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OFFICE OF APPEAL HEARINGS
DEPT. OF CHILDREN & FAMILIES

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

APPEAL NO. 08F-05962

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 17, 2007, at 8:30 a.m., in Fort Lauderdale, Florida. The petitioner was present with his mother, [redacted] The respondent was represented by Kenneth Hamlin, program operations administrator. Present on the telephone from Kepro was Dr. Robert Buzzeo, medical director, and Mary Wheeler, review operations manager.

ISSUE

The petitioner was appealing the Agency's August 20, 2008 action of denying 650 hours, and approving 250 hours of skilled home nursing services from July 11, 2008 to January 6, 2009. On September 19, 2008, the Agency approved the petitioner for 657 hours of skilled home nursing services from September 19, 2008 to February 6, 2009. At the hearing, the petitioner's representative appealed, and was concerned that these

nursing hours would be reduced when the petitioner attends school. The respondent has the burden of proof.

FINDINGS OF FACT

1. The petitioner is 16 years old, date of birth / He is a Medicaid benefits recipient in Broward County, Florida.

2. Included in the evidence are copies of a Recipient Denial Letters, dated July 11, 2008 and July 14, 2008, stating that a request for 900 hours of skilled home nursing services were denied, and 640 hours were approved for the petitioner from July 11, 2008 to January 6, 2009.

3. Included in the evidence is a copy of a Recipient Reconsideration Denial notice, dated August 20, 2008, stating upon reconsideration 650 hours of skilled home nursing services were denied, and 250 hours were approved for the petitioner from July 11, 2008 to January 6, 2009.

4. The notices sent to the petitioner explained that it was determined by Kepro that the medical care of the skilled home nursing services of 650 hours was determined to be not medically necessary.

5. The July 11, 2008 denial for services was reviewed by a Kepro physician consultant, board certified in pediatrics. The August 20, 2008 reconsideration denial was reviewed by another Kepro physician consultant, board certified in pediatrics.

6. Included in the evidence is a copy of a Kepro Internal Focus Review Findings report on the petitioner, dated July 9, 2008, stating that he was diagnosed with Cerebral Palsy, seizures, Scoliosis, and Lordosis.

7. Included in the evidence is a copy of a Kepro Synopsis of Case Report concerning the petitioner. According to Modification PC4, dated September 19, 2008, a fourth Kepro Physician consultant, board certified in pediatrics, who had not issued the previous decisions made another decision based on information that the petitioner would not be returning to school.

8. According to the Kepro Synopsis of Case Report, on September 19, 2008, the petitioner was approved for additional nursing care hours for a total of 10 hours per day on Mondays through Saturdays from 8:00 a.m. to 6:00 p.m., from September 19, 2008 to February 6, 2008, for a total of 657 home skilled nursing care.

9. Dr. Buzzeo explained at the hearing that when the petitioner was in school from 8:00 a.m. to 2:30 p.m., nursing care was previously denied because he would not be home to receive the nursing care.

10. At the hearing, the petitioner's representative appealed, and was concerned about when he returns to school, that his nursing hours would be reduced. As discussed at the hearing, when the petitioner is home, he would be approved for the 10 hours of daily nursing care from Mondays through Saturdays, however the nursing hours would not be approved for him when he is not home, and in school.

CONCLUSIONS OF LAW

By agreement between the Agency for Health Care Administration and the Department of Children and Families, the Agency for Health Care Administration has conveyed jurisdiction to the Office of Appeal Hearings to conduct this hearing pursuant to Chapter 120.80 F.S. Fla. Admin. Code 59G-1.010 states in part:

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

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

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

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

The Home Health Services Coverage and Limitations Handbook explains on page 2-15 that skilled home nursing services must be ordered by the attending physician, and documented as medically necessary. Upon reconsideration, on August 20, 2008, 650 hours of skilled home nursing services were denied, and 250 hours were approved for the petitioner from July 11, 2008 to January 6, 2009. This action was taken based on the information received that the petitioner was attending school on week days from 8:00 a.m. to 2:30 p.m.

When information was received that the petitioner was not attending school, on September 19, 2008, the skilled home nursing services were increased to 657 hours from September 19, 2008 to February 6, 2009. The petitioner's representative appealed, and was concerned about when he returns to school, that his nursing hours would be reduced. As of the time of the hearing, the status was that the petitioner was not attending school, and he was approved for 657 hours of skilled home nursing services. According to the Fla. Admin. Code 65-2.048, an individual can appeal an action that has been taken to reduce or discontinue benefits. Also as of the time of the hearing, action was not taken to reduce the petitioner's 657 hours of skilled home nursing services from September 19, 2008 to February 6, 2009, therefore the appeal is denied.

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 18th day of November, 2008,

in Tallahassee, Florida.

Stuart Imberman

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

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

APPEAL NO. 08N-00162

PETITIONER,

Vs.

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing convened before the undersigned hearing officer on October 22, 2008, at 2:00 p.m., in Sebring, Florida. The petitioner was present. His daughter, [redacted], was present and offered testimony. [redacted], interim nursing home administrator, represented the respondent. [redacted], finance director; [redacted], resident care manager; [redacted], director of nursing and [redacted], director of social services, were present as witnesses for the respondent. [redacted], district ombudsman manager, and [redacted], ombudsman, Department of Elder Affairs, were also present.

ISSUE

At issue is whether or not the nursing home's action to transfer and discharge the petitioner is an appropriate action based on the federal regulations found at 42 C.F.R. § 483.12. The nursing home is seeking to transfer and discharge the petitioner because

his "bill for services at the facility has not been paid after reasonable and appropriate notice to pay". The nursing home has the burden of proof to establish that the transfer and discharge action is consistent with the federal regulations.

FINDINGS OF FACT

1. On August 26, 2008, the facility issued a Nursing Home transfer and Discharge Notice to the petitioner. The notice indicated that the facility proposed discharging the petitioner on September 26, 2008. The proposed discharge is due to his failure to pay his bill at the facility following reasonable and appropriate notice to pay. He is residing in the facility pending the outcome of this hearing.

2. The petitioner entered the nursing facility in May 2008 under Medicare payment. He had been in and out of the facility several times. He became private pay in July 2008. Calls were placed to the petitioner's son in New Jersey concerning the petitioner's bill on July 25, 2008, August 20, 2008, two times in September 2008, and on October 2, 2008. Monthly statements were also issued. Protective Services of the Department, was called because the petitioner's money was being used to pay household expenses; not for his care. A payment of $1950 was received on August 28, 2008 and another payment of $1200 was received on September 29, 2008. Medicaid was applied for in August 2008, but at the time of the hearing, no decision on eligibility had been rendered.

3. The daily co-pay rate for private pay is $205. At that rate, the outstanding bill at the end of October 2008 was $16,374.65, which included $5058.75 over 90 days old; $3840.00 over 60 days old; $7475.90 over 30 days old, and the current charges of

$6150.00 (Respondent's Exhibit 2). The charges or the amount of the bill are undisputed.

4. The discharge location on the discharge notice is "will assist in finding" (Respondent's Exhibit 1). The petitioner stated that if he is ready to be discharged therapeutically, he wants it to be done. He wanted to finish progressing with his prosthetic leg before going home. He is able to walk with it now. His therapy was completed on October 10, 2008. The respondent explained that he maxed out his physical therapy at the facility, but that he can get a different type of therapy at home.

5. The petitioner has residences in both Florida and New Jersey. His daughter explains that the residence in Florida is wheelchair accessible and that she is capable of taking care of him. During discharge planning, the respondent was looking at assisted living facilities in both states, or discharging the petitioner to his home in either state with 24 hour care. The petitioner just wants the best care he can get, wherever it is.

CONCLUSIONS OF LAW

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

Federal Regulations at 42 C.F.R. § 483.12(a) states in relevant part:

> (2) Transfer and discharge requirements. The facility must permit each resident to remain in the facility and not transfer or discharge the resident from the facility unless...(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 owed to the facility for the cost of his care. The petitioner does not dispute the charges or balance due on his account. The facility established that the petitioner or his representative failed to pay the balance following reasonable and appropriate notice to do so. Therefore, the facility has met its burden to show that the discharge does meet one of the reasons set forth in the controlling federal regulations. Once discharge planning has been completed and an adequate location has been determined, the respondent may proceed with the discharge of the petitioner in accordance with the requirements set forth by the Agency for Health Care Administration.

DECISION

The appeal is denied as the facility's action to discharge the petitioner is correct and in accordance with federal regulations. The facility may proceed with the discharge in accordance with the requirements set forth by the Agency for Health Care Administration.

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 26th day of November, 2008,

in Tallahassee, Florida.

Margaret Poplin

Margaret Poplin
Hearing Officer
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OFFICE OF APPEAL HEARINGS

APPEAL NO. 08N-00134

PETITIONER,

Vs.

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned-hearing officer on October 21, 2008, at 10:10 a.m., at the facility. The petitioner was present and represented herself. Present as witnesses for the petitioner were her husband, [redacted], a friend, [redacted] and [redacted], certified ombudsman, Florida Long-Term Care Ombudsman Program. The respondent was represented by [redacted], administrator. Present as witnesses for the respondent were [redacted], social services director and [redacted], director of nursing.

The hearing was scheduled on September 16, 2008. However, at the request of the petitioner, a continuance was granted.

ISSUE

At issue is whether or not the action by the facility to discharge the petitioner, on the basis that her needs cannot be met by the facility and the safety of other individuals in the facility was endangered, is correct.

The facility has the burden of proof to establish by clear and convincing evidence that the discharge is appropriate under federal regulations found in 42 C.F.R. §483.12.

FINDINGS OF FACT

1. The petitioner has been a resident of the facility since September 2, 2002.

2. On May 7, 2008, the facility gave the petitioner a letter related to lighters and matches in possession of residents or resident rooms. The petitioner signed the letter on May 12, 2008. The above letter notified the residents of the facility that it was the facility's policy that smoking materials were not allowed to be kept in the possession of a resident or in his or her room. The notice also stated that there would be no tolerance for the deviation from the strict facility policy and that any resident found with lighters or matches in his or her possession or in his or her room would be issued a 30-day discharge notice.

3. Nurses' notes dated June 5, 2008, show that the petitioner came in from the smoking area and that the nurse asked her for her cigarettes and lighter. However, the petitioner would not give the nurse her cigarettes and lighter and told the nurse that she would give them to the nurse on the next shift.

4. Nurses' notes dated June 7, 2008, show that the petitioner was outside smoking and when she came back into the facility, would not give the nurse her cigarettes or lighter.

5. The respondent determined that the petitioner was in violation of the facility's smoking policy to not allow residents to have lighters while in the facility due to the incidents that occurred on June 5, 2008 and June 7, 2008. The respondent believes that the petitioner has been in compliance with the facility's smoking policy since the incident of June 7, 2008.

6. The respondent, by Nursing Home Transfer and Discharge Notice dated July 2, 2008, notified the petitioner of its intent to discharge her, effective August 2, 2008, because her needs cannot be met in the facility and the safety of other individuals in the facility was endangered. The notice listed another nursing facility as the location to which the petitioner was to be discharged. In support of the action to discharge the petitioner, the notice stated that the petitioner continued non-compliance with the facility smoking policy. The notice was not signed by the petitioner's physician or the facility medical director. There was no evidence presented offering the opinion of the treating physician to show his recommendations for discharge. The respondent believes that the facility's medical director verbally recommended that the petitioner be discharged. However, there was no documentation in the petitioner's medical records that showed that the petitioner's physician or the facility's medical director recommended a discharge of the petitioner.

7. There was no evidence presented to show that the petitioner's needs could not be met in the facility due to a medical condition.

CONCLUSIONS OF LAW

Jurisdiction to conduct this type of hearing is conveyed to the Department by federal regulations appearing in 42 C.F.R. §431.200. Additionally, federal regulations

limit the reasons for which a Medicaid or Medicare certified nursing facility may discharge a patient.

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

> (2) Transfer and discharge requirements. The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless--
> (i) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility;
> (ii) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;
> (iii) The safety of individuals in the facility is endangered;
> (iv) The health of individuals in the facility would otherwise be endangered;
> (v) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or
> (vi) The facility ceases to operate.
> (3) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (a)(2)(i) through (v) of this section, the resident's clinical record must be documented. The documentation must be made by--
> (i) The resident's physician when transfer or discharge is necessary under paragraph (a)(2)(i) or paragraph (a)(2)(ii) of this section; and
> (ii) A physician when transfer or discharge is necessary under paragraph (a)(2)(iv) of this section.

Florida Statutes 400.0255, Resident transfer or discharge; requirements and procedures; hearings, states in relevant 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...
> (7) At least 30 days prior to any proposed transfer or discharge, a facility must provide advance notice of the proposed transfer or discharge to the resident and, if known, to a family member or the resident's legal guardian or representative, except, in the following circumstances, the facility shall give notice as soon as practicable before the transfer or discharge:
> (a) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility, and the circumstances are documented in the resident's medical records by the resident's physician; or
> (b) The health or safety of other residents or facility employees would be endangered, and the circumstances are documented in the resident's medical records by the resident's physician or the medical director if the resident's physician is not available.

One of the two reasons stated by the facility for the discharge is that the safety of other individuals in the facility is endangered as the petitioner did not comply with the facility's smoking policy. The above authorities require that when the health or safety of other residents is endangered that the circumstances be documented in the resident's medical records by the resident's physician or medical director if the resident's physician is not available. There was no evidence presented from the petitioner's medical records that documented that the petitioner's physician or the medical director determined that the petitioner's behavior or non-compliance with the facility's smoking policy created an unsafe or dangerous situation for other residents.

The other reason stated by the facility for the discharge was that her needs could not be met by the facility. There was no evidence presented that the hearing officer can rely upon that showed that the petitioner's needs could not be met in the facility because of a medical condition. Additionally, the petitioner's physician or medical director did not sign the discharge notice as required by the above authorities.

The hearing officer has reviewed all of the evidence presented. According to the above authorities, the facility's burden of proof must be clear and convincing evidence. Based solely on the facts as presented in this case, the hearing officer cannot conclude that the safety of other individuals in the facility is endangered or that the petitioner's needs cannot be met by this facility. Therefore, it is determined that the respondent did not meet its burden and the respondent's action to discharge the petitioner is not justified. The petitioner is to be allowed to remain at the nursing facility.

DECISION

The appeal is granted. The respondent may not proceed with the proposed discharge.

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 7th day of November, 2008,

in Tallahassee, Florida.

Morris Zamboca

Morris Zamboca
Hearing Officer
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Tallahassee, FL 32399-0700
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DEPARTMENT OF CHILDREN AND FAMILIES
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APPEAL NO. 08N-00172

PETITIONER,

Vs.

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on November 4, 2008, at 11:50 a.m., in Lake Worth, Florida. The petitioner was not present. Representing the petitioner was his father, [redacted] It is noted that the father is neither the petitioner's power of attorney (POA) nor health care surrogate. Representing the respondent was [redacted], social services director. Appearing as witnesses were: [redacted], social services, and [redacted], director of nursing.

This hearing was originally scheduled for October 15, 2008. Prior to the start of the hearing on October 15, 2008 the respondent gave this hearing officer notice that the petitioner had left the facility "on his own accord, Against Medical Advice (AMA) on October 14, 2008". To date the petitioner has not returned to the facility.

Presuming that this is voluntary, the hearing officer was prepared to dismiss the case. However, the petitioner's father came to the hearing and requested that a new date be set. This was done and the hearing was convened as noted above.

ISSUE

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

FINDINGS OF FACT

1. The petitioner is presently hospitalized. He has not returned to the facility following his departure October 14, 2008.
2. On September 4, 2008, the facility issued a Nursing Home Transfer and Discharge Notice to the petitioner with an effective transfer date of October 4, 2008. The Notice indicated the reason for transfer as his improved health condition no longer required the facility's services.
3. Subsequent to this notice, the facility received two orders from the facility medical director, [redacted] M.D. On September 24, 2008 he ordered that the "pt is to not be allowed any leave of absence priveleges [sic]". This order was repeated and verified. The second

order came October 11, 2008, repeating this and noting that an AMA (against medical advice) would occur.

4. The respondent explains that the petitioner requires therapeutic and rehabilitative services. He requires less level of care (LOC) given at the facility.
5. The original physician's order was signed by the previous medical director, [redacted] M.D. He noted on September 3, 2008 that the facility "may transfer resident to ALF [assisted living facility] when bed available". The Transfer Notice was issued the next day.
6. The respondent explains that the petitioner is independent of his activities of daily living (ADL). He would go outside to smoke on his own power. He took care of himself and was very independent.
7. The respondent further explains that when the petitioner left on October 14, 2008 against medical advice, he was not allowed to return. This would be even if he went to seek additional medical advice from an outside physician. The respondent explains this would present insurance difficulties.
8. Lastly, the facility requires that neither the father nor the petitioner sought permission to leave on October 14, 2008. This was against the facility's doctor's order.

9. The father explains that his son did not leave voluntarily. The father took his son to a family physician. The father explains that he was able to do this according to the facility's rules.

10. The father wanted to get blood tests from the family physician because the facility would not provide this medical care. He explains that the medical treatment was lacking at the facility. He could not explain why he would want his son to stay at the facility if the medical care was lacking.

11. The father did not submit any medical evidence that an ALF could not provide the care he believes his son requires. He does note that his son has been in and out of the hospital since October 14, 2008 and at this time is presently hospitalized.

12. Lastly, the father repeats that his son did not receive proper medical care but the facility says that the petitioner refused some medical care. The petitioner is his own agent and that the father has no authority in the treatment.

CONCLUSIONS OF LAW

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

(a) Transfer and discharge--

(1) Definition: Transfer and discharge includes movement of a resident to a bed outside of the certified facility whether that bed is in the same physical 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—

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

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

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

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

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

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

(i) The reason for transfer or discharge;

(ii) The effective date of transfer or discharge;

(iii) The location to which the resident is transferred or Discharged....

Pursuant to federal guidelines, the nursing facility issued a Nursing Home Transfer and Discharge Notice to the petitioner September 4, 2008. [redacted] social services, signed the Notice. Also, as required, a transfer order from the medical director Dr. [redacted] was attached. By authorizing the transfer, Dr. [redacted] concurred with the facility's reason for discharge.

The Notice, as required, indicated the reason for transfer or discharge as "your health as improved sufficiently so that you no longer need the services provided by this facility". The effective date of the transfer or discharge was given as October 4, 2008. The location to which the petitioner was to be transferred or discharged was given as [redacted]

Although the petitioner had left the facility on October 14, 2008, the core issue for discharge was the petitioner's improvement of his health. This was not contradicted by any medical evidence. This hearing allowed the father to present any evidence that would require his son to be at a skilled level facility rather than the ALF.

All requirements have been met by the nursing facility. By the petitioner leaving the facility without medical authorization, it just compounds the discharge reason.

DECISION

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

NOTICE OF RIGHT TO APPEAL

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

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

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

in Tallahassee, Florida.

Melvyn Littman

Melvyn Littman
Hearing Officer
Building 5, Room 203
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APPEAL NO. 08N-00154

PETITIONER,

Vs.

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing convened before the undersigned hearing officer on October 24, 2008, at 10:00 a.m., in Fort Pierce, Florida. The petitioner was present and represented herself. [redacted] nursing home administrator, represented the respondent. Witnesses for the respondent included [redacted] director of nursing; [redacted] social worker and [redacted], LPN nurse manager.

ISSUE

The respondent will have the burden to prove by a clear and convincing evidence that the petitioner's discharge in the notice dated August 11, 2008 is in accordance with the requirements of Code of Federal Regulation at 42 C.F.R. § 483.12(a):

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

FINDINGS OF FACT

1. The petitioner has been residing at this nursing facility for three years. She is still in residence pending the outcome of this appeal. Her diagnosis includes a medical history of substance abuse, hypertension, chronic pain syndrome, neuropathy, hepatitis C, subarachnoid hemorrhage, cervical neck injury, and other medical conditions (Respondent's Exhibit 5).

2. The respondent entered into evidence as Exhibit 1, the Nursing Home Transfer and Discharge Notice, dated August 11, 2008. The reason cited for the discharge was "Your needs cannot be met in this facility". It was signed by Dr. [redacted] a treating physician, on the same date. Notes on the bottom of the form shows that the petitioner "tested positive for drugs not prescribed to her. She continues to take drugs that is not prescribed to her. She is on several prescribed medication and when dispensing her regular prescribed medications, we are not aware of her illegal drugs intake, which may lead to an over dose".

3. The petitioner stipulated she took narcotics two times that were not prescribed to her, since she has been in the facility. She tried to kill herself in November 2007 on Ativan she got from another resident. The second time she took narcotics they were used as a sleep aid.

4. The Respondent's Exhibit 3 is the Progress Notes from Social Services. It also includes a contract the petitioner signed on March 28, 2008 attesting that she would not use any drugs when she went outside of the facility, and that she would allow random drug testing. Random drug tests were performed. On July 27, 2008, the drug screen urine test showed elevated numbers, not related to her normal medications

(Respondent's Exhibit 7). Normal medications had to be withheld until the others were flushed from her system.

5. The Respondent's Exhibit 2 is the nurses' progress notes. An entry on April 1, 2008, shows the petitioner demanded to go to the hospital due to pain. She was sent to the hospital. She had a history of going to the hospital on nights and weekends to drug seek, or get more pain medications. She was warned at the hospital that if she continued this behavior to abuse prescription medications, she could be arrested. An entry on July 15, 2008 shows her eyes were very glassy, pupils were equal and reactive to light, and that she was exhibiting inappropriate giggling. An entry on August 5, 2008, shows the results of a random drug screen in which the petitioner's Ativan level was greater than 200mg/ml.

6. The respondent fears that the nurses could overdose the petitioner if she continues to use unprescribed drugs. She was asked not to bring drugs in the facility as it is illegal; she then used them in the parking lot. The respondent explains that the petitioner gets verbally abusive and loud as documented in the notes. The respondent believes that its goal is to keep the petitioner safe, and while she is seeking drugs, they cannot keep her, or the other residents safe.

7. The discharge location on the Transfer Notice is the petitioner's parents' home. It is not a suitable location. At the time of the hearing, no other discharge location had been found that would be clinically appropriate for the petitioner. Other facilities declined to take her. The petitioner does not want to leave this facility as she fears her mother would not be able to find her in a different location.

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, transfer and discharge is addressed at 42 C.F.R. § 483.12 stating in relevant part:

> (2) Transfer and discharge requirements. The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless-
>
> (i) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility;...
>
> (3) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (a)(2)(i) through (v) of this section, the resident's clinical record must be documented. The documentation must be made by-
>
> (i) The resident's physician when transfer or discharge is necessary under paragraph (a)(2)(i) or paragraph (a)(2)(ii) of this section; and
>
> (ii) A physician when transfer or discharge is necessary under paragraph (a)(2)(iv) of this section.
>
> (4) Notice before transfer. Before a facility transfers or discharges a resident, the facility must-
>
> (i) Notify the resident and, if known, a family member or legal representative of the resident of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand.
>
> (ii) Record the reasons in the resident's clinical record; and
>
> (iii) Include in the notice the items described in paragraph (a)(6) of this section.
>
> (5) Timing of the notice.
>
> (i) Except when specified in paragraph (a)(5)(ii) of this section, the notice of transfer or discharge required under paragraph (a)(4) of this section must be made by the facility at least 30 days before the resident is transferred or discharged. ...
>
> (6) Contents of the notice. The written notice specified in paragraph (a)(4) of this section must include the following:
>
> (i) The reason for transfer or discharge;
>
> (ii) The effective date of transfer or discharge;
>
> (iii) The location to which the resident is transferred or discharged...

The treating physician indicated his plan or order for the discharge by his signature on the discharge and transfer notice, therefore the hearing officer has given this considerable weight in the decision. The petitioner has failed to refrain from taking medications not prescribed to her, or sought out more prescribed medications after signing a contract stating she would not do so. Based on all evidence and testimony presented, it is concluded the current facility cannot adequately meet the needs of the petitioner, as described in the notice.

Once discharge planning has been properly completed and an adequate facility has been found, the respondent may proceed with the discharge of the petitioner in accordance with the requirements set forth by the Agency for Health Care Administration.

DECISION

The appeal is denied as the facility's action to discharge the petitioner is in accordance with federal regulations. The facility may proceed with the discharge as determined by the treating physician and in accordance with applicable Agency for Health Care Administration requirements.

NOTICE OF RIGHT TO APPEAL

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

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

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. 08N-00158

PETITIONER,

Vs.

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on October 24, 2008, at 11:05 a.m., in Orange Park, Florida. The petitioner was present and testified. The petitioner was represented by his sister, [redacted] and his brother, [redacted]. The respondent was represented by [redacted], administrator; [redacted] director of nursing and [redacted] quality regulatory consultant.

ISSUE

The respondent will have the burden to prove by clear and convincing evidence that the petitioner's discharge is in accordance with the requirements of the Code of Federal Regulation at 42 C.F.R. §483.12(a).

FINDINGS OF FACT

1. The petitioner has been a resident of the respondent facility since November 23, 2005. The petitioner's date of birth is . the petitioner is age 65. The respondent's clinical records show the petitioner's impairments include infantile cerebral palsy, anxiety, hypertension and depression.

2. The respondent entered into evidence records of incidents of non-compliant behavior potentially dangerous to the safety and well being of the petitioner and the other residents in the facility, specifically violations of the established facility smoking policy (Respondent's Composite Exhibit 3). The records show non-compliant behavior, such as smoking in non-designated areas, dating back to January 2006. Some of the incidents occurred on the following dates: January 8, 2006, June 24, 2006, December 2, 2006, January 21, 2007, February 24, 2007, November 17, 2007, February 12, 2008, and July 8, 2008 (Respondent's Composite Exhibit 3).

2. The facility has established rules and regulations regarding resident smoking. The residents may smoke in two designated areas (on a patio outside the dining hall and during bad weather under a covered area outside the activities room); residents are not allowed to smoke anywhere else on the premises. All smoking paraphernalia must be kept at the nurses' station; the paraphernalia is distributed and recollected at designated smoking times. The facility smoking schedule consists of two to three smoking sessions during the morning and evening shifts and one smoking

session during the overnight shift. In addition, individual requests to smoke are granted based on staff availability to supervise.

3. Respondent clinical notes dating back to January 2006 show repeated incidences of petitioner non-compliance with the smoking policy. The notes show that the petitioner smokes in non-designated areas (most frequently in front of the facility's main entrance) at non-designated times. The notes show repeated warnings, education and redirection. The notes show the petitioner has a history of collecting used cigarette butts and storing them in his room. A typed note dated July 6, 2006 and signed by the petitioner lists five terms to which the petitioner agreed; the terms included not picking through trash or picking up cigarette butts off the ground. Clinical notes dated August 13, 2008 state in part "This writer and ADNS met with [redacted] to discuss condition of room. [redacted] had cigarette butts in his room scattered on floor. He picks them up outside and pulls tobacco out of them and smokes tobacco in his pipe. He had 2 lighters in his room..."

4. The facility's director of nursing testified that she has personally observed the petitioner on multiple occasions smoking at non-designated times, in non-designated areas and attempted to confiscate his pipe and lighter. She asserted that the petitioner would not always relinquish the items; he hides the pipe by sitting on it or putting it down his pants. She has observed burn holes in the petitioner's sheets from sitting on his pipe. The director of nursing further testified that on one occasion, when smoking paraphernalia was confiscated, the petitioner told her that he would just buy another

pipe and lighter. The facility administrator asserted that repeated attempts to counsel and educate the petitioner have not been successful. The petitioner has agreed multiple times to quit smoking and has been given cessation assistance, but it was not successful. Family members were enlisted to assist with petitioner compliance, also without long term success.

5. The facility administrator explained that a smoking related fire in a neighboring nursing facility earlier this year resulted in a resident death and prompted the facility to have a mandatory meeting with all residents on April 30, 2008 to emphasize the importance of compliance with the smoking policy and to emphasize zero tolerance for violations. The facility required participants sign an attendance sheet. The attendance sheet was included as part of Respondent's Composite Exhibit 3; the sign in sheet contains the petitioner's signature. Subsequent to the April 2008 meeting, the clinical notes show the petitioner was again observed violating the smoking policy; the facility decided to initiate discharge action. The facility served the petitioner with a discharge notice on August 21, 2008, effective September 21, 2008. The notice shows another nursing facility as the proposed discharge location.

6. The petitioner asserted that he would like to remain in the facility. Regarding facility allegations that he has been non-compliant with the smoking policy, the petitioner responded "I have done wrong...being out front", but did not elaborate further. The petitioner's brother and sister acknowledged that the petitioner is addicted to smoking. They believe the facility should have contacted one of them to assist with

obtaining the petitioner's compliance with smoking policy instead of contacting the cousins who admitted the petitioner into the facility and signed to be the facility contacts within the family. The facility responded that verbal counseling and warnings from family and staff yielded short term results only and do not believe the petitioner's siblings could have been of greater assistance in part because they do not visit the petitioner as frequently or consistently as the cousins.

7. The petitioner's family believes the petitioner suffers from mental retardation and does not understand the facility's smoking policy or the consequences of his actions. The facility disputes the family's assertions. Respondent's Composite Exhibit 3 includes a list of petitioner impairments upon admission into the facility; mental retardation is not listed as an impairment. The facility asserted that the petitioner sees a physician quarterly and has never received a diagnosis of mental retardation. No evidence was submitted to support the family's belief.

8. The family questioned facility supervision of the petitioner's smoking paraphernalia. The facility explained that all smoking paraphernalia is kept at the nurses' station and is distributed at designated times and then collected prior to the residents re-entering the facility. When questioned about why multiple lighters and pipes have been found on his person and in his room, the petitioner admitted that he buys additional lighters and pipes when he goes on outings.

9. The petitioner offered to quit smoking if the facility would allow him stay. The facility declined the petitioner's offer. The facility administrator explained that over a

three year period the petitioner repeatedly broke promises to quit smoking. The facility believes the petitioner's behavior puts the other residents and the petitioner himself at risk. The facility would like to go forward with the discharge action.

CONCLUSIONS OF LAW

Jurisdiction to conduct this type of hearing is conveyed to the department by federal regulations appearing in 42 C.F.R. §431.200. Additionally, federal regulations limit the reasons for which a Medicaid or Medicare certified nursing facility may discharge a patient.

In this case, the notice of discharge specifies the reasons for discharge that appear in 42 C.F.R. §483.12(a) (2), which states, in part:

> (2) Transfer and discharge requirements. The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless-
>
> (i) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility;
>
> (ii) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;
>
> (iii) The safety of individuals in the facility is endangered;
>
> (iv) The health of individuals in the facility would otherwise be endangered;
>
> (v) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or
>
> (vi) The facility ceases to operate.
>
> (3) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (a) (2) (i) through

(v) of this section, the resident's clinical record must be documented. The documentation must be made by-

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

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

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

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

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

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

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

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

(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...

The Findings of Fact show that the facility has repeatedly counseled the petitioner regarding compliance with the smoking policy. In spite of the facility's efforts, the petitioner continued to smoke in unapproved areas at non-designated times. The petitioner buys smoking paraphernalia during outings and stores the items in his room. The petitioner acknowledged that he had "done wrong." The petitioner's family believes

that he does not comprehend the consequences of his actions because he suffers from mental retardation. However, there was no evidence provided to support this belief.

The undersigned hearing officer carefully reviewed the evidence and controlling legal authorities and concluded the respondent's proposed discharge of the petitioner from the facility is in accordance with the reasons stated in the Federal Regulations.

DECISION

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

NOTICE OF RIGHT TO APPEAL

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

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

in Tallahassee, Florida.

Leslie Green

Leslie Green
Hearing Officer
Building 5, Room 203
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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. 08F-05310

PETITIONER,

Vs.

CASE NO. 1013242220

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

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned hearing officer convened an administrative hearing in the above matter on September 4, 2008, at 4:40 p.m., in Orlando, Florida. The petitioner did not appear. [, petitioner's authorized Medicaid representative, appeared for the petitioner. Teresa Birkbeck, economic self-sufficiency specialist II, appeared and represented the respondent-Department.

ISSUE

At issue is the respondent's action of July 23, 2008, denying the petitioner's application for Institutional Care Program (ICP) Medicaid benefits for failure to verify assets. The petitioner bears the burden of proof in this appeal.

FINDINGS OF FACT

1. The petitioner submitted an application to the respondent for Institutional Care Program (ICP) Medicaid on June 23, 2008.

2. The respondent reviewed the application and completed an eligibility interview with the petitioner. The petitioner informed the respondent that he and his wife were currently separated and had been so for approximately five years but were still legally married.
3. The respondent placed the application into pending status to await the return of verification of the petitioner's assets and his spouse's assets including any bank accounts, etc.
4. The petitioner signed and submitted an Assignment of Rights to Support form to the respondent. This assigns any interests he has to the state in exchange for ICP Medicaid benefits. He also submitted all information he could obtain regarding his own assets. However, his wife was uncooperative in declaring her assets. The petitioner provided a letter to the respondent from his wife which indicated that the couple held no assets jointly but that she refused to "be involved with his financial matters moving forward." The respondent interpreted this statement as a refusal from the spouse to declare her assets.
5. Without the declaration of the spouse's assets, the respondent decided it was unable to determine eligibility and denied the application for failure to verify assets. A Notice of Case Action, dated July 23, 2008, was issued to the petitioner informing him of this decision.
6. The petitioner appeals. He has complied to the best of his ability to provide the respondent with the information it needs to determine his eligibility for ICP Medicaid. He cannot force his wife to cooperate when

she has plainly refused. He stated that any assets his wife has are unavailable to him and beyond his control. He should not be penalized for her failure to cooperate.

7. The respondent stated that its policy requires that the spouse declare her assets in order to determine eligibility. Without this information, it cannot determine whether the petitioner is within the resource limits for ICP Medicaid. As a result, the respondent had no choice but to deny the application.

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 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.

20 C.F.R. § 416.1205 sets forth the maximum asset limit in the ICP program at $2,000, for an individual.

Fla. Admin. Code 65A-1.712 provides for resource limits in SSI-Related Medicaid eligibility and states in relevant part:

> (g) The institutionalized community spouse shall not be determined ineligible based on a community spouse's resources if all of the following conditions are found to exist:
>
> 1. The institutionalized individual is not eligible for Medicaid institutional services because of the community spouse's resources and the community spouse refuses to use the resources for the institutionalized spouse; and 2. The institutional spouse assigns to the State any rights to support from the community spouse by submitting the Assignment of Support Rights form referenced in Rule 65A-1.400, F.A.C., signed by the institutionalized spouse or

their representative; and 3. The institutionalized spouse would be eligible if only those resources to which they have access were counted; and 4. The institutionalized spouse has no other means to pay for the nursing home care.

The petitioner meets the requirements in this passage. His spouse refuses to not only use her assets for the petitioner's support, but refuses to even declare what those assets are. The petitioner signed the right of support form and appears eligible for ICP Medicaid based solely on the resources he can access which are his own. Finally, he has no other means of paying his nursing home bill.

Fla. Integrated Pub. Asst. Policy Manual states in part:

1640.0314.04 Undue Hardship (MSSI)

The institutionalized spouse will not be determined ineligible based on a community spouse's assets if all of the following conditions are found to exist:

1. The institutionalized individual is not eligible due to the community spouse's assets and the community spouse refuses to use the assets for the institutionalized community spouse; and
2. The Assignment of Support Rights form (CF-ES Form 2504) is signed; and
3. The institutionalized community spouse would be eligible if only those assets to which he has access were counted; and
4. The institutionalized community spouse has no other means to pay for the nursing home care.

1640.0321 Assets Unavailable: Circumstances Beyond Control (MSSI, SFP)

Assets unavailable due to circumstances beyond the individual's control are not considered in the determination of eligibility.
The individual must present convincing evidence to prove the asset is unavailable to him due to circumstances beyond his control. The ESS will make an independent assessment of the availability based on the evidence presented. Additional guidance can be requested from the District Program Office, District Legal Office, or central office through the District Program Office.

The petitioner argued both of these provisions from the respondent's policy manual as the basis for why the petitioner should not be penalized for his wife's refusal to cooperate in declaring and verify assets. The evidence establishes that the petitioner's community spouse has not taken responsibility for his care. The evidence establishes that she "wishes" not to be involved in his financial matters moving forward which implies she has made no efforts to obtain Medicaid to pay for his care in the nursing facility. The respondent does not dispute that the petitioner reported the difficulties in obtaining the requested information from the community spouse and the fact that their marriage was estranged.

Policy Transmittal P02-11-0110, dated November 22, 2002, states in relevant part:

> Disclosure of Community Spouse's Assets for Applications Involving Assignment of Support Rights...
>
> ...When an individual applies for ICP, and the individual's spouse remains in the community (community spouse), we must consider the total assets owned by the couple, both individually and jointly, to determine eligibility. Recently, an increasing number of applicants are being advised by the legal community to protect their assets by transferring them into the community spouse's name, and advising the community spouse to simply refuse to make the assets available for the support of the institutionalized spouse. If the community spouse indicates they will not use their assets to benefit the institutionalized spouse, staff must follow certain procedures, and certain conditions must be met before excluding any assets in determining eligibility. ...The institutionalized spouse must first be determined ineligible for ICP due to the community spouse's assets. This means that both spouses must declare and document *all* assets in their names. [emphasis original] If the community spouse refuses to verify all assets owned independent of the institutionalized spouse, we cannot determine eligibility for ICP.

> Without complete verification, the eligibility specialist cannot determine what assets belong to the institutionalized spouse and whether or not assets in the institutionalized spouse's name are within program limits. ...**REMEMBER:** If the community spouse refuses to verify their assets, the assignment of rights support provision cannot be used because the second condition is not met. [emphasis original] ...

This memo was the respondent's primary argument at the hearing and is the main basis for its denial of the petitioner's application. Based on this memo, the respondent is unable to determine eligibility for benefits because the petitioner's estranged spouse refuses to report and verify her own assets.

The Integrated Public Assistance Policy Manual states in relevant part in the following passages:

> **1640.0314.01 Assets Available to Community spouse (MSSI)**
>
> The following policy applies to ICP, ICP-MEDS, and ICP-Hospice individuals admitted to institutions on or after September 30, 1989. This includes SSI recipients applying for institutional services. (If the client was institutionalized prior to September 30, 1989, refer to Chapter 2200).
> Although the assets of a Medicaid recipient's community spouse may not have been considered available to the client in the community (e.g., when the couple is separated), when the client applies for institutional services, the assets of both spouses must be considered in determining the client's eligibility for institutional services.
> The portion of a couple's assets available to the institutional spouse is the amount remaining after the community spouse's asset allowance is subtracted from the couple's total included assets. If this figure is over the program's allowable asset limit, the individual is ineligible until the assets are reduced to within the program's standard.
> **If after declaring and verifying his assets, the community spouse refuses to make them available to the client, the institutionalized may assign his rights of support to the state and obtain institutional care benefits** [emphasis added] (refer to passages 1640.0314.03 and 1640.0314.04 for policy). Community spouses who refuse to make their assets available to the

institutionalized spouse are not entitled to a community spouse income allowance...

1640.0314.03 Assignment of Support Rights (MSSI)
If the community spouse refuses to make available assets attributed to the institutionalized spouse, the institutionalized spouse may assign his rights of support to the state and obtain institutional care benefits. This situation may arise when assets allocated to the client actually solely belong to the community spouse who, in turn, refuses to make them available to the client. The institutionalized spouse may complete CF-ES Form 2504, Assignment of Support Rights, which allows the state to pursue recovery from the community spouse. Refer to CF Manual 165-24, Integrated Public Assistance Forms Manual, for proper completion (including who can sign the form). The original copy of this form is to be sent to Economic Self-Sufficiency Services, Policy Bureau, in Tallahassee, Attention: SSI-Related Medicaid Program staff. This form is not an option that an ESS suggests to an ineligible couple, but rather a solution to an existing situation which is brought to the ESS' attention.
When all conditions in passage 1640.0314.04 are met, the allocated assets being withheld by the community spouse will no longer be considered available to the institutionalized community spouse. If the institutionalized spouse does not assign the rights of support to the state, continue to consider the assets available to the institutionalized individual. (emphasis added)

The first provision above requires that before an institutionalized spouse can assign his rights of support to the state (the Department); the community spouse must first declare and verify her assets. In this case, the spouse has refused to do so. As a result, the petitioner's assignment of right to support to the Department, found in the second provision, is moot because the first condition of the manual provision, **declaration and verification of assets by the community spouse**, is not met.

The evidence shows that the spouse is resistant to the Medicaid process. However, she and the petitioner are still married and therefore she has a legal

duty to support the petitioner. This includes cooperation in the application for ICP benefits. Any assets owned by the community spouse must be reported to the respondent in order for it to complete a proper eligibility determination. Although the petitioner has demonstrated a good faith effort at compliance with the respondent's requirements by verifying his own assets and signing the Assignment of Rights to Support Form, all requirements have not been met due to lack of the spouse's asset information. As a result, the hearing officer concludes that the respondent's action to deny the application for ICP benefits was correct.

DECISION

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

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 3rd day of November 2008,

in Tallahassee, Florida.

Jeannette Estes

Jeannette Estes
Hearing Officer
Building 5, Room 203
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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. 08F-06160

PETITIONER,

Vs.

CASE NO. 1270445880

FLORIDA DEPARTMENT OF
CHILDREN AND FAMILIES
DISTRICT: 01 Okaloosa
UNIT: ICP

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on October 13, 2008, at 12:00 p.m., in Ft. Walton Beach, Florida. The petitioner was present and represented herself. Testifying on behalf of the petitioner was [redacted], patient advocate, [redacted] Also present was the petitioner's mother, [redacted] The Department was represented by Lenn King, adult payment supervisor, ACCESS Florida.

ISSUE

The petitioner is appealing the Department's action of July 21, 2008 to deny Institutional Care Program (ICP) and Medicaid benefits based on the contention that she is not disabled. The petitioner bears the burden of proof.

FINDINGS OF FACT

1. In September 2007, the petitioner filed an application for adult-related

Medicaid and ICP alleging disability. The petitioner was born on [redacted] and is under 65 years of age. Therefore, she did not meet the aged criteria and a disability assessment was required to determine whether she was disabled and eligible to receive Medicaid benefits.

2. On September 24, 2007, the petitioner filed an application with the Social Security Administration (SSA) for Supplemental Security Income (SSI) and Medicaid benefits based on her claim of disability. At the time of her application for ICP and Medicaid with the Department, the petitioner's application for SSA and SSI was pending. A request for a disability determination was sent to the Division of Disability Determination (DDD). The petitioner was approved for presumptive disability effective September 2007 through October 2007. Subsequently she was determined presumptively eligible for SSI beginning November 2007. On January 30, 2008, the SSA terminated the petitioner's application and SSI as it determined that she was not disabled.

3. The petitioner's Medicaid coverage was terminated on April 30, 2008.

4. The petitioner applied for Institutional Care Program (ICP) and Medicaid benefits through the Department on June 30, 2008. Following a hospital admission in June 2008, the petitioner was discharged to a skilled nursing facility on or about June 13, 2008 with an admitting diagnosis of diabetic foot ulcer, alcoholic dementia, and diabetes. The petitioner was subsequently discharged from the nursing facility in late June or early July 2008.

5. As part of the eligibility determination process for ICP Medicaid, the petitioner, in addition to other factors, must be determined to be disabled as she is under age 65. A Level I PASRR Screening tool was completed prior to her admission to the nursing facility. In addition, the petitioner was determined to meet a skilled level of care with a placement recommendation of a nursing facility or temporary nursing facility. The Level of Care effective date was June 13, 2008.

6. The Department's District Medical Review Team(DMRT) did not complete an independent determination of disability as the petitioner had a disability decision by the Social Security Administration, within the past 12 months and the petitioner had not alleged a disability condition different from, or, in addition to, that considered by the Social Security Administration in making its determination. The Social Security Administration disability determination found no disability with an N32 code, which means, "capacity for substantial gainful activity-other work, no visual impairment." The Department adopted SSA's decision of not disabled.

7. The Department explained that the petitioner would have to meet a medical level of care and be determined disabled to be eligible for ICP Medicaid. The Comprehensive Assessment and Review for Long Term Care Services (CARES) unit determined the petitioner met the level of care required for a stay at the nursing facility. However, without a determination of disability, the Department

could not allow the ICP or Medicaid benefits. Notice was sent on July 21, 2008, informing the petitioner of the denial of her application.

8. The petitioner claims to be disabled because of high blood pressure, diabetes, and foot ulcers due to diabetes. She believes her medical condition has worsened. These conditions existed at the time of her application for Social Security benefits. The petitioner did not request a reconsideration of the SSA denial. She reapplied for SSA and SSI in July 2008. A decision of disability was still pending at the time of the hearing.

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...

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

> (a) *Determinations made by SSA.* The following rules and those under paragraph (b) of this section apply where an individual has applied for Medicaid on the basis of disability... (2) The agency may not make an independent determination of disability if SSA has made a disability determination within the time limits set forth in §435.911 on the same

issue presented in the Medicaid application. A determination of eligibility for SSI payments based on disability that is made by SSA automatically confers Medicaid eligibility...(b) Effect of SSA determinations. (1)(i) An SSA disability determination is binding on an agency until the determination is changed by SSA... (c) *Determination made by the Medicaid agency.* The agency must make a determination of disability in accordance with the requirements of this section if any of the following circumstances exist:... (4) The individual applies for Medicaid as a non-cash recipient, whether or not the State has a section 1634 agreement with SSA, and.. (i) Alleges a disability condition different from, or in addition to, that considered by SSA in making its determination...

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

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

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

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

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

The Department's Fla. Integrated Pub. Policy Manual states in part:

1440.1204 **Blindness/Disability Determinations (MSSI, SFP)**

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...

The District Medical Review Team (DMRT) handles all other necessary disability determinations (including ICP, OSS, HCBS, and PACE).

The Department's Fla. Integrated Pub. Policy Manual states in part:

1440.1206 **Change in disability Determination by SSA (MSSI, SFP)**

When the Social Security Administration (SSA) renders a disability decision that is different than that made by DCF, the SSA decision must be adopted unless the SSA decision was based on a condition different than that which the state reviewed.
If SSA determines the individual is not disabled or that the disability has ceased, action must be taken to close the SSI-Related Medicaid benefits on FLORIDA that are based upon disability, allowing for ten days advance notice of adverse action...

The Department's published Transmittal No.: I-03-04-0016, Disability Determination for ICP and HCBS dated April 14, 2003 states in part:

Individuals under age 65 must meet the disability criteria established by the Social Security Administration (SSA) in order to qualify for most SSI-related Medicaid programs. The DMRT is responsible for making the disability determination for ICP and most HCBS waivers when no disability decision has previously been made by SSA or the Division of Disability Determination (DDD) In order to be considered disabled for SSI-related Medicaid, the applicant must meet federal disability criteria.

The Findings of Fact show that the petitioner is under age 65 and was not disabled based on the unfavorable decision made by the SSA. The evidence presented does not show that the petitioner has a condition different, or in addition to, what the SSA considered in making the determination of the denial.

The Findings show SSA denied disability after initially determining the petitioner presumptively disabled. According to the above federal regulation, the SSA's denial of

the petitioner's disability is binding and must be relied upon by the Department. In addition, the above authorities indicate the DMRT is responsible for making the disability determination for ICP when **no** (emphasis added) disability decision has previously been made by SSA or the Division of Disability Determinations. Therefore, the Department correctly denied the petitioner's application for ICP and SSI-Related Medicaid Program benefits as the petitioner has not met the disability requirement.

DECISION

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

NOTICE OF RIGHT TO APPEAL

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

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

in Tallahassee, Florida.

Linda Garton

Linda Garton
Hearing Officer
Building 5, Room 203
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Tallahassee, FL 32399-0700
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STATE OF FLORIDA
DEPARTMENT OF CHILDREN AND FAMILIES
OFFICE OF APPEAL HEARINGS

APPEAL NO. 08F-05534

PETITIONER,

Vs.

CASE NO. 1278020977

FLORIDA DEPARTMENT OF
CHILDREN AND FAMILIES
DISTRICT: 12 St. Johns
UNIT: 88209

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing convened before the undersigned hearing officer on October 15, 2008, at 10:58 a.m., in St. Augustine, Florida. The petitioner was not present. The petitioner was represented by his wife, [redacted] Present as a witness for the petitioner was his daughter, [redacted] The Department was represented by Janet Williams, economic self sufficiency specialist.

ISSUE

At issue is whether the community spouse income allowance in the Institutional Care Program was correctly determined. The petitioner is seeking an increase in the spousal allowance. The petitioner bears the burden of proof.

FINDINGS OF FACT

1. The petitioner is residing in a nursing facility. The petitioner is married; his wife is living in the community (for Institutional Care Program purposes, she is known as the community spouse). The petitioner is age 79, his wife is age 80.

2. The petitioner's income is $1265 Navy pension and $917 Social Security; total income for petitioner is $2182. Income for the petitioner's wife includes $334.61 pension from a former husband (not the petitioner), $224.26 pension from [redacted], $1045 Social Security and $10.76 interest; the total income for the petitioner's wife is $1614.63 The petitioner's income exceeded the Institutional Care Program (ICP) income standard of $1911, however, an income trust was established and funded in an amount sufficient to reduce the petitioner's countable income to below the ICP standard, thus allowing the petitioner to receive ICP Medicaid.

3. The family believes the portion of the petitioner's income allotted to the community spouse is insufficient to meet her needs and would like an increase in the spousal allowance. The Department determines the community spouse allowance by a budgeting procedure that considers shelter and utility expenses as well as the community spouse's income. The community spouse's monthly mortgage is $712.81 (this amount includes property tax), monthly homeowner's insurance is $101.16; the Department uses the standard utility allowance of $198. Total allowable shelter costs are $1011.97. The Minimum Monthly Maintenance Income Allowance (MMMIA) was set at $1750 effective July 1, 2008, and is based on federal law. Thirty percent of that figure (30% X $1750), or $525, was deducted from the community spouse's shelter costs ($1011.97) to determine an excess shelter cost amount of $486.97. The excess

shelter amount was then added to the MMMIA ($486.97+$1750=$2236.97) for a beginning figure to determine the community spouse allowance. The community spouse's gross income of $1614.63 was then subtracted from that figure to determine the community spouse's income allowance of $622.34. The community spouse allowance ($622.34) and $35 personal needs allowance were subtracted from the petitioner's income of $2182; the balance of $1524.66 was the petitioner's patient responsibility.

5. The community spouse asserted that she can not meet her financial obligations in the community unless she is allowed to keep more of the petitioner's income. She detailed her monthly expenses: mortgage $712.81, homeowner's insurance $101.16, car payments $248, car insurance $127, home telephone $81, cell phone for self $46.84, cell phone for daughter $46.84, security alarm $27.51, Direct TV $71, food $200, lawn care $50, gas $200, credit cards $525 and salt for well $35. These monthly bills total $2472.16. The petitioner's daughter believes her stepmother can not afford to live in the community unless she is allocated a larger portion of the petitioner's income.

CONCLUSIONS OF LAW

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

> (4) Spousal Impoverishment. The department follows 42 U.S.C. § l396r-5 for resource allocation and income attribution and protection when an institutionalized individual, including a hospice recipient residing in a nursing facility, has a community spouse...(c) The community spouse resource allowance is equal to the maximum resource allocation standard allowed under 42 U.S.C. § 1396r-5 or any court-ordered support, whichever is larger.
> (d) After the institutionalized spouse is determined eligible, the department allows deductions from the eligible spouse's income for the community

spouse and other family members according to 42 U.S.C. § 1396r-5 and paragraph 65A-1.716(4)(c), F.A.C...
(f) Either spouse may appeal the post-eligibility 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. Exceptional circumstances that result in extreme financial duress include circumstances other than those taken into account in establishing maintenance standards for spouses. An example is when a community spouse incurs unavoidable expenses for medical, remedial and other support services which impact the community spouse's ability to maintain themself in the community and in amounts that they could not be expected to be paid from amounts already recognized for maintenance and/or amounts held in resources. Effective November 1, 2007, the hearing officers must consider all of the community spouse's income and all of the institutionalized spouse's income that could be made available to a community spouse. If the expense causing exceptional circumstances is a temporary expense, the increased income allowance must be adjusted to remove the expenses when no longer needed.

Florida Administrative Code 65A-1.7141, ***SSI-Related Medicaid Post-Eligibility Treatment of Income,*** states in part:

After an individual satisfies all non-financial and financial eligibility criteria for Hospice, institutional care services or Assisted Living waiver (ALW/HCBS), the department determines the amount of the individual's patient responsibility. This process is called "post eligibility treatment of income".
(1) For Hospice and institutional care services, the following deductions are applied to the individual's income to determine patient responsibility:
(a) Individuals residing in medical institutions shall have $35 of their monthly income protected for their personal need allowance...
(d) The department applies the formula and policies in 42 U.S.C. section 1396r-5 to compute the community spouse income allowance after the institutionalized spouse is determined eligible for institutional care benefits. The standards used are found in subsection 65A-1.716(5), F.A.C. The current standard Food Stamp utility allowance is used to determine the community spouse's excess utility expenses...
(f) For ICP or institutionalized Hospice, income is protected for the month of admission and discharge, if the individual's income for that month is obligated to directly pay for their cost of food or shelter outside of the facility.

(g) Effective January 1, 2004, the department allows a deduction for the actual amount of health insurance premiums, deductibles, coinsurance charges and medical expenses, not subject to payment by a third party, incurred by a Medicaid recipient for programs involving post eligibility calculation of a patient responsibility, as authorized by the Medicaid State Plan and in accordance with 42 CFR 435.725.

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

(c) Spousal Impoverishment Standards...
2. State's Minimum Monthly Maintenance Income Allowance (MMMIA). The minimum monthly income allowance the department recognizes for a community spouse is equal to 150 percent of the federal poverty level for a family of two.
3. Excess Shelter Expense Standard. The community spouse's shelter expenses must exceed 30 percent of the MMMIA to be considered excess shelter expenses to be included in the maximum income allowance: MMIA *x* 30% = Excess Shelter Expense Standard. This standard changes July 1 of each year.

The Department's Integrated Policy Manual, 165-22, section 2640.0122, Minimum Monthly Maintenance Income Allowance (MSSI), explains in part:

The following policy applies to ICP...
This income allowance is the basic monthly allowance the state recognizes for a community spouse whose spouse was institutionalized on or after 9/30/89. The state's minimum monthly maintenance income allowance (MMMIA), is based on 150% of the poverty level for two individuals.

The Department's Integrated Manual 165-22, Appendix A-9 shows the spousal impoverishment standards.

Spousal Impoverishment Income Standards

Minimum Monthly Maintenance Needs Allowance (MMMIA):

July 1, 2007	July 1, 2008
$1,712	$ 1,750

Excess Shelter Standard:

July 1, 2007	July 1, 2008
$ 514	$ 525

The maximum monthly community spouse income allowance (MMMIA plus excess shelter costs) remains $2,610. This cap (maximum) standard changes annually in January.

The Department's budgeting methodology, as outlined in the Findings of Facts, correctly reflects the budgeting methodology set forth in the above authorities in calculating a possible spousal income diversion allowance. However, Florida Administrative Code permits possible adjustment to this methodology and the resulting spousal diversion amount, if proof is presented of exceptional circumstances that result in financial duress.

The petitioner's wife argued that her monthly living expenses exceed her income. The undersigned hearing officer carefully reviewed the pertinent legal authorities which specify the circumstances that must exist in order to increase the spousal allowance. The rule requires that there first be an exceptional circumstance resulting in extreme financial duress before the community spouse allowance can be upwardly adjusted. An exceptional circumstance resulting in extreme financial duress is defined in the Florida Administrative Code as a circumstance other than one already considered in establishing the maintenance standards for spouses. The expenses detailed in the Findings of Fact are recurring expenses consistent with the every day maintenance of a household and do not meet the criteria of exceptional as required by the governing legal authorities. The Department included in the budget the maximum allowance for utility expenses in addition to the monthly mortgage and homeowner's insurance; no

provisions could be found which allow deductions for car payments, car insurance, gas, credit cards, lawn care, security alarms, and Direct TV. No mathematical errors were found in the calculation of the petitioner's patient responsibility or the community spouse allowance amount. Therefore, based on the findings and the above controlling legal authorities, the undersigned can find no basis to increase the community spouse diversion amount.

DECISION

The appeal is denied and the Department's action is affirmed. No eligibility could be found for any additional community spouse diversion amount.

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 18th day of November, 2008,

in Tallahassee, Florida.

Leslie Green

Leslie Green
Hearing Officer
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STATE OF FLORIDA
DEPARTMENT OF CHILDREN AND FAMILIES
OFFICE OF APPEAL HEARINGS

PETITIONER,

Vs.

APPEAL NO. 08F-02904

FLORIDA DEPARTMENT OF
CHILDREN AND FAMILIES
DISTRICT: 13 Citrus
UNIT: 88083

CASE NO. 1251770436

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned-hearing officer on September 1, 2008, at 1:30 p.m., in Wildwood, Florida. The petitioner was not present. Present representing the petitioner was [redacted] attorney at law. Present as a witness for the petitioner was [redacted] The Department was represented by Joyce Miller, district legal counsel. Present as witnesses for the Department were Kane Lamberty, senior human services program specialist and Edward Broom, economic eligibility specialist.

Hearings were scheduled on June 13, 2008, July 21, 2008 and August 22, 2008. However, as stipulated by both parties continuances were granted.

The record was held open for 14 days to allow the submission of proposed orders. Neither party submitted a proposed order.

ISSUE

The petitioner is appealing the Department's action to terminate Institutional Care Program Medicaid effective March 2008 due to assets exceeding the program's limit.

FINDINGS OF FACT

1. During October 2006, the petitioner was determined eligible to receive Institutional Care Program benefits through the Department. The petitioner continued to receive Institutional Care Program benefits through at least February 2008. Prior to her admission into the above facility, the petitioner was living in her home located at [redacted] Florida. The home was her principal place of residence and was excluded as an asset in determining her eligibility for Institutional Care Program benefits because the petitioner had the intent to return to her home.

2. On January 5, 2007, the petitioner sold her home and netted $80,842.50 from the sale. The petitioner used some of the proceeds from the sale of her home to pay off debts and used $39,640 to purchase a mobile home on April 2, 2007. The mobile home is located at [redacted] Florida. The petitioner has never resided in the mobile home and it is not her principal place of residence. The petitioner continues to reside in the nursing facility. The mobile home is not up for sale and is not used as an income producing property.

3. The petitioner did not report the sale of her home and the purchase of her mobile home. During January 2008, a redetermination of the petitioner's eligibility for Institutional Care Program benefits was completed. During the redetermination, the eligibility specialist checked the County Property Appraiser's website to verify continued ownership of the petitioner's homestead. The eligibility specialist discovered

that the petitioner sold her home on January 5, 2007. The eligibility specialist requested proof of the fair market value of the home, documentation of the net proceeds from the sale and documentation of the disposition of the net proceeds from the sale. On January 14, 2008, the eligibility specialist received documentation of the expenditure of the proceeds from the sale and the purchase of the mobile home.

4. The Department determined that the exclusion of the home provision did not apply as the petitioner never lived in the mobile home and did not own the mobile home prior to entering the nursing facility. The Department considered the value of the home an asset to the petitioner. As the value of the home exceeded the $2,000 asset limit for the Institutional Care Program, the Department determined that the petitioner was not eligible to receive Institutional Care Program Medicaid and terminated that coverage effective March 2008.

CONCLUSIONS OF LAW

The Department's SSI-Related Medicaid Programs, Fact Sheets, July 2008 explains the basis for the ICP program and states in part:

> SSI Related Programs
> The programs listed below are based on Titles XVI and/or XIX of the Social Security Act, as amended, which establish the policy for Supplemental Security Income (SSI) and Medicaid.
> □ Supplemental Security Income (SSI)
> □ Medicaid programs that have full benefits include:
> - Individuals who receive SSI cash benefits administered by SSA are automatically eligible for Medicaid in Florida.
> - MEDS for certain aged and disabled individuals (MEDS-AD).
> - Institutional Care Program (ICP) ...

Florida Administrative Code 65A-1.716 in part states:

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

Florida Administrative Code 65A-1.712 in part states:

(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) Exclusions. The department follows SSI policy prescribed in 20 C.F.R. Part 416 in determining what is counted as a resource with the following exceptions, as mandated by federal Medicaid policies, or additional exclusions, as adopted by the department under section 42 U.S.C. § 1396a(r)(2)...

Federal Regulations at 20 C.F.R. § 416.1212 sets forth the definition of home and the exclusion of the home:

(a) Defined. A home is any property in which an individual (and spouse, if any) has an ownership interest and which serves as the individual's principal place of residence. This property includes the shelter in which an individual resides, the land on which the shelter is located and related outbuildings.
(b) Home not counted. We do not count a home regardless of its value...
(c) If an individual changes principal place of residence. If an individual (and spouse, if any) moves out of his or her home without the intent to return, the home becomes a countable resource because it is no longer the individual's principal place of residence. If an individual leaves his or her home to live in an institution, we still consider the home to be the individual's principal place of residence, irrespective of the individual's intent to return as long, as a spouse or dependent relative of the eligible individual continues to live there. The individual's equity in the former home becomes a countable resource effective with the first day of the month following the month it is no longer his or her principal place of residence.

The Department's Public Assistance Policy Manual 165-22, Section 1640.0543.01 in part states:

> Home as Principal Place of Residence (MSSI,SFP):
> Intent to return policy applies only to the continued exclusion of property which met the definition of the individual's home prior to the time the individual left the property. The individual must have lived in the home prior to the temporary absence in order to have it excluded based on his intent to return.

The Social Security Administration's Program Operations Manual System (POMS), under SSI, at SI 01130.110 – Home Replacement Funds, explains the application of this policy and states at B.2.:

> Use of proceeds to pay other costs will warrant their exclusion if such costs are identified and documented prior to occupancy and stem directly from the purchase or occupancy of the new home. ...

The Department's Public Assistance Policy Manual 165-22, Section 1640.0543.03, states in part:

> Home Replacement Exclusion (MSSI, SFP)
> The proceeds from sale of an excluded home and any other excluded property sold with the home can be excluded from assets for up to three months while the home is being replaced. Policy details on the three-month exclusion limit are provided in passage 1640.0543.04.
> In order to qualify for the exclusion, the individual must replace the excluded home with another excluded home or property within the three month time limit. Otherwise, the proceeds from the sale will be an included asset beginning the month after the three-month period ends, allowing for ten days advance notice of adverse action.
> If a home is being replaced due to loss or damage resulting from a disaster or accident, the in-kind replacement (temporary housing or support) is excluded for nine months from the date received.
> This policy also applies if the individual applies for benefits after selling a home that would have been excluded as an asset under current policy. In this case the three-month exclusion period begins the day the individual applies.

The Social Security Administration's Program Operations Manual System (POMS) states in relevant part:

> SI 01130.100 The Home
> A. Policy Principles ...
> 2. Definition of the Home
> An individual's home is property in which he or she has an ownership interest and that serves as his or her principal place of residence. It can include:
> the shelter in which he or she lives;
> the land on which the shelter is located; and
> related buildings on such land. ...
> 5. Absences From The Home
> c. 'Intent to Return' Development
> If the individual has left his or her home but intends to return to it, see SI 01130.100D. for the necessary development.
> NOTE: 'Intent to return' development applies only to the continued exclusion of property which met the definition of the individual's home prior to the time the individual left the property. See SI 01130.100A.2. for the definition of 'home.'

Policy memorandum dated February 15, 2008, Transmittal No.: C-08-02-0004 from Nathan Lewis, chief, program policy, titled "Evaluating Principal Place of Residence and Intent to Return For Institutional Care Program Medicaid" in part states:

> This memorandum provides guidance on how to evaluate real property as an individual's principal place of residence when determining if it may or may not be excluded based on an intent to return...
> An individual's principal place of residence may be excluded during an extended absence if the individual has an intent to return to the home. This exclusion only applies if the property served as the individual's principal place of residence prior to nursing home admission.

The petitioner argued that the home replacement policy carried over to the petitioner's replacement residence, as the home was replaced within the Department's requisite three month period. The petitioner also argued that the Florida's homestead exemption is a constitutionally protected right under Article X, Section 4 of the Florida

Constitution and that Florida's homestead exemption not only protects an individual's primary residence, the exemption also protects the proceeds if used to purchase a replacement residence.

The Department argued that the excluded home provision does not apply to a home that the petitioner did not live in and own prior to entering the nursing facility and that the petitioner cannot intend to return to a home she never lived in.

The above cited SSI POMS discusses the home replacement policy and explains that the use of proceeds to pay other costs will warrant their exclusion if such costs are identified and documented prior to occupancy. The hearing officer concludes that this policy allows for a home to be replaced; however the replacement home must then be evaluated under ICP Medicaid policy. The applicable ICP policy addressing the exclusion of a home has been cited above and is being relied upon by the hearing officer.

The home is excluded for ICP Medicaid when the individual is temporarily absent and intends to return. The POMS manual notes that the intent to return development only applies to the continued exclusion of property that met the definition of a "home" prior to the individual's entry into a nursing facility. This is reiterated in the policy manual at 1640.0543.01 cited above that requires the person to have lived in the home for "intent to return" to apply as an exclusion for ICP. Additionally, the Department's memorandum dated February 15, 2008, states that the exclusion of the individual's principal place of residence applies only if the property served as the individual's principal place of residence prior to nursing home admission.

Whether or not the petitioner's property meets the Florida homestead exemption is not relevant as it is not considered in determining the home property and/or the principal place of residence under ICP Medicaid policy.

Based on the above-cited authorities, the hearing officer concludes that for the replacement home to meet the asset exclusion of "intent to return" the individual must have lived in the home first. An individual cannot return to a home he or she never lived in. Therefore, the hearing officer can only conclude that the Department correctly determined that the mobile home purchased on April 2, 2007, cannot be excluded under the "intent to return home" provision. Additionally, there was no evidence presented by the petitioner that the property at issue met any of the ICP Medicaid asset exclusions. Therefore, it is concluded that the Department was correct to terminate the ICP Medicaid, as the value of the mobile home exceeded the asset limit of $2,000.

DECISION

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

NOTICE OF RIGHT TO APPEAL

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

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DEPT. OF CHILDREN & FAMILIES

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

APPEAL NO. 08F-06869

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 31, 2008, at 8:30 a.m., in Fort Lauderdale, Florida. The petitioner was not present. He was represented by his mother[redacted] Also present was[redacted] nurse from the[redacted] The respondent was represented by Ken Hamlin, program operations administrator. Present on the telephone from Kepro was Dr. Ratesh Mical, and Edna Clifton, operations manager.

ISSUE

At issue is the Agency's September 24, 2008 action of approving the petitioner's skilled home nursing services for 3,525 hours, and denying 795 hours from September 21, 2008 to March 19, 2008. The petitioner has the burden of proof.

FINDINGS OF FACT

1. The petitioner, date of birth is 17 years old. He is a Medicaid benefits recipient in Broward County, Florida.

2. Included in the evidence is a copy of a Recipient Denial Letter that is dated September 24, 2008, stating that 3,525 hours of skilled home nursing services were approved, and 795 hours were denied for the petitioner from September 21, 2008 to March 19, 2008.

3. Included in the evidence is a copy of a Recipient Reconsideration Denial Upheld Letter dated October 6, 2008. This notice informs the petitioner that upon reconsideration, the approval of 3,525 hours of skilled home nursing services, and the denial of 795 hours from September 21, 2008 to March 19, 2008, was upheld.

4. Included in the evidence is a copy of a Kepro Internal Focus Review Findings form dated September 23, 2008, stating that skilled home nursing services of 24 hours 7 days per week were requested for the petitioner.

5. Included in the evidence is a copy o of a Kepro Synopsis of Case form stating that taking into account the petitioner's mother's work schedule, the following skilled home nursing services hours were approved for him: Mondays through Fridays 7:00 a.m. to 7:00 p.m., and 10:00 p.m. to 7: 00 a.m., and on the weekends, 12 noon to 6:00 p.m., and 10:00 p.m. to 7:00 a.m.

6. According to the Internal focus Review Findings form, the petitioner was diagnosed with Autism, Cerebral Palsy, seizures, and tracheostomy. He uses a G-tube for nutrition, a suction machine, a pulse oximeter, and a nebulizer machine.

7. According to the petitioner's mother, in addition to the petitioner and herself, the household consists of the petitioner's step father, who works, and a 1½ year old sibling, for a household size of four people.

8. At the hearing, Dr. Mical offered to have 24 hours 7 days per week skilled home nursing care for the petitioner for the next 60 days, if the petitioner's mother agrees to receive training on how to take care of her son using the various machines that are utilized by the petitioner. The petitioner's mother agreed to this arrangement.

CONCLUSIONS OF LAW

By agreement between the Agency for Health Care Administration and the Department of Children and Families, the Agency for Health Care Administration has conveyed jurisdiction to the Office of Appeal Hearings to conduct this hearing pursuant to Chapter 120.80 F.S. Fla. Admin. Code 59G-1.010 states in part:

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

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

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

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

The Home Health Services Coverage and Limitations Handbook explains on page 2-15 that private duty nursing services must be ordered by the attending physician, and documented as medically necessary. Physicians at Kepro for the Agency, approved the petitioner for skilled home nursing services of 3,525 hours, and denied 795 hours for the time period of September 21, 2008 to March 19, 2008.

Skilled home nursing services of 24 hours 7 days per week were requested for the petitioner. At the hearing, Dr. Mical offered to have 24 hours 7 days per week skilled home nursing care for the petitioner for the next 60 days, if the petitioner's mother agrees to receive training on how to take care of her son using the various machines that are

utilized by the petitioner. The petitioner's mother agreed to this, and the hearing officer agrees with this plan. Since the issue is resolved in favor of the petitioner for the 60 days agreement, the appeal is granted.

DECISION

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

NOTICE OF RIGHT TO APPEAL

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

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

in Tallahassee, Florida.

Stuart Imberman

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

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DEPT. OF CHILDREN & FAMILIES

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

APPEAL NO. 08F-06359

PETITIONER,

Vs.

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

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on October 21, 2008, at 9:05 a.m., in Tampa, Florida. The petitioner was not present. He was represented by his mother, [redacted]. The respondent was represented by David Beaven, program analyst. Witnesses for the respondent from Keystone Peer Review Organization (KePRO) were Robert A. Buzzeo, M.D. consulting physician, and Edna Clifton, quality manager.

After taking testimony, the record was closed. Additional evidence was received from the petitioner on October 30, 2008. The record was not left open for additional evidence. The evidence was regarding the mother's medical condition. The mother's medical condition was already considered and not disputed by the respondent; the additional evidence was not considered by the hearing officer and not entered into record.

ISSUE

The petitioner is appealing the notice of September 29, 2008 for the respondent's action to deny 720 hours of private duty nursing for the period of September 10, 2008 through March 8, 2009. The respondent has the burden of proof.

FINDINGS OF FACT

1. The petitioner care is medically complex. The petitioner is 14 years old. He was receiving Medicaid private duty nursing sixteen hours a day seven days a week for the period that ended on September 9, 2008. The hours were 7:00 a.m. to 11:00 p.m. From 11:00 p.m. to 7:00 a.m., the petitioner apparently has nursing services provided through the Medicaid Developmental Disabilities Waiver Program. The petitioner's mother is his primary caregiver. The petitioner's mother is working. The mother is capable of caring for the petitioner. The step-father lives in the home. He helps when available but is not fully trained in the petitioner's care.

2. The provider for private duty nursing is ;ome Health. The provider, on behalf of the petitioner, requested 2,880 hours of private duty nursing for the 60 day period of September 10. 2008 through March 8, 2009. The provider reported that the petitioner works 6:00 a.m. to 2:30 p.m.

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

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

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

5. The initial physician consultant determined the provider failed to provide sufficient documentation. All 2,880 hours were denied. The respondent sent the petitioner a PDN/PC Recipient Denial Letter on September 16, 2008.

6. The provider requested a reconsideration. A second physician consultant reviewed the reconsideration. The physician consultant's decision was to approve 12 hours a day from 7:00 a.m. to 7:00 p.m. The recommendation was to approve 2,160 hours and deny 720 hours for the period of September 10. 2008 through March 8, 2009. The 720 hours denied would be the hours from 7:00 p.m. to 11:00 p.m. The physician review recommended that the skilled nursing could be replaced by a HHA (home health aide) assisting the mother.

7. On behalf of the petitioner, the mother is requesting 16 hours a days of private duty nursing from 7:00 a.m. to 11:00 p.m. The mother based her request on the following. She is working 7:00 a.m. to 4:00 p.m. She is having back problems for which she takes medication. She does not take the medication

during the day. Her back hurts due to sitting with the petitioner when providing his care and medication. She needs to take the medication due to her pain but cannot as it makes her drowsy. If she becomes drowsy she cannot care for her son and needs someone to be there for her son.

8. The reviewers agreed that skilled nursing was not medically necessary. The reviewers agreed that if the petitioner applied for a home health service that service could be provided during the hours of 7:00 p.m. to 11:00 p.m.

CONCLUSIONS OF LAW

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

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

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

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

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

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

The Home Health Services Coverage and Limitation Handbook under Covered Services for Children (page 2-9)

Medicaid reimburses for the following services provided to eligible recipients under age 21 years:
Licensed nurse and home health aide visits;
Private duty nursing;
Personal care;

The Home Health Services Coverage and Limitation Handbook defines personal care service (page 2-21):

Personal care services are to provide medically necessary assistance with activities of daily living that support a recipient's medical care needs.

The mother is available and capable of providing care to the petitioner from 7:00 p.m. to 11:00 p.m. with assistance due to possible drowsiness from her medication. The recommendation of the reviewers was for either home health aid or personal care services which are basically the same service. It would be up to the home care provider to apply for one or both of these services. Therefore, service could be provided during the hours of 7:00 p.m. to 11:00 p.m. by either personal care or home health aide service. Personal care and home health aide services are less costly services than a private duty nurse while still meeting the needs of the petitioner. Therefore, private duty-nursing request does not meet the definition of medical necessity. Based on the above-cited authorities, the respondent's action to deny 720 hours of private duty nursing for the period of September 10, 2008 through March 8, 2009 was within the rules of the Program.

DECISION

This appeal is denied.

NOTICE OF RIGHT TO APPEAL

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

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

in Tallahassee, Florida.

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

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DEPT OF CHILDREN & FAMILIES

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

APPEAL NO. 08F-06146

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 22, 2008, at 10:55 a.m., in Miami, Florida. The petitioner was not present. She was represented by her mother, [redacted] Jeffrey Douglas, program operations administrator, Agency for Health Care Administration (AHCA), represented the respondent. Witnesses for the respondent from Keystone Peer Review Organization (KePRO) were Rakesh Mittel, M.D., consulting physician, and Edna Clifton, register nurse, KePRO. [redacted] interpreted for the petitioner.

ISSUE

At issue is the respondent's action of September 2, 2008, to deny the petitioner 52 hours of private duty nursing (PDN) services of 4,320 requested for

the certification period August 28, 2008 to February 22, 2009. The petitioner has the burden of proof.

FINDINGS OF FACT

1. The petitioner is a thirteen year old recipient of Medicaid benefits who has been diagnosed with cerebral palsy and respiratory distress syndrome. She is deaf, blind and non-verbal. The petitioner has a tracheotomy and is ventilator dependent.

2. The petitioner's mother is a single mother. She works from 7:00 a.m. to 9:00 p.m., Monday through Friday. There are no siblings at home.

3. Prior to review under challenge, the petitioner received 4,320 hours of PDN services. On August 28, 2008, Alliance Home Health Inc, as the provider, submitted a request on behalf of the petitioner for 4,320 hours of private duty nursing for the period of August 28, 2008 to February 22, 2009.

4. The provider indicated on the request for PDN services that the petitioner's mother has been trained in her care in an emergency and that she participates in her care.

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

6. On September 2, 2008, a board certified pediatric specialty physician consultant reviewed the request for PDN services. Based on the information

provided, the physician consultant recommended petitioner's mother cover two hours from 7:00 p.m. to 9:00 p.m. on Sundays when she is not working.

7. On September 2, 2008, the respondent approved 4,268 hours of private duty nursing and denied 52 hours pursuant to rule 59G-4.130.

8. Reconsideration occurred on September 14, 2008, and the original decision was upheld. The petitioner disagreed with this decision and a hearing was requested on September 17, 2008.

9. The respondent explained that the agency's decision was based on the information provided by the petitioner's service provider that the petitioner's mother has been trained in the care of the petitioner, including the care of the tracheostomy and G tubes, and that there are not siblings at home.

10. The petitioner's mother purported that she suffers from panic when she is alone with her daughter. She explained that her daughter uses a lot of machines and devises and she does not know how to handle them. She explained that her daughter sometime pulls out her tracheostomy and GT tubes and she is very concerned because she knows that she will not be able to replace them. The petitioner's representative asserted that [redacted] care is very complex and she does not have the skills necessary to care for her.

11. Included in the evidence is a letter from petitioner's treating physician, [redacted] M.D., explaining [redacted] medical condition and requesting that skilled nursing service be provided daily for 24 hours.

CONCLUSIONS OF LAW

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

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

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

The Home Health Services Coverage and Limitations Handbook (July 2007), page 2-17 states in part:

> *Private Duty Nursing Definition*
> Private duty nursing services are medically necessary skilled nursing services that may be provided in a child's home or other authorized settings to support the care required by the child's complex medical condition.
>
> *Parental Responsibility*
> Private duty nursing services are authorized to *supplement* care provided by parents and caregivers. Parents and caregivers *must*

> participate in providing care to the fullest extent possible. Training can be offered to parents and caregivers to enable them to provide care they can safely render. Medicaid does not reimburse private duty nursing services provided solely for the convenience of the child, the parents or the caregiver.

Fla. Admin. Code 65-2.056, **Basis for Hearings**, states in part:

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

The respondent, through KePRO, took action on September 2, 2008, to deny 52 hours (two hours per week) of PDN for the period of August 28, 2008 to February 22, 2009.

The petitioner's mother has provided relevant and credible testimony indicating she is unable to care for the petitioner. Evidence did not establish the petitioner's representative was capable of providing the skills necessary to care for her daughter. While the respondent may have followed acceptable review guidelines, the de novo evidentiary standards preclude a conclusion that the denial has been justified by adequate evidence. Therefore, it is concluded that the denial has not been justified.

Careful consideration of the proper authorities and evidence, including the petitioner's diagnosis and condition, and the petitioner's mother incapability to care for the petitioner were taken into account in making this decision

DECISION

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

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 12th day of November, 2008,

in Tallahassee, Florida.

Alfredo Fernandez

Alfredo Fernandez
Hearing Officer
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