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

PETITIONER,

Vs.

FLORIDA DEPT OF
CHILDREN AND FAMILIES
CIRCUIT: 11 Dade
UNIT: 88601

RESPONDENT.

_______________________________/

APPEAL NO. 11F-00065

CASE NO. 1012358551

FILED
Mar 31, 2011
OFFICE OF APPEAL HEARINGS
DEPT. OF CHILDREN AND FAMILIES

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing in the above-referenced matter on March 14, 2011, at 10:38 a.m., in Miami, Florida.

APPEARANCES

For the Petitioner: The petitioner did not appear. , Director of Admissions for appeared as authorized representative.

For the Respondent: Paula Heno, second party reviewer (SPR) with Department of Children and Families of the Institutional Care Program (ICP) unit.

STATEMENT OF ISSUE

The petitioner is appealing the denial by the respondent of Institutional Care Program (ICP) benefits, due to the lack of a level of care (LOC) determination.

PRELIMINARY STATEMENT

On December 27, 2010, the respondent informed the petitioner that his ICP benefits were denied. On January 4, 2011, the petitioner timely requested a hearing to challenge the denial.

Emmanuel Meniru, CARES representative appeared as a witness for the respondent.

[redacted] director of nursing; [redacted] social services; and [redacted] ASAR Coordinator from [redacted] Care Center all appeared as witnesses for the petitioner.

Entered into evidence is Respondent's Exhibit 1 and 2.

Entered into evidence is Petitioner's Exhibit Composite 1.

FINDINGS OF FACT

1. The petitioner (age 68) has been a resident at [redacted] Center, since March 25, 2010.

2. On April 2, 2010, a Level I screening/determination was conducted by [redacted] Center and it was determined a Level II determination was required due to petitioner's mental illness.

3. On April 2, 2010, a Level II determination was requested by [redacted] Center for petitioner.

4. On April 9, 2010, the petitioner applied for ICP benefits. The director of admissions at [redacted] was designated by the petitioner to be his

representative in the application process. The request was for ICP benefits starting April 2, 2010.

5. On April 12, 2010, the respondent mailed a request for information to the facility, which also indicates an evaluation by the Department of Elder Affairs CARES Unit is required to determine if the petitioner needs the services provided by the nursing facility.

6. APS Healthcare PASRR/MI Level II determination Summary, dated September 14, 2010, on the petitioner indicates both CARES and [redacted] Center were notified of a disposition stating, *"…Administrative Close due to incomplete documentation…"*

7. Handwritten notations on Determination Summary Report indicate the facility refaxed documentations on September 27, 2010.

8. APS Healthcare PASRR/MI Level II determination Summary, dated October 2, 2010, on the petitioner indicates both CARES and [redacted] Center were notified of a disposition stating, *"…Thank you for the requested information, however the SS Quarterly Note received was only page 2 of 2. It is missing page 1 and it was not dated. Please send the complete SS Quarterly Note…"*

9. Handwritten notations on Determination Summary Report indicate the facility refaxed documentations on October 5, 2010.

10. By notice dated October 11, 2010, APS Healthcare acknowledged the receipt of Level II referral packet and requested necessary clinical documentation stating:

> In order to complete the PASRR/MI Level II Review, we are requesting you fax the following information: Thank you for the additional information provided however please still address aspects of the following given resident's reported history: Please provide

> follow up psychiatric/Psychological assessments (since 08/24/10) indicating mental status and care and also current nursing (last week summary on 09/02/10) and social services notes (last quarterly on 07/13/10) through the date of faxing indicating mood and behavior and care…This information should be faxed as quickly as possible, but no later than by close of business on 10-13-2010.

11. The facility left a message on October 12, 2010 and again on October 13, 2010, but received no response.

12. By Notice of PASSR/MI Determination, dated October 13, 2010, APS Healthcare notified both CARES and the facility that they were unable to complete petitioner's review due to incomplete documentation.

13. On December 27, 2010, CARES Department of Elders Affairs unit provided the facility with Notification of Level of Care which indicates the petitioner does not meet LOC. This document includes comments stating, "…No evidence provided supporting medical necessity for …services on a 24/7 basis. No need for assistance at any level…"

14. The petitioner requested a hearing disputing the respondent's denial of ICP benefits for April 2010.

CONCLUSIONS OF LAW

15. 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.

16. In accordance with Fla. Admin. Code § 65-2.060(1), the burden of proof was assigned to the petitioner.

17. The ACCESS Policy Manual sets forth appropriate placement and who determines placement in the following passages:

> 1440.1300 APPROPRIATE PLACEMENT (MSSI)
>
> To qualify for the Institutional Care Program (ICP) or Home and Community Based Services (HCBS), or the Program for All-Inclusive Care for the Elderly (PACE), the individual must meet special institutional eligibility criteria, including “appropriate placement.”
>
> Appropriate placement means that an individual must be placed in a facility or program certified to provide the type and level of care the Department has determined the individual requires.
>
> Two basic requirements must be met for placement to be considered appropriate. These are:
>
> 1. the person must be determined by the Department to be medically in need of the type of care provided by the specific program, and
>
> 2. the person must be actually receiving the services (or for HCBS, must be enrolled in the waiver) which the Department has determined that the individual needs.
>
> To be appropriately placed for ICP, a person must have been determined in need of an ICP level of care (by CARES) and actually be placed in a Medicaid facility which provides the specified level of care. No level of care is required for a QMB eligible individual (Medicaid eligible individual with income less than the federal poverty level) in a nursing home during the Medicare coverage period.
>
> …Note: The need for a level of care or the need for waiver services is verified in the case record by the same form, DOEA CARES Form 603, the Notification of Level of Care.
>
> 1440.1302 Who Determines Need for Placement (MSSI)
>
> The agency or office responsible for determining the need for care depends on the applicant's age and what kind of facility or program is needed. After the eligibility specialist requests a determination, he

must receive DOEA CARES Form 603 (Notification of Level of Care) from the responsible office to document the specific need in the case record.

Note: The eligibility specialist does not request level of care decisions for HCBS waivers but must receive documentation of decisions from case managers or CARES.

The determination will be obtained from one of the following offices:

CARES (Comprehensive Assessment and Review for Long Term Care Services), Department of Elder Affairs:

1. For ICP: determines Level of Care for applicant/recipients over age 21 in nursing facilities, swing beds or hospital based nursing facility beds. …

18. The Code of Federal Regulations at 42 C.F.R. § 483.128 sets forth the rule for Preadmission screening and Annual review for Mental illness.

(a) Level I: Identification of individuals with MI or MR. The State's PASARR program must identify all individuals who are suspected of having MI or MR as defined in Sec. 483.102. This identification function is termed Level I. Level II is the function of evaluating and determining whether NF services and specialized services are needed. The State's performance of the Level I identification function must provide at least, in the case of first time identifications, for the issuance of written notice to the individual or resident and his or her legal representative that the individual or resident is suspected of having MI or MR and is being referred to the State mental health or mental retardation authority for Level II screening.
(b) Adaptation to culture, language, ethnic origin. Evaluations performed under PASARR and PASARR notices must be adapted to the cultural background, language, ethnic origin and means of communication used by the individual being evaluated.
(c) Participation by individual and family. PASARR evaluations must involve--
(1) The individual being evaluated;
(2) The individual's legal representative, if one has been designated under State law; and
(3) The individual's family if--
(i) Available; and
(ii) The individual or the legal representative agrees to family participation.
(d) Interdisciplinary coordination. When parts of a PASARR

evaluation are performed by more than one evaluator, the State must ensure that there is interdisciplinary coordination among the evaluators.

(e) The State's PASARR program must use at least the evaluative criteria of Sec. 483.130 (if one or both determinations can easily be made categorically as described in Sec. 483.130) or of Sec. Sec. 483.132 and 483.134 or Sec. 483.136 (or, in the case of individuals with both MI and MR, Sec. Sec. 483.132, 483.134 and 483.136 if a more extensive individualized evaluation is required).

(f) Data. In the case of individualized evaluations, information that is necessary for determining whether it is appropriate for the individual with MI or MR to be placed in an NF or in another appropriate setting should be gathered throughout all applicable portions of the PASARR evaluation (Sec. Sec. 483.132 and 483.134 and/or Sec. 483.136).

The two determinations relating to the need for NF level of care and specialized services are interrelated and must be based upon a comprehensive analysis of all data concerning the individual.

(g) Preexisting data. Evaluators may use relevant evaluative data, obtained prior to initiation of preadmission screening or annual resident review, if the data are considered valid and accurate and reflect the current functional status of the individual. However, in the case of individualized evaluations, to supplement and verify the currency and accuracy of existing data, the State's PASARR program may need to gather additional information necessary to assess proper placement and treatment.

(h) Findings. For both categorical and individualized determinations, findings of the evaluation must correspond to the person's current functional status as documented in medical and social history records.

(i) Evaluation report: Individualized determinations. For individualized PASARR determinations, findings must be issued in the form of a written evaluative report which--

(1) Identifies the name and professional title of person(s) who performed the evaluation(s) and the date on which each portion of the evaluation was administered;

(2) Provides a summary of the medical and social history, including the positive traits or developmental strengths and weaknesses or developmental needs of the evaluated individual;

(3) If NF services are recommended, identifies the specific services which are required to meet the evaluated individual's needs, including services required in paragraph (i)(5) of this section;

(4) If specialized services are not recommended, identifies any specific mental retardation or mental health services which are of a

lesser intensity than specialized services that are required to meet the evaluated individual's needs;

(5) If specialized services are recommended, identifies the specific mental retardation or mental health services required to meet the evaluated individual's needs; and

(6) Includes the bases for the report's conclusions.

(j) Evaluation report: Categorical determinations. For categorical PASARR determinations, findings must be issued in the form of an abbreviated written evaluative report which--

(1) Identifies the name and professional title of the person applying the categorical determination and the data on which the application was made;

(2) Explains the categorical determination(s) that has (have) been made and, if only one of the two required determinations can be made categorically, describes the nature of any further screening which is required;

(3) Identifies, to the extent possible, based on the available data, NF services, including any mental health or specialized psychiatric rehabilitative services, that may be needed; and

(4) Includes the bases for the report's conclusions.

(k) Interpretation of findings to individual. For both categorical and individualized determinations, findings of the evaluation must be interpreted and explained to the individual and, where applicable, to a legal representative designated under State law.

(l) Evaluation report. The evaluator must send a copy of the evaluation report to the--

(1) Individual or resident and his or her legal representative;

(2) Appropriate State authority in sufficient time for the State authorities to meet the times identified in Sec. 483.112(c) for PASs and Sec. 483.114(c) for ARRs;

(3) Admitting or retaining NF;

(4) Individual's attending physician; and

(5) The discharging hospital if the individual is seeking NF admission from a hospital.

(m) The evaluation may be terminated if the evaluator finds at any time during the evaluation that the individual being evaluated--

(1) Does not have MI or MR; or…

19. The Code of Federal Regulations at 42 C.F.R. § 483.112 sets forth the rule for Preadmission screening of applicants for admission to Nursing Facilities:

(a) Determination of need for NF services. For each NF applicant with MI or MR, the State mental health or mental retardation

> authority (as appropriate) must determine, in accordance with Sec. 483.130, whether, because of the resident's physical and mental condition, the individual requires the level of services provided by a NF.
> (b) Determination of need for specialized services. If the individual with mental illness or mental retardation is determined to require a NF level of care, the State mental health or mental retardation authority (as appropriate) must also determine, in accordance with Sec. 483.130, whether the individual requires specialized services for the mental illness or mental retardation, as defined in Sec. 483.120.
> (c) Timeliness--(1) Except as specified in paragraph (c)(4) of this section, a preadmission screening determination must be made in writing within an annual average of 7 to 9 working days of referral of the individual with MI or MR by whatever agent performs the Level I identification, under Sec. 483.128(a) of this part, to the State mental health or mental retardation authority for screening. …

20. Based on the above governing authorities, the nursing facility staff prescreens the individual for the presence of mental illness. Once the individual has been determined to have a mental illness the individual is then referred to an APS Healthcare staff that screens the individual's need for nursing home care, giving them a level of care which is forwarded to the CARES staff. The APS Healthcare staff's decision hinges upon the receipt of required documentations from the nursing facility. The respondent's decision to approve ICP benefits is based on the level of care decision received through CARES, originating from the APS Healthcare staff.

21. As the Findings of Facts shows, the nursing facility was notified by APS Healthcare on September 14, 2010, October 2, 2010 and October 13, 2010 of missing documentation required to complete the determination of LOC for the petitioner. APS Healthcare acknowledged the receipt of documents on October 10, 2010, that were requested on September 14, 2010; and on October 13, 2010 that were requested on

October 10, 2010. However, there was no evidence provided that APS received all the documents requested on October 13, 2010, or that they were provided by the nursing facility.

22. The petitioner argues they provided all requested documentation to APS in order to obtain a LOC for the petitioner. The petitioner explained several attempts to contact APS Healthcare by phone on their final request for documents were made, but have all gone unanswered.

23. The respondent contends the nursing facility is responsible for providing the required documentation to APS Healthcare, in order for a LOC to be determined for the petitioner. Therefore, without the APS decision on the LOC status, they are unable to approve ICP benefits.

25. Based on the above cited authorities and evidence presented, the respondent's action to deny ICP benefits for April 2, 2010 was within the rules of the Program, as they did not receive a LOC determination for the petitioner from APS Healthcare via CARES staff. Although, the petitioner argues there was a lack of communication between their office and APS Healthcare, the Findings of Fact shows they were in contact, through correspondences with APS Healthcare during September 2010 through October 2010. No evidence was presented during the hearing to indicate APS Healthcare's final request for documents on October 13, 2010 was provided. Therefore, the hearing officer finds concludes that the respondent's action was correct and is upheld.

DECISION

The appeal for the denial of ICP benefits by the respondent is denied.

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this ______ day of ________________________, 2011,

in Tallahassee, Florida.

____
Ida Smith
Hearing Officer
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