver Services providers enrolled in the Medicaid program must comply with the Developmental Services Waiver Services Florida Medicaid Coverage and Limitations Handbook, October 2003, incorporated by reference, and the Florida Medicaid Provider Reimbursement Handbook, Non-Institutional 081, October 2003. Both handbooks are available from the Medicaid fiscal agent. The Developmental Disabilities Waiver Services Provider Rate Table, November 2003, is incorporated by reference. The Developmental Disabilities Waiver Services Provider Rate Table is available from the Medicaid fiscal agent.

The Developmental Services Waiver Services Florida Medicaid Coverage and Limitations Handbook at page 2-22 states in relevant part:

Description Behavior analysis services are provided to assist a person or persons to learn new behavior that are directly related to existing challenging behaviors or functionally equivalent replacement behaviors for identified challenging behaviors. Services may also be provided to increase existing behavior, to reduce existing behavior, and to emit behavior under precise environmental conditions. The term "behavior analysis services" includes the terms "behavior programming" and "behavioral programs." Behavior analysis includes the design, implementation and evaluation of systematic environmental modifications for the purposes of producing socially significant improvements in and understanding of human behavior based on the principles of behavior identified through the experimental analysis of behavior.
It includes the identification of functional relationships between behavior and environment. It uses direct observation and measurement of behavior and environment. Contextual factors, establishing operations, antecedent stimuli, positive reinforcement and other consequences are used, based on identified functional relationships between behavior and environment, in order to produce practical behavior change.
Behavioral services must include procedures to insure generalization and maintenance of behaviors. The services are designed to engineer environmental modifications including ongoing styles of interactions, and contingencies maintained by significant others in the recipient's life. Training for parents, caregivers and staff is also part of the services when these persons are integral to the implementation or monitoring of a

behavior analysis services plan. Services should be provided for a limited time and discontinued as the significant others gain skills and abilities to assist the recipient to function in more independent and less challenging ways.
Behavior analysis does not rely on cognitive therapies and expressly excludes psychological testing, neuropsychology, psychotherapy, sex therapy, psychoanalysis, hypnotherapy and long-term counseling as treatment modalities. Provision of behavioral services must comply with Chapter 65B- 4.030(9)(10), F.A.C. Services provided by behavior analysts with limited experience in the problem area or by behavior analysts who are not Board Certified Behavior Analysts with three years of experience or licensure under Chapter 490 or 491, F.S., should receive oversight and approval of services with a more experienced behavior analyst or with the above described highest level of certification.

The Developmental Disabilities Waiver Services Coverage and Limitations Handbook pg. 2-66 states:

Residential habilitation provides supervision and specific training activities that assist the recipient to acquire, maintain or improve skills related to activities of daily living. The service focuses on personal hygiene skills such as bathing and oral hygiene; homemaking skills such as food preparation, vacuuming and laundry; and on social and adaptive skills that enable the recipient to reside in the community. This training is provided in accordance with a formal implementation plan, developed with direction from the recipient and reflects the recipient's goal(s) from their current support plan.
Recipients with challenging behavioral disorders may require more intense levels of residential habilitation services described as behavioral residential habilitation, or intensive behavioral residential habilitation. The necessity for these services is determined by specific recipient behavioral characteristics that impact the immediate safety, health, progress and quality of life for the recipient, and the determination that less intensive services have not been sufficient to alter these behaviors. The need for more intense levels of residential habilitation, behavioral residential or intensive behavioral residential habilitation will be verified by the Developmental Disabilities Program Office.

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

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

The Developmental Services Waiver Services and Limitations Handbook includes definitions of services, specific requirements, and limitations on those services. The support plan must provide a clear explanation of need for the services. Maximus made the determination on medical necessity based on the information provided with the support plan and cost plan, and determined that medical necessity was not established for the requested hours of residential habilitation or behavior analysis services. The basis for the respondent's decision was the lack of a behavior plan and data sets for behavior analysis services and the lack of an annual summary for residential habilitation (standard) services. A behavioral intervention plan is a document needed to justify receipt of behavioral analysis, and without one, medical necessity could not be determined.

Mr. Cancel understood the transition period for the reduction in residential habilitation services, but argues that there had been no decrease in the petitioner's behaviors.

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

The hearing officer has considered the evidence and testimony and concludes there was not sufficient medical necessity evidence to rebut the agency's expert testimony and qualified professionals who made the medical necessity decision on the services at issue. It cannot be concluded that the additional hours of residential habilitation and behavior analysis services are necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain.

In summary, the hearing officer finds that the agency's action to approve with changes the petitioner's request for residential habilitation services and the action to terminate behavior analysis services is justified.

DECISION

The appeal is denied.

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 19th day of October, 2006,

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 T

M. Catherine Lannon, ... eneral

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

APPEAL NO. 06N-00183

PETITIONER,

Vs.

CASE NO.

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on November 2, 2006 at 9:24 a.m., in Ft. Myers, Florida. The petitioner was not present. She was represented by her daughter, [redacted] telephonically. The facility was represented by Brenda Hebden, administrator. Present as a witness for the petitioner was her friend, [redacted] Present as witnesses for the facility were Kathleen Gulnick, social worker; and Jennifer Vybiral, office manager.

ISSUE

At issue is the August 4, 2006 notice from the facility proposing to discharge the petitioner for failure to pay for services at the facility.

FINDINGS OF FACT

On August 4, 2006, the facility issued a Nursing Home Transfer and Discharge Notice to the petitioner. The facility proposed to discharge the petitioner as her bill for services at the facility had not been paid after reasonable and appropriate notice to pay. The petitioner was admitted to the facility on February 1, 2006.

The petitioner is not competent. She is represented by her daughter. She was admitted to the facility under a Medicare HMO titled United HMO. From February 1, 2006 to April 10, 2006, the petitioner owes the co-pay not covered by United HMO. The petitioner became private pay at the facility on April 11, 2006. She no longer met the skilled criteria required by the Medicare HMO.

CONCLUSIONS OF LAW

Jurisdiction to conduct this type of hearing is conveyed to the Department by Florida Statutes at 400.0255. Matters that are considered at this type of hearing are the decisions by the facilities to discharge patients. Federal regulations limit the reason for which a Medicaid or Medicare certified nursing facility may discharge a patient. In this case, the petitioner was sent notice indicating that he would be discharged from the nursing facility in accordance with the Code of Federal Regulations at 42 CFR § 483.12(a):

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

The petitioner was aware that there is an outstanding debt through her representative. The petitioner's representative argued that she was not sure

what coverage the petitioner had through her Medicare HMO. They have not paid the nursing home any money from the petitioner's funds claiming the nursing home has not answered all of their questions. In addition, the representative has complaints regarding the care her mother has received at the facility.

The respondent's position is that there is an outstanding balance and as a payment agreement has not been reached, discharge is appropriate. They have discussed the petitioner's coverage through her Medicare HMO. The representative was told that the HMO would not cover payment since the petitioner did not meet their skilled criteria. The petitioner response through the representative is "do what they need to do" to make her meet the HMO's skilled criteria.

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

DECISION

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

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 17th day of November, 2006,

in Tallahassee, Florida.

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

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dministration

FINDINGS OF FACT

On September 8, 2006, following a facility determination of nonpayment for services after reasonable and appropriate notice to pay, a Nursing Home Transfer and Discharge Notice was issued to the petitioner, Respondent's Exhibit 1. That notice was challenged (Petitioner's Exhibit 1).

After receiving the hearing request, on September 13, 2006, the undersigned issued an Order to Produce Notice and Begin Hearing Process, including a request for review by the Agency for Health Care Administration (AHCA). That review occurred and is Hearing Officer's Exhibit 1, as shared with the parties of record. It reflected the AHCA determination of care deficiencies but did not appear to give discernible information about quality of the discharge notice relative to regulations. That review is not controlling for hearing purposes, but it is customarily requested due to the obvious implication, when a hearing is requested, that the patient (or someone on her behalf) believes an erroneous discharge is intended.

The petitioner has resided at the facility since February 2006, following discharge from two other long term care facilities. Applications for Institutional Care Program (ICP) Medicaid were made, and approval occurred effective June 1, 2006, as related to need for existence, authorization and funding of an income trust. In the meantime, out of her monthly income, payments were made to other care facilities and for other expenses incurred by the petitioner in the past, but full payments for current care at the [illegible] were not made. The balance owed at [illegible] continued to increase and notices of such were issued as reflected in Respondent's Exhibit 3. By

August 2006, the balance owing was $16,053.57 and responsible family members were informed of such.

Power of Attorney is held by the son, who has reportedly had severe health difficulties, and that authority is conveyed to her granddaughter in event of his inability, Respondent's Exhibit 2. The granddaughter is in law school in New York, her capability is limited (according to family testimony) by time and other adversities, and the payment problem did not resolve through those individuals. With written notices and attempts at conferences (telephone messages left), the son and the granddaughter were informed and notified repeatedly during August 2006, as well as previously, as shown in Respondent's Exhibit 3. Details of payments and costs were reflected, and at least one effort at certified mail to the granddaughter was unsuccessful.

After determining insufficient payment for continued stay, the facility issued notice of discharge previously described, and declared the location for discharge was planned as the local son's address. Discharge would not proceed without planning, orientation, and arrangements for home health care, according to testimony of facility staff.

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 § 483.12 states as follows:

§ 483.12 **Admission, transfer and discharge rights.**

(a) Transfer and discharge--

(1) Definition: Transfer and discharge includes movement of a resident to a bed outside of the certified facility whether that bed is in the same physical plant or not. Transfer and discharge does not refer to movement of a resident to a bed within the same certified facility.

(2) Transfer and discharge requirements. The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless--
(i) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility;
(ii) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;
(iii) The safety of individuals in the facility is endangered;
(iv) The health of individuals in the facility would otherwise be endangered;
(v) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or
(vi) The facility ceases to operate.

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

(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:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement that the resident has the right to appeal the action to the State;
(v) The name, address and telephone number of the State long term care ombudsman;
...

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

Regulations require adequate planning and orientation in order to "ensure safe and orderly transfer or discharge..." Unsafe discharge is simply not permissible. However, based upon the findings of fact and the regulations cited, it can be concluded that reasonable and appropriate notice to pay was repeatedly issued, serious efforts to inform occurred by nursing facility staff, and insufficient payment has occurred.

In final analysis, it is concluded that facts and regulations provide sufficient support for the discharge notice as issued on September 8, 2006. Nonpayment following reasonable and appropriate notice has occurred. With adequate orientation and preparation, with home health care, and if safety is ensured, then discharge has been justified and may proceed as set forth in notice.

DECISION

The appeal is denied and the 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 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 2nd day of November, 2006, in Tallahassee, Florida.

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

Copies Furnished To:

GS, Respondent
on

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

APPEAL NO. 06N-00171

PETITIONER,

Vs.

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on August 28, 2006 at 10:10 a.m., at [redacted] Facility in Palatka, Florida. The petitioner was not present. However, she was represented by her granddaughter, [redacted] at the hearing. The Nursing Facility was represented by Leonard Stuck, Administrator, Victoria Medley, Social Services Director. Lynnette Stuck, Care Plan Coordinator and Gladys Lee, Director of Nursing.

ISSUE

At issue is whether or not the nursing home's action of June 21, 2006 to discharge the petitioner is an appropriate action based on the federal regulations found

at 42 C.F.R. §483.12. The nursing facility has a clear and convincing burden of proof to establish that the discharge action is consistent with the federal regulations.

FINDINGS OF FACT

The petitioner was provided with a discharge notice on June 21, 2006. This notice indicated the petitioner was being discharged due to "...needs cannot be met in this facility and the safety of other individuals in the facility is endangered." The nursing home representative submitted into evidence nurses' notes to show that the petitioner had a history of cursing, combative and aggressive behavior. The nursing home documentation showed the petitioner had demonstrated such behaviors on April 30, 2006, May 8 and 10, 2006 and June 20, 2006.

The petitioner's representative believed the disruptive behavior could be attributed to several medication changes that took place in a relative short period of time. It was noted that the petitioner is currently on a regimen of Xanax. The petitioner's representative believes this has improved the problematic behavior.

The facility believes it cannot meet the needs of the petitioner because her representative will not allow the psychiatrist, Dr. Mhatre, to prescribe certain drugs. The petitioner's representative took issue with the medication being prescribed by the psychiatrist because of past experiences. The petitioner's representative allowed the petitioner's attending physician, Dr. Prudencio to prescribe Xanax. However, Dr. Prudencio is not doing follow up on this prescription as he is a medical doctor. The nursing home considered it a liability to have the petitioner receiving psychotrophic medications without proper follow up from a qualified professional.

The nursing home did not put a discharge location on the discharge notice. The notice was signed by the facility's "SSD." It was explained that this was done to allow the petitioner's representative to choose the nursing home facility of her choice. The nursing home representative indicated the facility would assist with placement but currently no other facility is willing to accept the petitioner. The nursing home did not submit into evidence any clinical documentation from the petitioner's attending physician.

CONCLUSIONS OF LAW

Jurisdiction to conduct this type of hearing is conveyed to the department by federal regulations appearing 42 C.F.R. §431.200. These regulations limit the reasons for which a Medicaid or Medicare certified nursing facility may discharge a patient.

In the case hand, the discharge notice specifies reasons that appear at 42 C.F.R. §483.12 **Admission, transfer and discharge rights**, which state in part:

> *(2)Transfer and discharge requirements.* The facility must permit each resident to remain in the facility unless...(i) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility...(iii) The safety of individuals in the facility is endangered:.. (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...

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

> 3) When a discharge or transfer is initiated by the nursing home, the nursing home administrator employed by the nursing home that is discharging or transferring the resident, or an individual employed by the nursing home who is designated by the nursing home administrator to act

> on behalf of the administration, must sign the notice of discharge or transfer. Any notice indicating a medical reason for transfer or discharge must either be signed by the resident's attending physician or the medical director of the facility, or include an attached written order for the discharge or transfer. The notice or the order must be signed by the resident's physician, medical director, treating physician, nurse practitioner, or physician assistant.

Due to disruptive behavior the petitioner was provided with a Notice of Discharge on June 21, 2006. The notice cited needs cannot be met in the facility and endangerment to the safety of others at the facility, as the reasons for the discharge. The nursing facility representatives presented evidence to show that the petitioner has exhibited combative, aggressive, verbally abusive and disruptive behaviors.

The federal regulation requires that the clinical record must be documented by the resident's physician when the discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility. The Florida statute requires that any notice indicating a medical reason for transfer or discharge must either be signed by the resident's attending physician or the medical director of the facility, or include an attached written order for the discharge or transfer. The notice or the order must be signed by the resident's physician, medical director, treating physician, nurse practitioner, or physician assistant.

There was no documentation from the petitioner's attending physician, Dr. Prudencio, submitted into evidence. There was no evidence that any of the other designated individuals signed the notice or provided an order for the discharge. A psychological evaluation completed by Dr. Mhatre was submitted into evidence; this documentation simply stated that the nursing home has the option of giving a 30 day

notice to discharge. Without the physician's (or other designated individual's) order or signing of the discharge notice, it is unclear if the resident requires discharge. Based upon a careful analysis of the evidence presented, the hearing officer concludes that the Nursing Facility did not meet its burden of proof. As such, the action to discharge the petitioner is not justified.

DECISION

This appeal is granted. The nursing facility is not authorized to proceed with the discharge action.

NOTICE OF RIGHT TO APPEAL

The decision of the hearing officer is final. Any aggrieved party may appeal the decision to the district court of appeals in the appellate district where the facility is located. Review procedures shall be in accordance with the Florida Rules of Appellate Procedure. To begin the judicial review, the party must file one copy of a "Notice of Appeal" with the Agency Clerk, Office of Legal Services, Bldg. 2, Rm. 204, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. The party must also file another copy of the "Notice of Appeal" with the 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 27th day of October, 2006,

in Tallahassee, Florida.

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

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

APPEAL NO. 06N-00184

PETITIONER,

VS.

SING CENTER

RESPONDENT.
_____/

ORDER CANCELLING HEARING

A request for hearing on August 21, 2006 in the above styled matter is before this hearing officer. The petitioner has two representatives [redacted] and [redacted]

Pursuant to notice based on a May 22, 2006 hearing request, an administrative hearing was convened before the undersigned hearing officer on July 18, 2006, at 1:15, p.m., at [redacted], in Sarasota, Florida. The petitioner was not present. The petitioner was represented by her cousin, [redacted]. The respondent was represented by Louis Maltaghati, administrator. The issue under appeal was the petitioner's discharge in the notice dated May 12, 2006.

The appeal was denied and the Final Order was issued on August 3, 2006. The conclusion of that Final Order was that the respondent did not have the ability to meet the petitioner's needs for her inappropriate actions and as the respondent was unable to meet the petitioner's needs, the discharge was in the best interest of the petitioner. The decision indicated that the respondent's action to discharge the petitioner was in accordance with federal regulations and that the facility may proceed with the discharge to a facility that would have the ability to meet the behavioral issues needs of the petitioner, as determined by the treating physician and in accordance with applicable Agency for Health Care Administration requirements including skilled level of care.

On August 21, 2006, the petitioner requested a hearing and an appeal was entered. On August 30, 2006, the Office of Appeal Hearings received a Nursing Home Transfer and Discharge Notice dated August 29, 2006. A hearing was scheduled for October 20, 2006 at 9:15 a.m.

As there had been no evidence that the facility rescinded the discharge of May 12, 2006, an Order for Clarification of Issue was sent to both parties on September 27, 2006. The Order for Clarification of Issue requested information as to the reason of the petitioner's hearing request on August 21, 2006. Both parties had ten days to respond to this Order. After the ten days, the hearing officer would determine if the hearing officer has jurisdiction in this matter based on the responses received. If the hearing officer determines that hearing officer does not have jurisdiction, the hearing scheduled for October 20, 2006 would be cancelled.

On October 3, 2006, the administrator contacted the hearing officer. The administrator stated that the discharge of May 12, 2006 had not been rescinded. While the petitioner was awaiting the discharge as ordered on August 3, 2006, an emergency discharge was indicated for the petitioner to Bayside Center under a Baker Act.

The conduct of hearing is set forth in the Florida Administrative Code at Fl. Admin. Code 65-2.057 and states in relevant part:

> (11) A Hearings Officer shall not grant a motion for rehearing or reconsideration.

The Final Order of the hearing officer is a final order as stated in the Florida Administrative Code at Fl. Admin. Code 65-2.066:

> (1) Orders issued by the Hearings Officers of the Office of Appeal Hearings of the Department of Children and Family Services are final orders...

The rules do not provide for a rehearing or reconsideration by the hearing officer for an issue that has been heard. The petitioner received a discharge notice on May 12, 2006. A hearing was requested. The hearing was scheduled. A Final Order was issued. The decision of that Final Order was that the facility may proceed with the discharge. That discharge of May 12, 2006 was not rescinded. Any subsequent emergency discharge after a Final Order for discharge cannot be heard. Therefore as set forth in the Order for Clarification of Issue the hearing scheduled for October 20, 2006 at 9:15 a.m. is cancelled.

DONE and ORDERED this 11th day of October, 2006,

in Tallahassee, Florida.

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

Copies Furnished T

, Respondent
Care Admin

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

APPEAL NO. 06N-00167

PETITIONER,

Vs.

CASE NO.

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened on August 25, 2006, at 2:25 p.m., at the respondent/facility location. The respondent facility was represented by the facility administrator, Chris Tetrault, who also testified. The petitioner was present as a potential witness, but was represented by his wife, [redacted] who also testified. [redacted]s niece, T[redacted] translated from Spanish to English and vice versa. The petitioner's brother, [redacted] appeared as a witness for the petitioner

The following individuals appeared as potential witnesses for the facility:

- Tina Mitchell, social services director,
- Veronica Johnson, interim director of nursing,

- Debbie Pauley, registered nurse and case manager with Tidewell Hospice.

ISSUE

At issue is the correctness of the respondent facility's action of June 29, 2006, to discharge the petitioner based on the assertion that the petitioner's health has improved sufficiently so that the petitioner no longer needs the services provided by the facility.

FINDINGS OF FACT

The petitioner was initially admitted to the respondent facility on March 20, 2006, and has remained a resident of the facility as of the hearing date. The petitioner is 29 years old with a birth date of [illegible]. Prior to the petitioner's admission to the facility, he had been hospitalized at Manatee Memorial Hospital. At the time of the hospitalization, the petitioner had a primary diagnosis of end stage HIV, with other diagnoses to include meningitis, and Hepatitis C. When the petitioner was hospitalized, he was on total care to include a trach, oxygen suctioning and catheter.

When the petitioner was admitted to the facility on March 20, 2006, he was bed-ridden, acutely ill and under hospice care. The petitioner then weighed 93 pounds and required total care. The petitioner was then believed to be dying.

The petitioner underwent treatment while at the facility. By July 31, 2006, the facility medical director determined the petitioner was no longer incapacitated in making health care decisions. As of August 5, 2006, the petitioner's weight

had increased to 141.5 pounds. Beginning in approximately June 2006, the petitioner would voluntarily sign himself out and voluntarily exit the facility. As of the hearing date, the petitioner was spending the majority of his time outside the facility, sometimes without staff knowledge. On July 29, 2006, the facility treating physician provided orders that the petitioner could be medically discharged to his home, per Respondent Exhibit 8. On August 25, 2006, the petitioner was evaluated by the Hospice physician, who then discharged him based on longer meeting hospice criteria.

As of the date of hearing, the petitioner was fully independent of ADL's, needing only prompting to take prescribed oral medications. On June 29, 2006, the facility issued a discharge notice with the assertion that the petitioner's health had improved sufficiently so that he no longer needed facility services. This assertion is not disputed and is factually established. The listed discharge location is to his wife's [redacted] residence. [redacted] previously believed that the petitioner would be discharged to the petitioner's mother's residence, but the petitioner's mother returned to Mexico.

The petitioner's wife [redacted] lives with their mutual four year-old child, [redacted]'s sister, brother and nephew. The petitioner's wife alleges that she is unable to provide care for the petitioner due to a stress-related disorder. The Petitioner Exhibit 1 is a letter dated July 6, 2006 from Dr. Ahmad Sahebzamanin indicating that [redacted]s physically unable to care for the petitioner. However, this physician has not recently seen the petitioner and the petitioner is now nearly

totally independent in care needs. Therefore, it is not factually established that the petitioner's wife is physically unable to provide care for the petitioner.

About one month prior to the hearing, the facility was making arrangements for the petitioner to be discharged to the residence of his wife. However, as of the hearing date, the petitioner's wife testified that she does not wish to expose their mutual minor child to the petitioner's condition. The petitioner's wife's main concern is that their minor child may need to be tested and may not take appropriate precautions. The facility administrator opines that the petitioner's condition is not considered a communicable disease.

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 reason for which a Medicaid or Medicare certified nursing facility may discharge a patient. In this case, the discharge notice indicates the petitioner is to be discharged from the respondent/facility because the petitioner's health has sufficiently improved so that he no longer needs nursing facility services. Federal Regulations do permit a discharge for this reason, as set forth at 42C.F.R. §483.12(a)(2)(ii), as follows:

> "The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility"

Sub-paragraph (3) shows that when a resident is transferred or discharged for this reason, then that resident's clinical record must be

documented by a physician that the transfer is necessary. The Findings of Fact show that the petitioner's clinical record is documented by the facility physician that the discharge is appropriate for this reason. There is no dispute that the petitioner's health has improved to this level. Therefore, the nursing facility is correct to discharge the facility for this listed reason.

The Code of Federal Regulations at 42 C.F.R.§483.12(a)(6)iii) require the content of the discharge notice to include "the location to which the resident is transferred or discharged." The Findings of Fact show that the facility listed the residence of his wife as the discharge location. This discharge location was listed based on prior discussions with the facility. Findings do not establish that the petitioner's wife is unable to physically care for the petitioner's needs, since the petitioner is almost totally independent in care needs. Therefore, this location is concluded as a meaningful discharge location. The respondent facility has the responsibility to implement appropriate discharge planning per 42 C.F.R.§483.12(a)(7).

In summary conclusion, the respondent facility is concluded as having met its burden to justify its intended discharge action based on the improvement in the petitioner's health. Further, the respondent facility has listed a meaningful discharge location as his wife's residence.

DECISION

The appeal is denied. The facility is permitted to discharge the petitioner to the listed discharge location.

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 11th day of October ,2006,

in Tallahassee, Florida.

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

Copies Furnished T

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

FILED
OCT 0 2 2006
OFFICE OF APPEAL HEARINGS
DEPT. OF CHILDREN & FAMILIES

APPEAL NO. 06N-00172

PETITIONER,

Vs.

)N CENTER

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned-hearing officer on September 11, 2006, at 9:27 a.m., at the ... in Hollywood, Florida. The petitioner was present and represented herself at the hearing. Also present representing the petitioner was the petitioner's son, [redacted], and the petitioner's husband, [redacted] Present as a witness for the petitioner was the petitioner's friend, [redacted] The respondent was represented at the hearing by Sandra Yerks, executive director, ... r. Present as witnesses of the respondent were Sarah Santiago, risk manager; Shalves Anderson, director of nursing; and Sandra Austin-White, director of social services, all from ...

ISSUE

The respondent notified the petitioner that she was to be discharged for the following reasons: "Your needs cannot be met at this facility..." 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 FS 400.0255.

FINDINGS OF FACT

The facility notified the petitioner on or about June 28, 2006 that she was to be discharged by July 27, 2006. The discharge location was given: "[redacted]. This location is another nursing home. Currently the petitioner resides at the H[redacted]he petitioner's treating physician agreed with the discharge, Respondent Exhibit 1. The form was signed; however, by the physician's designee.

The respondent explained that the petitioner has rejected the above nursing home site and that this facility also does not have a "bed" available at this time. The respondent has provided the petitioner's representatives with other nursing home sites for the petitioner to consider. The petitioner's representative is also considering a nursing home in the Miami area for the petitioner to be discharged.

The respondent discharge notice to the petitioner provides the discharge reason as; "Your needs cannot be met at this facility...". This notice also indicates that; "The safety of other individuals in this facility is endangered." The respondent also submitted into evidence, Respondent Exhibit 1, which is a copy of the petitioner's progress notes.

The petitioner is currently wheelchair bound and needs assistance with all of her activities of daily living. As provided by the above mentioned progress notes and by

testimony from the respondent's witnesses, the petitioner has been verbally abusive toward staff and the petitioner's roommate. There have been several instances of the above documented by the facility. The petitioner has also accused the facility's staff of being abusive towards her. Based on this, the facility has been forced to always provide two staff members to handle her; to protect the staff. Additionally, as the petitioner will sometimes flail her arms about, the respondent fears for the safety of staff. The facility indicated that the facility can no longer meet the petitioner's needs; thus the discharge notice was provided to 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;...
>
> (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; ...

As shown in the Findings of Fact, the facility notified the petitioner on or about June 28, 2006 that she was to be discharged by July 27, 2004 to "

he facility has indicated that the facility can no longer meet the needs of the petitioner.

The petitioner argued that she would not physically harm anyone and that she has never, as a mother, even hit her children while raising them. She also argued that the staff at the facility have been abusive toward her, partly based on disparaging holocaust remarks made by a staff member toward her. The petitioner's representatives argued that they did not want the facility transferring the petitioner to a substandard nursing facility. The respondent argued that they, at least, have provided the petitioner's representatives with a list of other facilities to explore for the transfer of the petitioner. The respondent also argued that their reason for discharge of the petitioner, as noted in the Findings of Fact, remains correct. The hearing officer agrees with the last respondent's 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 transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility." The facility has met its burden of proof.

DECISION

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

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 2nd day of October, 2006,

in Tallahassee, Florida.

Robert Akel

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

Copies Furnished To

J CENTER,

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

APPEAL NO. 06N-00182

PETITIONER,

Vs.

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative Hearing was scheduled before the undersigned hearing officer on August 29, 2006, per the request of the petitioner for an expedited hearing. On August 28, 2006, the petitioner requested a continuance as he no longer needed an expedited hearing when he found a place to live and requested at least a 30 days continuance to prepare his case. Motion was granted and hearing was rescheduled to October 3, 2006.

All documents that the respondent was submitting into evidence were received by the petitioner and the hearing officer on September 27, 2006. On October 2, 2006, the petitioner requested another continuance. The petitioner renewed that motion at the hearing. Motion was denied.

The hearing was convened on October 3, 2006, at 8:33 a.m., at [redacted]n St. Petersburg, Florida. The petitioner was present.

Present on behalf of the petitioner was ombudsman Douglas Watson. Witnesses for the petitioner were [redacted], resident, and Sharon Nelson, physical therapist. The respondent was represented by Virginia Ramos, assistant administrator. Witnesses for the respondent were Linnea Gleason, social services director, Greg Dennis, psychiatric nurse manager, and Patricia Duckham, director of nursing. Katherine Sherril-Hager, administrator, observed part of the proceedings.

ISSUE

The respondent will have the burden to prove by a preponderance of evidence that the petitioner's discharge in the notice dated August 10, 2006 is in accordance with the requirements of Code of Federal Regulation at 42 C.F.R. §483.12(a):

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

FINDINGS OF FACT

The petitioner admitted to the facility on August 10, 2005 due to a motor vehicle accident. He has a leg prosthesis and ambulates with the use of a wheelchair. The petitioner has medical issues as a result of this accident. While in the facility, the petitioner was receiving physical therapy and medication.

On July 8, 2006, Dr. Bremmer, M.D. of the Department of Elder Affairs determined that as of July 11, 2006 the petitioner no longer met a skilled nursing home level of care. The placement recommendation was the "community". Discharge planning had begun for the petitioner's transfer to an assisted living facility or an apartment.

For the year that the petitioner was in the facility, the petitioner had signed himself out of the facility on several occasions to go into the community. The petitioner was cautioned about crossing the street at the light. On at least three occasions in which the petitioner signed himself out, the petitioner was gone from the facility overnight and the facility did not know where the petitioner was. The facility documented occasions of violation of the smoking rules for the residents.

On August 10, 2006, the director of nursing received a call from the police that the petitioner was drunk and disorderly. The director of nursing suggested to the police the petitioner be detained; however, the petitioner was returned to the facility by a police officer. It was the director of nursing professional opinion that the petitioner was intoxicated and a danger to himself and others. The petitioner was thrashing about the floor and tried to hit the director of nursing. The assistant administrator saw the petitioner trying to strike other residents.

The psychiatric nurse manager opined that the petitioner was disruptive and that the petitioner posed a risk to himself and other residents. The psychiatric nurse directed the staff to call the sheriff's office. The sheriff determined that the petitioner was a risk.

Jerry Evans, licensed clinical social worker examined the petitioner and signed the Certificate of Professional Initiating Involuntary Examination. The licensed clinical social worker's diagnosis was atypical psychosis and observed that the petitioner was agitated, verbally threatening, attempting to hit others and seemed to be intoxicated. Doctor DiCandido telephonically ordered the

discharge for per the Baker Act. The ambulance was called. The emergency medical technicians had to restrain the petitioner due to his behavior.

The petitioner concurred that he was in an impaired state on August 10, 2006. However, it is his opinion that his impairment was caused by the facility and insinuated a possible medication mix-up. No evidence was submitted to support the petitioner's statement that the reason for his impaired stated on August 10, 2006 was the result of a possible medication mix-up.

, resident, and n, physical therapist were not present for the incident that occurred on August 10, 2006. The professional opinion of a police officer, the director of nursing, the assistant administrator, the psychiatric nurse manager, the licensed clinical social worker and a sheriff was that the petitioner was intoxicated.

The petitioner is currently residing in the community and has been since approximately August 28, 2006. He took the bus from this residence with his wheelchair to attend the hearing. He is not receiving 24 hour skilled care at this time and has not received skilled care from at least August 28, 2006 through October 3, 2006. He does take daily medication.

CONCLUSIONS OF LAW

Federal Regulation limits the reason for which a Medicaid or Medicare certified nursing facility may discharge a patient. In this case, the petitioner was sent notice on August 10, 2006 indicating that he would be discharged from Jacaranda Manor in accordance with of Code of Federal Regulation at 42 C.F.R. § 483.12(a):

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

Code of Federal Regulation at 42 C.F.R. § 483.352 define emergency safety situation:

> Emergency safety situation means unanticipated resident behavior that places the resident or others at serious threat of violence or injury if no intervention occurs and that calls for an emergency safety intervention as defined in this section.

Jerry Evans, licensed clinical social worker examined the petitioner and signed the Certificate of Professional Initiating Involuntary Examination. The Certificate of Professional Initiating Involuntary Examination indicates that the signature can be a licensed clinical social worker. The licensed clinical social worker's diagnosis was atypical psychosis. The licensed clinical social worker observed that the petitioner was agitated, verbally threatening, attempting to hit others and seemed to be intoxicated. These behaviors on August 10, 2006 were witnesses by the assistant administrator, the psychiatric nurse manager and the director of nursing. The hearing officer finds that the petitioner's behavior on August 10, 2006, met the definition of emergency safety situation, as the behavior was unanticipated and placed the petitioner and others at serious threat of violence or injury if no intervention had occurred.

Doctor DiCandido telephonically ordered the discharge per the Baker Act. This indicates that the petitioner's treating physician concurred with the discharge per the Baker Act. The discharge is consistent with the recommendation of the treating physician. The hearing officer finds that based on the petitioner's behavior on August 10, 2006 and concurrence of the treating physician, the

discharge per the Baker Act was appropriate and in accordance with Federal Regulations.

The hearing officer reviewed the appropriateness for permitting the petitioner to return to facility, at this time. The Code of Federal Regulation at 42 C.F.R. § 483.12(b) sets forth the conditions for permitting a resident to return to a facility:

> (3)(i) Requires the services provided by the facility; and
> (ii) Is eligible for Medicaid nursing facility services.

Appropriate placement in a nursing facility is set forth in the Florida Administrative Code at Fl. Admin. Code 65A-1.701:

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

Eligibility for Institutional Care Program (ICP) benefit is set forth in the Florida Administrative Code at Fl. Admin. Code 65A-1.711:

> (2) for ICP benefits, an individual must be:
> (a) Living in a licensed nursing facility, or confined to a hospital swing bed or to a hospital-based skilled nursing facility bed, or in an ICF/DD facility that is certified as a Medicaid provider and provides the level of care that the client needs as determined by the department; or living in a Florida state mental hospital and be age 65 or over; and
> (b) Determined to be in medical need of institutional care services according to Rules 59G-4.180 and 59G-4.290, F.A.C...

The criteria for Intermediate Care Services and Skills Services is defined in the Florida Administrative Code at Fl. Admin. Code 59G-4.00:

59G-4.180 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...

(3) Intermediate Services criteria.

(a) To be classified as requiring intermediate care services, level I or level II in the community or in a nursing facility, the applicant or recipient must require the type of medical, nursing or rehabilitation services specified in this subsection.

(b) Intermediate Care Services. To be classified as intermediate care services, the nursing or rehabilitation service must be:

1. Ordered by and remain under the supervision of a physician;

2. Medically necessary and provided to an applicant or recipient whose health status and medical needs are of sufficient seriousness as to require nursing management, periodic assessment, planning or intervention by licensed nursing or other health professionals...

(e) To qualify for placement in a nursing facility, the applicant or recipient must require 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 services provided in a hospital or that meets the criteria for skilled services...

59G-4.290 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...

(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...

(10) To qualify for placement in a nursing facility, the applicant or recipient must require 24 hour observation and care and the constant availability of medical and nursing treatment and

care, but not to the degree of care and services provided in a hospital.

On July 8, 2006, Dr. Bremmer, M.D. of the Department of Elder Affairs determined that as of July 11, 2006 the petitioner no longer met a skilled nursing home level of care. The placement recommendation was the "community". On July 12, 2006, discharge planning had begun for the petitioner's transfer to an assisted living facility or an apartment. Since approximately August 28, 2006, the petitioner has resided in the community and has not received 24 hours skilled nursing care. The petitioner is able to take his own medication. There was no doctor's order for continued physical therapy or placement in a skilled nursing facility. The petitioner is capable of maintaining himself in the community without 24 hour skilled nursing care or 24 hour medical supervision. The evidence does not support that petitioner's impairments meet a level of severity that requires the petitioner to have rehabilitative services that can only be provided in a nursing facility, skilled nursing care or 24 hour medical supervision. The petitioner has medical issues and this finding does not indicate that he is not in need of medical care and medication. However, the petitioner does not require a skilled level of nursing care that meets the criteria as set forth in the rules to qualify for placement in a nursing facility. Appropriate placement is the community.

DECISION

This appeal is denied as [redacted] action to discharge the petitioner was correct and in accordance with Federal Regulations.

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 11th day of October, 2006,

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

Care Admin

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

PETITIONER,

Vs.

APPEAL NO. 06N-00188

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned-hearing officer on October 25, 2006, at 4:05 p.m., at the [redacted]r, Ocala, Florida. The petitioner was not present. Present representing the petitioner was her daughter, [redacted]nd son-in-law, [redacted] The respondent was represented by Sandy Sternefeld, administrator. Present as witnesses for the respondent were Virginia Hainline, business office manager, Cindy Fishbaugh, assistant social worker, Ann Baker, Medicaid specialist, and Angela Deas, social service director.

ISSUE

At issue is whether or not N[redacted] action of August 21, 2006, to discharge the petitioner was correct on the basis of nonpayment for care and services provided.

FINDINGS OF FACT

The petitioner is a resident of [redacted] Ocala, Florida. As of October 31, 2006, the petitioner's outstanding bill at the facility was approximately $33,035 for services that would be provided through October 31, 2006 as a private pay resident. The facility mailed the petitioner statements reflecting the balance due on her account and has also notified the petitioner of the need for payment of the outstanding bill.

On August 21, 2006 the facility, by Nursing Home Transfer And Discharge Notice, notified the petitioner that she was being discharged because her bill for services at the facility had not been paid after reasonable and appropriate notice to pay. The location to which the petitioner was to be discharged as listed on the above notice was her daughter's home that is located at [redacted] Florida. The facility has a discharge plan, which includes making arrangements through their social services office and home health care services to insure the safe and orderly transfer of the petitioner to her daughter's home or to another facility.

[redacted] nd C[redacted] id the facility $2,000 for the cost of the petitioner's care. Additionally, the petitioner's Social Security income of approximately $201 per month has been sent to the facility to pay for the cost of the petitioner's care. However, the petitioner has an outstanding balance owed to the facility after applying the above payments towards the cost of her care.

The petitioner recently sold property in the Bahamas that she jointly owned with another individual. However, through no fault of her own, it has taken a long time to receive the proceeds from the sale of the property. It is the petitioner's intent to pay the

outstanding balance owed to the facility when she receives the funds from the sale of her property.

CONCLUSIONS OF LAW

42 C.F.R. §483.12(a)(2)(v) allows a facility to discharge a resident when the resident has failed, after reasonable and appropriate notice, to pay for a stay at the facility and states:

> (2) Transfer and discharge requirements. The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless...(v) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid...

The Findings of Fact show that the petitioner has an outstanding balance, due to the facility, for the cost of her care and that the facility has notified the petitioner of the balance due for the cost of her care. According to the above federal authority, the facility acted correctly to discharge the petitioner due to non payment for the cost of her care.

Based on the facility's discharge plan, the location to which the petitioner is to be discharged is considered an appropriate discharge location.

DECISION

The appeal is denied. The action to discharge the petitioner from the facility is affirmed.

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 17th day of November, 2006,

in Tallahassee, Florida.

Morris Zamboca

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

Copies Furnished To:

Respondent

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

PETITIONER,

Vs.

APPEAL NO. 06F-04089

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

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned-hearing officer on October 6, 2006, at 2:25 p.m., in Gainesville, Florida. The petitioner was present. Present representing the petitioner was [redacted]. Present as witnesses for the petitioner were his parents, [redacted] and [redacted] The respondent was represented by Lucy Goddard-Teel, Department of Children and Families' District 3 legal counsel. Present testifying by telephone on behalf of the respondent was Dr. Emma Guilarte of Maximus.

The hearing was scheduled for August 30, 2006. However, at the request of the petitioner a continuance was granted.

ISSUE

The petitioner is appealing the respondent's action of June 19, 2006, to reduce his residential habilitation services from 16 hours per day to 10 hours per day and to decrease his behavior assistant services from 23,296 quarter hours to 5,760 quarter hours. The agency holds the burden of proof.

FINDINGS OF FACT

The petitioner is developmentally disabled and is eligible to receive services from the respondent's Developmental Services Home and Community-Based Services Medicaid Waiver Program. He is 47 years old and lives at the [redacted] Group Home.

The petitioner, through his waiver support coordinator, submitted a support plan which was to be effective May 1, 2006. In the support plan, the waiver support coordinator requested 16 hours per day of residential habilitation at the standard level. Additionally, the petitioner's waiver support coordinator requested 23,296 quarter hours of behavior assistant services.

The respondent's Developmental Disabilities Program has contracted with Maximus to perform Prior Service Authorization (PSA) reviews on certain requested services or when costs of a support plan exceed certain levels. Maximus reviewed the petitioner's request to continue his 16 hours per day of residential habilitation services at the standard level. The 16 hours per day of residential habilitation services at the standard level was approved for 90 days to allow time to locate a residential habilitation-intensive behavior home. Maximus also reviewed the request for 23,296 quarter hours of behavior assistant services. Information received by Maximus indicated that on

March 30, 2006, the area behavior analyst approved the behavior assistant service for 90 days for 16 hours per day (5,760 quarter hours). The behavior assistant service is a time limited service that was also approved in order to find a residential habilitation-intensive behavior home. The information received by Maximus for both the residential habilitation and the behavior assistant service showed that a statewide search for a residential habilitation-intensive behavior home had been done with negative results. Information received by Maximus included graphic displays that extended to November 27, 2005. There was no challenging behaviors noted with an increase in total time out increasing in September 2005 but again reduced by November 2005. A summary from the behavior analysis indicated three to five incidences of challenging behaviors from January 2006 through April 2006. Documents submitted to Maximus showed that the petitioner responded to physical limits imposed by male staff and the absence of female peers in the group home. The reduction in target behaviors was also correlated to the number of individuals in the group home. Documentation showed that the petitioner's behaviors were improving and were stable. Maximus reduced the residential habilitation services at the standard level to 10 hours per day for the remaining 260 days of the support plan period as medical necessity for 16 hours per day of residential habilitation was not demonstrated. Maximus also approved 5,760 quarter hours of behavior assistant services as the request for 23,296 quarters was in excess of his needs and not medically necessary.

Maximus received a request for reconsideration for the residential habilitation and the behavior assistant service which were denied as the documentation submitted did not justify the medically necessity for 16 hours per day of residential habilitation

services at the standard level or the 23,296 quarter hours of behavior assistant services.

On June 19, 2006, Maximus notified the petitioner that his residential habilitation services at the behavior focus level was being reduced to 10 hours per day and his behavior assistant services was being reduced to 5,760 quarter hours as medical necessity for the 16 hours of residential habilitation services at the standard level and the 23,296 quarter hours of behavior assistant services was not demonstrated.

CONCLUSIONS OF LAW

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

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

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

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

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

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

Recipients with challenging behavioral disorders may require more intense levels of residential habilitation services described as behavioral

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

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

> Behavior Assistant Services include the performance of one-on-one activities related to the delivery of behavior analysis services, as defined under Behavior Analysis Services and Assessment, and are designated in and required by a behavior analysis service plan. Activities include monitoring of behavior analysis services, the implementation of behavioral procedures, data collection and display (e.g., graphics) as authorized by a beneficiary's behavior analysis service plan and training for caregivers. The behavior analysis service plan must be designed, implemented and monitored in accordance with Chapter 65B-4.030, F.A.C., and approved in accordance with Chapter 65B-4.029, F.A.C. Behavior assistant services are designed for beneficiaries for whom traditional residential habilitation services have been documented unsuccessful.

The Findings of Fact show that the petitioner's behaviors have been improving, there were no challenging behaviors and his behaviors were stable. The evidence submitted did not support the request for 16 hours per day of residential habilitation or 23,296 quarter hours of behavior assistant services. Therefore, the number of hours and or quarter hours requested would be in excess of the petitioner's needs and not medically necessary. Based on the evidence presented, it is determined that the respondent correctly approved 10 hours per day of residential habilitation and correctly approved 5,760 quarter hours of behavior assistant services.

DECISION

The appeal is denied. The respondent actions are affirmed.

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 23rd day of October, 2006,

in Tallahassee, Florida.

Morris Zamboca

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

Copies Furnished To:

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

APPEAL NO. 06F-05031

PETITIONER,

Vs.

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

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on September 27, 2006, at 1:05 p.m., in Jacksonville, Florida. The petitioner was present and represented by Lloyd Peterson, esq. The petitioner's mother and father, [redacted] and the petitioner's independent Waiver Support Coordinator, [redacted] were present but did not give testimony. The agency was represented by Ann Cocheu, assistant attorney general. Present from the agency was Chris Chrusciel, Medicaid Waiver liason. Testifying for the agency by speakerphone was Miranda Johnson, consultant reviewer with Maximus.

ISSUE

At issue is the agency's action of July 20, 2006 to deny a request for In Home Support Services-Hourly (IHSS) under the Developmental Services

Home and Community-Based Services Waiver. The agency was assigned the burden of proof.

FINDINGS OF FACT

The petitioner is 24 years old and receives services through the Developmental Services Home and Community Based Services Medicaid Waiver Program. A cost plan amendment effective July 1, 2006, was submitted with a total request of services in the amount of $137,922.70, including Personal Care Assistance. Due to the high cost of the total services, the agency had its contracted Prior Service Authorization unit, Maximus, review the request for medical necessity, as defined in the Florida Administrative Code 59G-1.101(166). Maximus performs desk reviews based on the information submitted for review.

Respondent's Exhibit 3 is the cost plan amendment and shows that the petitioner attends Adult Day Training (ADT) and returns home around 3:30 Monday through Friday. It further states, "In home supports are billed at a daily rate for the night shift 3:30 pm to 7:00 am Monday through Friday and 7:00 pm to 7:00 am Saturday and Sunday nights. In home supports are billed at the quarter hour rate on weekdays when ADT is closed and weekend days." This form also states, "If there was a fire in the home, [redacted] would not be able to get out safely and needs in home supports there 24 hours a day. On the days where she is not in the day program she is without services for a total of 5 hours because in home supports can only bill for 8 hours..."

The request was for both IHSS-daily and IHSS-hourly of eight hours per day for 140 days. Maximus has not previously reviewed IHSS. Maximus

approved the IHSS-daily (also referred to as IHSS Live-in daily) for 365 days per year and denied the IHSS-hourly. Ms. Johnson, of Maximus, determined the IHSS-hourly was not medically necessary as the IHSS-daily was approved and is a flat rate that covers from four hours up to twenty four hours per day. The IHSS-daily rate for the petitioner is $100.02. The Developmental Disabilities Waiver Services Coverage and Limitations Handbook (the handbook) instructs that IHSS in excess of eight hours per day must be billed as the daily rate. The handbook also defines medically necessary and requires that services under the waiver be medically necessary.

The petitioner no longer receives Personal Care Assistance. The cost of the approved IHSS-daily for 365 days per year is $36,507.30. That portion of the cost would have been $53,665.70 had the IHSS-hourly been approved. The petitioner also receives Waiver Support Coordination, specialized mental health services, non-residential support services, ADT, consumable medical supplies, transportation and supported living coaching services.

An example of when IHSS-hourly is approved in addition to the IHSS-daily, is when an individual has severe behavior problems which requires the temporary services of two providers at the same time.

The petitioner's position is that the IHSS-hourly is needed for times beyond what providers will furnish at the IHSS-daily rate; primarily when she cannot attend ADT or a portion of the weekends. It has been difficult to find providers who will work 24 hours per day at the daily rate as this equates to $4.17 per hour.

The agency's position is that this is a provider issue and does not change medical necessity for the denied service.

CONCLUSIONS OF LAW

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

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

Florida Administrative Code 59G-1.010, (166), defines medically necessary and states:

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

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

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

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

Developmental Services Waiver Services Florida Medicaid Coverage and Limitations Handbook, page 2-4 and 2-5, states:

Medical Necessity – Waiver services shall only be provided when the service or item is medically necessary. Chapter 59G-1.010 (166)...defines medical necessity...Medical Necessity Determinations – An appropriate qualified professional shall make the determination that the standards for medical necessity set forth in 59G-1.010 (166)(a)(c), F.A.C., are met, and that the requested item meets the service definition, as contained in the approved DD waiver...

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

In-home supports are services that provide a recipient in a supported living situation with four to 24-hours-a-day assistance from a support worker or support workers. The support worker may live in the recipient's home or apartment and share living expenses (rent, utilities, phone, etc.) with the recipient. The support worker provides companionship and personal care, and may assist with or perform activities of daily living and other duties necessary to maintain the recipient in supported living. The in-home support services are separate and not a replacement for the services performed by a supported living coach. Some recipient's in supported living may need only the services of an in-home support worker, or only the services of a supported living coach. Other recipient's may need both services. When both services are used, the providers must coordinate their activities to avoid duplication...Special Considerations - In-home supports provided by a provider or an employee of a provider who is living in a recipient's home must be billed at the live-in published stepped rate for the service. The live-in rate shall be determined based on from one to three recipients in the home receiving the service. The live-in rate includes a relief factor for primary staff performing the support. Additional in-home supports above the live-in rate may be approved by the District with concurrence from the Developmental Disabilities Central Office based on the support needs of the recipient. Additional supports above the live-in rate shall be billed by the quarter hour. A provider or employees of a provider do not have to "live-in" a recipient's home for the live-in rate to be applied for the service...In-home support services that are provided on an hourly basis instead of live-in shall be billed by the quarter hour in accordance with the published stepped rate for in-home supports awake staff for up to eight hours a day. If in-home hourly supports are required in excess of eight hours a day, or 32 quarter hour units, the service must be billed at the in-home live in daily rate. When periodic additional staff assistance is required for in-home live in services, an in-home hourly support service may be billed for up to eight hours a day in addition to the live in support if approved by the District with concurrence from the developmental disabilities central office. The rate for the service will be determined based on from one to three recipients in the home receiving the service. The rate ratio is determined by what is the usual and customary service delivery pattern and does not fluctuate with incidental absences of one or more recipients included in the rate ratio.

The agency cites the reason for the above noted denial for IHSS-hourly as, "Have not been determined to be medically necessary."

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

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

According to the above authorities, IHSS that are provided on an hourly basis instead of live-in shall be billed by the quarter hour in accordance with the published stepped rate for in-home supports awake staff for up to eight hours a day and if in-home hourly supports are required in excess of eight hours a day, the service must be billed at the in-home live in daily rate. There was no evidence presented to show that the request for IHSS-hourly of eight hours per day for 140 days, in addition to the IHSS-daily, meets the above definition of medically necessary. In addition, since the petitioner requires more than eight hours per day, the handbook directs that the IHSS must be billed as the daily

rate. No exception could be found due to a providers' unwillingness to accept the Medicaid rate. Therefore, the hearing officer concludes that the agency's action to deny the IHSS-hourly was in accordance with the above authorities.

DECISION

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

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 24th day of October, 2006,

in Tallahassee, Florida.

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

Copies Furnished To

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

PETITIONER,

Vs.

APPEAL NO. 06F-05519

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

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned-hearing officer on October 6, 2006, at 3:50 p.m., in Gainesville, Florida. The petitioner was present. Present representing the petitioner was [redacted] The respondent was represented by Lucy Goddard-Teel, District 3 legal counsel with the Department of Children and Families. Present testifying by telephone on behalf of the respondent was Bob Roberts of Maximus.

ISSUE

The petitioner is appealing the respondent's action of August 11, 2006, to decrease his residential habilitation services at the behavior focus level from fourteen hours of direct care staff per day to ten hours per day.

The petitioner is also appealing the respondent's action of August 11, 2006, to deny his request for a level of supervision of one to five for adult day training and to approve a level of supervision of one to six to ten.

FINDINGS OF FACT

The petitioner is a resident of Alachua County, Florida and was eligible to receive benefits through the Developmental Disabilities Home and Community-Based Services Waiver Program. The petitioner is 22 years old and is developmentally disabled. The petitioner's primary disability is mental retardation. The petitioner lives at the [redacted] Group Home.

The respondent's Developmental Disabilities Program has contracted with MAXIMUS to perform Prior Service Authorization (PSA) reviews on certain requested services or when costs of a support plan exceed certain levels.

The petitioner through his waiver support coordinator submitted a support plan, which was to be effective August 1, 2006. In the support plan, the waiver support coordinator requested the continuation of fourteen hours per day of residential habilitation at the behavior focus level to provide the petitioner with training and supervision to help him accomplish his goals to express his feelings in a better way, to brush his teeth in the evening without being reminded, to stop stealing, to cook without having to ask for help, to budget his money and to earn money on a lawn crew. From July 1, 2003 through July 31, 2005, the petitioner received seven hours per day of residential habilitation at the behavior focus level. From August 1, 2005 through July 31, 2006, Maximus approved fourteen hours per day of residential habilitation at the behavior focus level because of transitional issues related to the group home. Maximus approved this level on a temporary basis because of the transitional issue in the group home. On August 11, 2006, Maximus notified the petitioner that his residential habilitation services at the behavior focus level was being reduced to ten

hours per day, as medical necessity for the continuation of fourteen hours per day of residential habilitation services at the behavior focus level was not demonstrated and was in excess of his needs.

In the above support plan, the petitioner also requested 5,760 quarter hours of adult day training at a level of supervision of one to five. On August 11, 2006, Maximus notified the petitioner that his request for adult day training was approved at the level of supervision of one to six to ten and that his request for a level of supervision of one to five was denied as medical necessity for the level of supervision requested was not demonstrated as required in Rule 59G-1.010(166), Florida Administrative Code.

The petitioner is a capable person who is largely independent in most self help and daily living tasks and activities including several household chores. He is physically active, is mild mannered and respects authority. He is capable of interacting in an acceptable manner with others. The petitioner was doing well in the acquisition of his targeted skill acquisitions and reducing problem behaviors. The petitioner has a history of maladaptive behaviors that can seriously interfere with his social and vocational goals. However, the petitioner has adapted well to changes that have taken place.

Maximus requested that the petitioner provide a copy of his behavioral intervention plan. The response to the request indicated that the behavior intervention plan does not yet make mention of how it will be implemented at the adult day training service. Without the required documentation, Maximus could not determine that the level of supervision for adult day training of one to five was medically necessary. Therefore, Maximus approved a level of supervision of one to six to ten.

CONCLUSIONS OF LAW

Fla. Admin. Code 59.G-8.200, Home and Community-Based

Services Waivers, states in part:

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

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

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

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

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

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

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

Residential Habilitation with a Behavioral Focus

Service characteristics for residential habilitation with a behavioral focus include:

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

• Integration of behavioral services throughout residential and community programs,

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

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

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

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

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

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

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

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

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

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

Has resulted in one or more of the following:

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

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

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

Adult Day Training Services and ADT Off-Site Services, will be billed based on the published stepped rate for the services at the 1 staff to 10 recipient ratio rate level. Exceptions to this rate level shall be made only when it has been determined through use of the Department approved assessment and the support planning process that a recipient requires a different support staffing ratio. The rate and staffing ratio shall be identified in the individual's support plan and cost plan, and on the authorization for service submitted to the provider by the recipient's support coordinator. The rate ratio is determined by what is the usual and customary service delivery pattern and does not fluctuate with incidental absences of one or more recipients included in the rate ratio.

Personal care assistance services shall be billed at the standard rate level for the service based on the published rate system. The standard rate is paid when a recipient requires minimal assistance, through instructional prompts, cues, and supervision to properly complete the basic personal care areas of eating, bathing, toileting, grooming and personal hygiene. A rate other than the standard rate level for this service shall only be authorized when it has been determined through use of the Department approved assessment and the support planning process that an individual requires an enhanced level of supports.

Indicators of a one staff to five recipient staffing rate ratio level include:

Recipients who have a moderate level of support for personal care services on the Department approved assessment may receive the rate level identified as moderate for the service. The moderate rate is paid when a recipient routinely requires prompts, supervision and physical assistance to complete the basic personal care areas of eating, bathing, toileting, grooming, and personal hygiene; or

> A recipient who is on a behavioral services plan that is implemented by the adult day training provider, and who requires visual supervision during all waking hours and occasional intervention as determined by a Certified Behavioral Analyst. The recipient does not have to live in a licensed residential facility.

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

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

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

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

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

The Developmental Services Waiver Services Florida Medicaid Coverage and Limitations Handbook states that indicators of a one staff to five recipient staffing rate ratio level includes an individual who requires prompts on a routine basis, supervision and physical assistance to complete the basic personal care areas of eating, bathing, toileting, grooming, and personal hygiene or who is on a behavioral services plan that is implemented by the adult day training provider and who requires visual supervision during all waking hours and occasional intervention as determined by a Certified Behavioral Analyst.

The Findings of Fact show that the petitioner is independent, is capable of completing his personal care skills independently. Based on these findings, it is determined that the petitioner does not require a level of supervision of one to five for adult day training and that level of supervision was not justified by the evidence

presented and is in excess of his needs. Based on the evidence presented, it is concluded that the respondent correctly denied the petitioner's request for a level of supervision of one to five for adult day training and correctly approved a level of supervision of one to six to ten.

DECISION

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

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 15th day of November, 2006,

in Tallahassee, Florida.

Morris Zamboca

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

Copies Furnished To:

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

APPEAL NO. 06F-04069

PETITIONER,

Vs.

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

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on September 21, 2006 at 3:00 p.m., in Jacksonville, Florida. The petitioner was not present. However, he was represented by his parents, [redacted] The agency was represented by Ann Cocheu, Attorney with the Office of the Attorney General. Appearing as a witness for the agency was Marcella Kelley.

The record was left open to receive additional information. The respondent did provide additional information which will be considered in the hearing officer's final decision. This information will be marked as Respondent's Exhibit 6.

ISSUE

At issue is the agency's action of March 6, 2006 to deny the Agency for Persons with Disabilities Home and Community Based Services Medicaid Waiver Program because the petitioner was determined to not have a developmental disability as defined in Chapter 393.063 (12) Florida Statutes.

FINDING OF FACT

The petitioner applied for services under the Agency for Persons with Disabilities Home and Community Based Services (HCBS) Medicaid Waiver Program. The petitioner's birth date is December 21, 2002. He was given the Vineland Adaptive Behavior Scale at the age of 3 years. The Vineland Scale does not yield an I.Q. score but instead provides a mental development index. Based on the results of this test and other information provided, which included a social history, a Bayley Scales of Infant Development, a Developmental Profile, and a Beery-Buktenica Developmental Test of Visual-Motor Integration (attempted) the agency denied the request for services. None of the documentation reviewed to determine the petitioner's eligibility for waiver services yielded I.Q. scores. Although Agency for Persons with Disabilities Home and Community Based Services Medicaid Waiver was denied the petitioner was determined to be a high risk child.

The agency representative explained that because the petitioner is a high risk child the agency would continue to follow up with him at various intervals. It was also explained that the Agency for Persons with Disabilities Home and Community Based Services Medicaid Waiver Program recognizes I.Q. scores from standardized tests such

as the Stanford-Binet or the Wechsler. These tests are generally not given to infants. The minimum age for such tests is 5 to 6 years old.

The petitioner was notified of the agency's decision on March 6, 2006 and he requested a hearing on May 24, 2006.

CONCLUSIONS OF LAW

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

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

Pursuant to the Florida Administrative Code 65G-4.012 **Determination of Mental Retardation: Intelligence Tests to Be Administered**, which states in part:

> "(1) For the purposes of Chapters 393 and 916, F.S., the Stanford-Binet Intelligence Scale or the Wechsler Adult & Infant Intelligence Scale,

administered by or under the direct supervision of a psychologist or school psychologist licensed under Chapter 490, F.S., shall be used to determine mental retardation and the level of intellectual functioning.
(2) Notwithstanding subsection (1), if, given the condition of the individual to be tested, the Stanford-Binet Intelligence Scale or the Wechsler Adult & Infant Intelligence Scale are not valid and reliable as determined by the person authorized to administer such tests as specified in subsection (1), an alternative test or evaluation procedure, administered and interpreted in conformance with instructions provided by the producer of the tests or evaluation materials, may be used. The results of the testing or evaluation must include reference to published validity and reliability data for the specified test or evaluation procedure."

Developmental Disabilities Waiver Services Coverage and Limitations Handbook page 2-3, states in part:

"Recipients who are eligible for Medicaid benefits must also meet all of the following conditions to be eligible for enrollment in the waiver:

The recipient must meet one of the following Developmental Disabilities Program eligibility requirements, in accordance with Chapter 393, F.S.
• The recipient's intelligence quotient (IQ) is 59 or less; OR
• The recipient's IQ is 60-69 inclusive and the recipient has a secondary handicapping condition that includes cerebral palsy, spina bifida, Prader-Willi syndrome, epilepsy, autism, OR ambulation, sensory, chronic health, and behavioral problems, OR the recipient's IQ is 60-69 inclusive and the recipient has severe functional limitations in at least three major life activities including self-care, learning, mobility, self-direction, understanding and use of language, and capacity for independent living; OR
• The recipient is eligible under a primary disability of autism, cerebral palsy,spina bifida, or Prader-Willi syndrome. In addition, the condition must result in substantial functional limitations in three or more major life activities, including self-care, learning, mobility, self-direction, understanding and use of language, and capacity for independent living."

One of the eligibility criteria for the Agency for Persons with Disabilities Home and Community Bases Services Medicaid Waiver Program (Developmental Disabilities Program) requires either an I.Q. below a certain number or other specific diagnoses. In

this case, the agency determined the petitioner did not meet the I.Q. criteria. The Findings of Fact show the petitioner was given a Vineland Adaptive Behavior Scale at the age of 3 years. The Vineland Scale does not yield an I.Q. score but instead provides a mental development index. The other assessment documentation considered in the application for waiver services did not yield I.Q. scores either.

The petitioner was not given the Stanford-Binet or Wescheler I.Q. test and there was no evidence that the test given met the statutory exception criteria stated above. The above cited authorities require that the Stanford-Binet, the Wescheler or other I.Q. tests with proper justification be used to determine "mental retardation" and level of intellectual functioning. Based on a careful review of the evidence presented the hearing officer concludes that the agency's action to deny the Agency for Persons with Disabilities Home and Community Based Services Medicaid Waiver Program because the petitioner did not meet criteria for the program is a justified action that is consistent with the above cited authorities.

DECISION

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

DONE AND ORDERED this 12th day of October, 2006,

in Tallahassee, Florida.

James Abdur-Rahman

James Abdur-Rahman
Hearing Officer
Building 5, Room 203
1317 Winewood Boulevard
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Copies Furnished To:

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

APPEAL NO. 06F-04604

PETITIONER,

Vs.

AGENCY FOR PERSONS
WITH DISABILITIES
DISTRICT: 02 Leon
UNIT: APD

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on August 30, 2006, at 1:10 p.m., in Tallahassee, Florida. The petitioner was not present but was represented by her mother, [redacted]. Testifying on behalf of the petitioner was [redacted] R.N., nurse care coordinator, Children's Medical Services (CMS). Also testifying on behalf of the petitioner was [redacted] support coordinator, Fresh Start. The department was represented by Gail Scott Hill, assistant general counsel, Agency for Persons with Disabilities (APD). Testifying on behalf of the respondent was Cheryl Smith, senior human services program specialist. Also testifying on behalf of the respondent was Jane Tillman, operations management consultant II, and Terry McGarrity, senior management analyst supervisor, APD.

ISSUE

At issue is whether the agency has correctly approved the petitioner for crisis enrollment and recommended that the petitioner's needs be met by the Family and Supported Living Waiver (FSL) rather than Home and Community Based (HCBS) Waiver program. The petitioner bears the burden of proof.

FINDINGS OF FACT

The petitioner's mother, [redacted] filed an application for Developmental Services Home and Community Based Waiver (HCBS) program on behalf of the petitioner. The petitioner is a resident of Leon County. She is 8 years old and has a primary diagnosis of autism, cerebral palsy, moderate mental retardation, vision impairment, a mild hearing loss and exhibits behavioral problems. The petitioner submitted a crisis packet, and was requesting behavior assessment services, non-residential support services, personal care assistance, respite care, speech therapy, durable medical equipment, behavioral analysis and therapeutic massage, to be funded under the Developmental Services Home and Community-based Services Medicaid Waiver Program.

The petitioner has cut herself, runs into cars in parking lots, pulls her sister's hair, hits and pinches her sister and exhibits behaviors that are a danger to herself and others. She exhibits tantrums, has a tendency to unfasten her seat belt and bolt from the car and has a history of "escaping". The petitioner needs assistance with dressing and daily grooming. She has no sense of danger and does not respond appropriately to

injury. She exhibits behavior that is a health and safety risk to herself and her family. Her mother is a single parent and has a 7 year old daughter, [redacted] who also has disabilities and pulls her hair out. The petitioner's mother and caretaker, has a severe degenerative spinal condition which makes significant lifting very difficult and painful. As a result of the pain and incapacity due to her back, the petitioner's mother finds it difficult to provide care for her child.

The petitioner attends [redacted] School Monday through Friday from 7:50 a.m. to 3:00 p.m. and after school day care from 5:30-6 p.m. Her bed time is typically between 8:30 to 10 p.m. The petitioner receives services through the Center for Autism and Related Disabilities (CARD) and the public school system.

The Crisis Identification Tool evaluates an individual under three criteria (1) Homeless, (2) Danger to self or others, and (3) Caregiver unable to give care. The family requested a crisis determination. The district APD staff completed a preliminary crisis request and forwarded the request to the central office for a crisis determination in accordance with section (3) of Appendix F of the Developmental Disabilities Waiver Services and Coverage Limitations Handbook (Handbook). The district APD staff determined that there was a crisis based on the mother's medical issues and behavioral issue of the petitioner. Crisis is determined by priority. The petitioner met crisis based on the determination that the caregiver was unable to meet the needs of the petitioner and due to the combination of problems with behavior and the mother's inability to provide safe care. There are approximately 12,000 individuals on the wait list. There

were approximately 465 crisis determinations for the Fiscal Year 2005-2006. As there are only about 30 slots available, the crisis committee must make a determination based on the criteria outline in Appendix F of the Handbook to maintain fairness statewide.

The petitioner meets the basic requirements for the waiver program. As a result the petitioner was determined to be eligible for the waiver through the crisis procedure. The agency determined that the Family and Supported Living (FSL) waiver would adequately meet her needs. The FSL Waiver had a service limitation of $14,282 at the time of approval. The current service limitation is $14,792. The FSL Waiver offers 11 services versus the larger HCBS/Medicaid Waiver which offers 32 services. The Medicaid State Plan Services includes Durable Medical Equipment, Physical and Occupational Therapy and speech Therapy. The petitioner's representative believes that the petitioner's need for services may exceed the capped amount of the FSL waiver. In addition, the petitioner's representative believes that services, such as Personal Care Services required by the petitioner are not covered by the FSL Waiver. The petitioner's representative believes that she was advised that In Home Support Services (IHSS) could provide personal care assistance (PCA) services for the petitioner. It is her belief that the petitioner is not eligible for IHSS as she must be eligible for Supported Living and be age 18.

The Agency provided a copy of a veto of HCBS Services Waiver which states that all autistic clients be served through the Home and Community Based Services

Waiver. New clients, except autistic clients, must be determined by the agency or a contracted entity through prior service authorization to need nursing services not available on Medicaid state plan, residential waiver services in a licensed facility, or supported living services not available through the Family and Support Living Waiver. House Bill 5001 states From the funds in Specific Appropriations 296I and 296L, $10,000,000 from the General Revenue Fund and $14,254,184 from the Operations and Maintenance Trust Fund are provided to service additional clients from the developmental services waitlist and clients in crisis in either the Home and Community Based Services Waiver or the Family and Supported Living Waiver.

In May 2006, 63 crisis packages were submitted to the Central Office. Forty Six were approved. Of the 46 approvals 21 were approved for the FSL Waiver. There are 12,118 people on the wait list for DD/HCBS wavier service as of August 17, 2006. FSL waiver offers eligible individuals state Medicaid services which covers therapies for children. The FSL Waiver offers the following medically necessary services to individuals enrolled: Waiver support coordination, Supported Living coaching, Adult Day training, Supported Employment, Transportation, Respite, Consumable Medical Supplies, Environmental Accessibility Adaptations, Behavioral Analysis Services, Behavior Assistant Services, and Personal Emergency Response System.

The Agency indicated that the petitioner can receive personal care assistance under In Home Supports in the FWL wavier along with behavioral services. In addition, FSL can also meet the petitioner's request for respite. Durable Medical Equipment

(DME) can be provided under State Plan Services and massage can be provided under Physical Therapy. It was the determination of the Agency that the petitioner's needs could be met under the FSL program. Crisis criteria only related to the DS/HCBS Waiver. The petitioner can be served by the FSL Waiver and remain on the wait list for DS/HCBS Waiver in order of her position on that wait list.

CONCLUSIONS OF LAW

In the matter under review, the petitioner has applied for and is asserting eligibility for benefits under the HCBS/Medicaid Waiver program. The respondent placed the petitioner on the Crisis wait list and recommended enrollment in the Family Supported Living Waiver which has a service limitation cap of $14,792 and offers 11 services.

The respondent agrees that the petitioner meets the basic eligibility requirements for the Program at issue, however, the respondent argues that because of a lack of funding, only a limited number of new individuals are approved to receive benefits. The process used to decide if a new individual can be added to the waiver is called a crisis determination in accordance with Appendix F of the Handbook. The state is allowed to limit participation in waivers based on available funding. Both the Florida Constitution and Florida Statues prohibit agencies from contracting or agreeing to spend any moneys in excess of the amount appropriated to them unless authorized by law. See Art. VII, Sec. 1(c), Fla. Const.; § 216.311.(1), Fla Stat. (2002). Applicants are entitled to

receive services only within available resources, and the respondent has discretion to prioritize how it will distribute funds.

42 C.F.R. Ch. IV §441.300 Basis and purpose., states in part:

> Section 1915(c) of the Act permits States to offer, under a waiver of statutory requirements, an array of home and community-based services that an individual needs to avoid institutionalization.

The agency's published Transmittal No 05-04-0008, Family and Supported Living Waiver, April 26, 2005 states in part:

> Participants enrolled in the FSL Waiver do not lose their place on the waiting list for the DS Waiver. As space becomes available, individuals may move to the DS Waiver which provides more services than are available under the FSL Waiver.

The Developmental Disabilities Waiver Services and Coverage Limitation Handbook, Appendix F sets forth by rule, the method of determining an individual's entitlement to waiver services. This appendix states in part:

> (1) If the Individual is Determined Eligible: When an individual is determined to be eligible for waiver services, the District should consult with the Central Office to determine whether a vacancy and funding are available to service the individual.
> (i) If no vacancy or funding are available to serve the individual, the procedures outlined in the section on "Waiver Enrollment" shall be followed.
> (ii) If no vacancy or funding are available to serve the individual:
> I. The District will assess whether an assessment for crisis, using the Crisis Identification Tool (page 3 of this appendix) is needed. The District will complete the Crisis Identification Tool when it appears that the individual requires immediate placement into an Intermediate Care Facility for Developmental Disabilities (ICF/DD), absent the provision of waiver services or the individual, family or legal guardian makes a request for a crisis determination. If the Crisis Identification Tool is to be completed, the procedures outlined in Section 3 (page 3 of this appendix) shall be followed.

The Agency's FSL Service Directory showing the consumer FSL enrollment process as an alternative to the HCBS Waiver (September 2005) p. 21. B **Enrollment into the FSL Waiver**, states:

> Once Medicaid and the waiver eligibility requirements are met, the APD Area Office reviews the consumer's request for home and community-based supports and services. That office will determine if: 1) a waiver vacancy is available; 2) waiver participation with the understanding the FSL Waiver must keep waiver service to under the annual dollar cap. The determination will be made in accordance with legislatively appropriated funding and established annual priorities...
> Consumers eligible for FSL Waiver services will be prioritized in accordance with the DS/HCBS Waiver wait list in accordance with Appendix F of the DS/HCBS Waiver Medicaid Coverage and Limitations Handbook. (Note: Crisis criteria only relates to the DS/HCBS Waiver.) Consumers will be given the opportunity to choose to participate in the FSL Waiver in order of position on the DS/HCBS Waiver wait list. Consumers service by the FSL Waiver stay on the waiting list for the DS/HCBS Waiver while receiving FSL Waiver services. The Central Office maintains the statewide list of all consumers determined eligible and waiting for waiver services.
>
> A consumer's enrollment in the waiver continues indefinitely unless one of the following conditions exist, in which case dis-enrollment will occur:
>
> - The consumer does not adhere to the total dollar cap for the FSL Waiver
> - The consumer or guardian chooses to terminate participation in the program.
> - The consumer moves out of state or country.
> - The consumer becomes ineligible for the waiver because of a loss of eligibility for Medicaid benefits and this loss is expected to extend for a lengthy period.
> - The consumer receives services under another Medicaid Waiver program.....

Based on the evidence presented, the hearing officer concludes that a limited funding situation exists where the agency only adds a limited number of individuals to

the waiver each year in accordance with a process promulgated in rule. The Findings of Fact show the district completed the initial crisis assessment and forwarded the case to the central office for the final determination. The Findings also show that the central office reviewed the Crisis Identification Tool and concluded the petitioner did meet the criteria to be determined in crisis. The committee determined that the petitioner was receiving services in the school and that she was also receiving services through CARD. The committee further determined that the petitioner's needs could be met through enrollment in the Family Supported Living Waiver and that she could remain on the HCBS/Waiver crisis wait list.

According to the above authorities, consumers will be given the opportunity to choose to participate in the FSL Waiver while waiting in order of position on the DS/HCBS Waiver wait list. Consumers served by the FSL Waiver stay on the waiting list for the DS/HCBS Waiver while receiving FSL Waiver services. The hearing officer concludes that the agency may consider an array of home and community-based services that an individual needs to avoid institutionalization. Therefore, the undersigned has determined that the agency's action to enroll the petitioner in the FWL Waiver and place the petitioner on the Crisis wait list was correct.

DECISION

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

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 16th day of October, 2006,

in Tallahassee, Florida.

Linda Garton

Linda Garton
Hearing Officer
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STATE OF FLORIDA
DEPARTMENT OF CHILDREN AND FAMILIES
OFFICE OF APPEAL HEARINGS

APPEAL NO. 06F-05976

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 October 25, 2006, at 11:32 a.m., at the Opa Locka Service Center, in Opa Locka, Florida. The petitioner was present and represented herself at the hearing. Also present on behalf of the petitioner was the petitioner's friend, [redacted] [redacted] The agency was represented by Diane Weller, contract manager, Agency For Health Care Administration (AHCA), located in Tallahassee, Florida and present via the telephone. Present as witness for the agency, via the telephone, was Dr. Amy Tumanidas, medical director, from KePRO South. Also present, via the telephone, as witnesses for the agency was Susan Zueibell, review operations specialist, KePRO. KePRO is located in Tampa, Florida. Hector Gutierrez was present as an interpreter.

ISSUE

At issue is the agency's action of August 2006 to deny the request for a medical service treatment or Impatient Service for the petitioner. The petitioner has the burden of proof.

FINDINGS OF FACT

The petitioner is a Medicaid recipient in Miami-Dade County, Florida.

The petitioner is in the need of certain medical treatment. Prior to receiving certain medical treatment and as part of the Medicaid Program procedure, the medical treatment must be prior serviced authorized. For the Florida Medicaid Program, the contract entity to make Prior Service Authorization reviews is KePRO.

The petitioner's medical providers requested two treatments for the petitioner sometime in late July 2006. One of the treatments was for an Exploratory Laporatomy and the other was for a Hysterectomy. KePRO denied the request for the Exploratory Laporatomy, but approved the request for the Hysterectomy, both occurring in August 2006.

The agency explained that the request and denial for the Exploratory Laporatomy procedure is a moot point, as this type of procedure usually is required to determine if a Hysterectomy is necessary or not. As the Hysterectomy was approved; the request for the other procedure is moot.

The petitioner submitted as evidence, Petitioner Exhibit 1, which is a copy of a letter from one of her treating physicians, Dr. [redacted] which states in part: "This letter is to inform you that the above named patient warrants the need of a co-surgeon due to the patient's past medical history."

The agency explained that the above denial of service is not a denial of a co-surgeon. The agency explained that the petitioner's medical providers need to just properly provide post-operative billing for a co-surgeon to AHCA for the petitioner. The agency also explained that the above request through the post operative process goes directly through AHCA and not KePRO.

CONCLUSIONS OF LAW

In accordance with Fla. Admin. Code 59G-1.010:

(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.

As shown in the Findings of Fact, the agency or KePRO had denied the request for the Exploratory Laporatomy, requested for the petitioner, but approved the request for the Hysterectomy, both occurring in August 2006, as a medical service treatment or Impatient Service for the petitioner.

The petitioner argued that based on her current medical problems and her past medical problems, she is in the need of two specialized surgeons. She argued that if during her hysterectomy surgery, if a medical complication arises due to her medical conditions, a second surgeon may be needed to do a necessary and different surgery.

The respondent argued and explained that the petitioner's medical providers had chosen an improper method of requesting two different surgeons, as the request for the Exploratory Laporatomy was not necessary, as the hysterectomy was approved. Thus the issue is moot regarding the denial of the above procedure. They further argued that the petitioner's medical providers can just bill AHCA for the co-surgeon through the post operative process. This process was explained to the petitioner during the hearing and during a pre-hearing conference.

After considering the evidence, the Florida Administrative Code Rule and all of the appropriate authorities set forth in the findings above, the hearing officer affirms the agency's action to deny the request for the Exploratory Laporatomy procedure, as the medically necessary procedure was approved and thus this appeal is a moot issue.

DECISION

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

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 9th day of November, 2006,

in Tallahassee, Florida.

Robert Akel

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

Copies Furnished To