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

PETITIONER,

APPEAL NO. 09F-05020

Vs.

AGENCY FOR HEALTH CARE
ADMINISTRATION (AHCA)
CIRCUIT: 18 Seminole
RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned at 11:30 a.m. on September 9, 2009, in Orlando, Florida. The petitioner was not present but was represented by her daughter, The respondent was represented by Lisa Sanchez, senior human service program specialist, with telephone testimony from , also with , was a telephone observer. Arrangements were made during the hearing, for the participants to receive handbook or policy information relevant to the matter under challenge. That information was received and labeled as Respondent's Exhibit 2.

ISSUE

At issue was whether denial of two hours daily (weekdays) morning home health care was correct under the Medicaid long-term care community diversion pilot project. The petitioner bears the burden of proof.

FINDINGS OF FACT

1. The petitioner is profoundly ill and received hospice care while living at home. She lives with her daughter. Her daughter is not able to provide all the care she needs. That is undisputed.

2. Hospice is a service available under Medicare to those who qualify. Bathing assistance is available under hospice five times a week, along with two weekly visits from a nurse. The bathing assistance, according to the daughter, is limited to only twenty or thirty minutes. When hospice bath assistance is used, it creates a number of separate care providers coming to the home. Traffic in and out of the home is excessive, from the daughter's point of view. Also, as shown in Petitioner's Exhibit 1, "second day in a row...mom slept thru her bath visit...2 baths from them and we/hospice, agreed to temporarily stop their bath...I did cancel the bath..." given under Medicare hospice.

3. The petitioner has a long-term care insurance policy and Medicare. These provide for some daily care and assistance, but not 24 hours per day.

4. Due to her health, the petitioner is at risk of nursing home placement. Nursing home placement is often more costly than care at home. The petitioner applied for the Medicaid long-term care community diversion pilot project through . Benefits were approved.

5. authorized and provides home health aide for two hours at night, seven days a week, between 9:00 – 11:00.

6. The long-term care coverage provides daily care for seven to eight hours. (Testimony of the daughter was the coverage was seven hours daily, but Petitioner's Exhibit 1, repeatedly showed seven and a half hours a day.)

7. The petitioner requested two additional morning hours of home health aide service, particularly for bathing. The request was denied with a letter issued on July 8, 2009. In part, it informed:

> will be providing two hours of care in the mornings on days that Hospice is not providing care and we will provide 2 hours of care in the evenings....

A few days earlier, had informed that if the daughter was unable to "provide intermittent care" then they might "encourage you to explore local assisted living facilities..." The correspondence is included in Respondent's Exhibit 1.

8. Petitioner's Exhibit 1 includes a narrative and e-mail correspondence from the daughter to media plus individuals in and outside the AHCA - network. In the correspondence, the daughter described aka Medicare." It is noted that is not a Medicare service; it is an option available under the Medicaid Long Term Care Nursing Home Diversion Waiver Program. The e-mails note the petitioner "has been ordered by her doctor to have 24/7 hours watch...."

CONCLUSIONS OF LAW

By agreement between the Agency for Health Care Administration (AHCA) and the Department of Children and Families, AHCA has conveyed jurisdiction to

the Office of Appeal Hearing to conduct this hearing pursuant to Florida Statute, Chapter 120.80.

Florida Statute 409.912 addresses **Cost-effective purchasing of health care** and informs "The agency shall purchase goods and services for Medicaid recipients in the most cost-effective manner consistent with the delivery of quality medical care. ..." Florida Statute 409.913 addresses **Oversight of the integrity of the Medicaid program**, with (1)(d) informing that "...For purposes of determining Medicaid reimbursement, the agency is the final arbiter of medical necessity." Thus, decisions regarding Medicaid reimbursement to providers become part of an administrative review process.

Florida Statute 430.705 addresses the "**Implementation of the long-term care community diversion pilot projects**." Section (2)(a) says that the project is designed to "maximize the placement of participants in the least restrictive appropriate care setting." Section (10) says the Department "...is authorized to adopt any rules necessary to implement and administer the long-term care community diversion pilot projects..."

Consistent with statute, the Florida Administrative Code informs:

> **59G-4.130 Home Health Services.**
> (1) This rule applies to all home health agencies licensed under Chapter 400, Part III, F.S., and certified by the Agency for Health Care Administration for participation in the Medicaid program for home health care.
> (2) All home health agency providers enrolled in the Medicaid program must be in compliance with the Florida Medicaid Home Health Services Coverage and Limitations Handbook, July 2008, incorporated by reference, and the Florida Medicaid Provider Reimbursement Handbook, CMS-1500, which is incorporated in Rule 59G-4.001, F.A.C. ...

Florida Administrative Code 59G-1.010 (166) (a) says that in order for a service to be medically necessary, it must meet the following conditions:

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

These rules are restated and clarified in the Home Health Services Coverage and Limitations Handbook chapter 2, page 15 as follows:

> **Home Health Aide Service Requirements**
> Home health aide services may be reimbursed only when they are:
> • Ordered by the attending physician;
> • Documented as medically necessary;
> • Provided by an appropriately trained aide;
> • Consistent with the physician approved plan of care; and
> • Delegated in writing and provided under the supervision of a registered nurse.

After careful review of evidence, statutes, and regulatory guidelines, it cannot be concluded that an additional two hours daily of home health aide in the morning has been justified. While there is an indication that a doctor would prefer the petitioner receive around the clock "watch" such would not necessarily mean she needs a home health aide for the additional two hours. Further, no physician order for greater number of hours was presented. If it were presented,

it would be considered along with Medicare services already available. However, doctor's order would not automatically ensure authorization of the petitioner's request. Evidence simply does not establish medical necessity for the Medicaid waiver to provide the additional care. For these reasons, it is concluded the denial was justified.

DECISION

The appeal is denied and the respondent'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 29th day of October, 2009, in Tallahassee, Florida.

J W Alper
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
850-488-1429

Copies Furnished To: