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

[redacted]

APPEAL NO. 11F-00126

PETITIONER,

Vs.

CASE NO. 1165675731

FLORIDA DEPT OF CHILDREN AND FAMILIES
CIRCUIT: 17 Broward
UNIT: 88139

FILED
Apr 4, 2011
OFFICE OF APPEAL HEARINGS
DEPT. OF CHILDREN AND FAMILIES

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on January 25, 2011, at 11:39 in Fort Lauderdale, Florida. The petitioner appeared by telephone and everyone else appeared in person.

APPEARANCES

For the Petitioner: [redacted].

For the Respondent: Freadda Zeigler, Program Operation Administrator with Department of Elder Affairs (DOEA).

STATEMENT OF ISSUE

The petitioner is appealing the Department's action of terminate/cancel her Home and Community Based Services Medicaid Waiver coverage based on the contention that she no longer meets the Level of Care (LOC) after a recent Annual Waiver Recertification Assessment.

PRELIMINARY STATEMENT

By notice dated December 29, 2010, the Department notified the petitioner that her Home and Community Based Services (HCBS) Medicaid Waiver coverage was being terminated because she no longer meets the Level of Care, therefore no longer meets Waiver criteria. The Department of Elder Affairs, Cares Unit is required to conduct periodic review to determine whether benefits should continue for individuals who are receiving assistance from them. As part of their service eligibility and delivery process, they conducted Annual Waiver Recertification on December 13, 2010 and, based on that Assessment, they concluded that the petitioner no longer meets the Level of Care; consequently she no longer meets Waiver criteria. On January 4, 2011, the petitioner timely requested a hearing to challenge the Department's action.

Appearing as a witness for the petitioner was [redacted], case manager I with [redacted] Appearing as a witness for the Department was Jimena Alegre, Cares assessor with the DOEA.

FINDINGS OF FACT

1. Prior to the action under appeal, and while the appeal is pending, the petitioner, age 64, was enrolled in the Home and Community Based Services (HCBS) Medicaid Waiver Program from 2001 and has received Medicaid under that program for several years.

2. The petitioner is currently receiving Waiver services from the [redacted] Some of the services provided included homemaking, companionship visits, personal care, as well as case management.

3. The petitioner became eligible for Waiver service after she was diagnosed with Multiple Sclerosis (MS) back in 1989 and colon cancer in 2001. She had made significant improvements since then and would like to continue getting these services to prevent a possible deterioration of her medical condition.

4. In July 2003, the petitioner had undergone an annual review and failed to meet the Level of Care. However, the petitioner was issued an exception, Respondent Exhibit 3, by a Cares Supervisor citing the cost of her medication and the seriousness of her condition. The letter reads in part: "As a result an exception will be made in this case and a LOC will be determined based on the medical condition that can deteriorate if medication is not available. This is a matter of safety and demonstrates the failure of the system that should provide the proper eligibility. **This is an exception, not the rule**." (emphasis added)

5. The petitioner has been receiving HCBS services for several years which have resulted in major improvements in her medical conditions. The petitioner has had part of liver removed and had undergone several rounds of chemotherapy treatments. The success of the treatments can be documented as the cancer has been in remission for years now. However, the petitioner still has Multiple Sclerosis (MS), a chronic medical condition that affects her activities of daily living due to limited ambulation.

6. On October 6, 2010 [redacted] the petitioner's case manager with [redacted] completed an Annual Reassessment instrument (DOEA Form 701B). [redacted] documented her visit in a report that reads in part:

> Consumer was awake, alert and oriented times three. She was dressed neat and clean and appropriate for the visit. Her apartment was neat and clean and free of items that would impede ambulation. Her ambulation is

> fairly slow, but steady. Consumer reported that she is doing well. She denied any recent ER visits or Hospitalizations…She states that she eats well but would like to receive Meals on Wheels since standing for long periods is difficult for her due to her Multiple Sclerosis… [redacted] continues to need the following MW-funded services to prevent/delay institutionalization: CM/CA 2 hrs/month, Homemaking 6 hrs/week provided through Neuheart and EARS provided through Lifeline. (Respondent Exhibit 1)

7. The report was created and forwarded to the CARES Unit on October 18, 2010. This report included home delivered meals through Meals on Wheels as an additional service.

8. The CARES assessor reviewed the submitted Assessment form and made the following observations:

a) Client relies on assistive device for ambulating.

b) Client needs no help with all other ADL's as well as no help taking medications.

c) Client had a diagnosis of Multiple Sclerosis and colon/liver cancer.

d) Client had surgery to remove part of her liver and her cancer has been in remission for years.

9. On November 2, 2010, the assessor called the petitioner/client to schedule an on-site Assessment for December 2, 2010. Due to the assessor being out sick that day, the visit was re-scheduled for December 13. 2010.

10. On December 13, 2010, the assessor went to the petitioner's home and completed her own DOEA Assessment Instrument form 701B (Respondent Exhibit 2). This Assessment Instrument was later transcribed onto the case recording form for per Agency procedures (Respondent Exhibit 4). The final Assessment report reads in part:

> Client was alert and oriented x3 during visit. Client was diagnosed with multiple sclerosis in 1989 (on disability since 91) and reports that she remains very independent. Currently client is only on one prescribed medication, baclofen, for her multiple sclerosis. Client reported she has traditional Medicare and Advantage Plus as her part D plan which covers her baclofen. Client also has arthritis and a hx of colon cancer. Client reported she was diagnosed with colon cancer in 2001 and underwent surgery to remove part of her colon and liver. Client stated she received chemotherapy for 6 months after the surgery and then found out it has spread to her spinal cord and chest. Client reported she then received 15 more months of chemotherapy and has been in remission for the last 5 years. Client stated she visits her oncologist every 3 months for necessary follow ups….Client required no help with dressing, eating and toileting and relies on assistive device for bathing, transferring and ambulating. Client needs no help with using the phone and managing money, relies on assistive device (pill minder) for taking medications, some help with light housekeeping, preparing meals, shopping and transportation and total help with heavy chores (Respondent Exhibit 4).

11. On December 13, 2010, the assessor requested a current Medical Certification for Nursing facility/Home and Community-Based Services Form (3008) from the petitioner's primary care physician (PCP), [redacted] MD. (Respondent Exhibit 5). On December 16, 2010, the response was faxed back to her. The report mentioned Multiple sclerosis (MS) as the primary diagnosis and metastatic colon cancer as the secondary diagnosis. Based on that primary care physician (PCP) most recent report and the CARES case assessor current report. The Department concluded that the petitioner does not meet the Level of Care.

12. On December 29, 2010, the final notice was signed by another physician and sent to the petitioner to explain that she does not meet the Level of Care (Respondent Exhibit 6). Therefore does not meet the Waiver criteria.

13. On January 4, 2011, the petitioner timely requested an appeal to challenge the Department's action on the above-referenced matter.

CONCLUSIONS OF LAW

14. The Department of Children and Families, Office of Appeal Hearings has jurisdiction over the subject matter of this proceeding and the parties, pursuant to Fla. Stat. § 409.285. This order is the final administrative decision of the Department of Children and Families under Fla. Stat. § 409.285.

15. This proceeding is a de novo proceeding pursuant to Fla. Admin. Code § 65-2.056.

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

17. Fla. Admin Code 59G-4.290 addresses Skilled Services eiligibility criteria in part:

> (1) Purpose. This rule establishes the level of care criteria that must be met in order for nursing and rehabilitative services to qualify as skilled services under Medicaid.
> (2) Definitions as used in this section.
> (a) Continuous. The need for 24-hour care in a skilled nursing facility with professional nursing services available.
> (b) Direct supervision. Performance of a procedure in the presence of professional personnel or their presence in the facility during the time in which the procedure is being performed.
> (c) Licensed nursing personnel. Registered professional or licensed practical nurses, currently licensed by the State of Florida to practice as a registered nurse or licensed practical nurse respectively.
> (d) Professional personnel. Florida licensed or certified physicians, registered nurses, respiratory care practitioners/therapists, audiologists, physical, occupational or speech therapists.
> (e) Rehabilitative services. Individualized services prescribed by a health care professional that are designed to restore a recipient to self-sufficiency or to the highest attainable functional level in the shortest possible time following an illness or injury.
> (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; and

6. Consistent with the nature and severity of the individual's condition or the disease state or stage.

(c) Examples of services that qualify as skilled nursing services:

1. Intravenous medication or fluids.

2. Intramuscular or subcutaneous injection and hypodermoclysis when:

a. Administered by licensed nursing personnel at least 5 times weekly, excluding daily insulin administration, and

b. Observation is necessary to assess the recipient's response to treatment or to identify adverse reactions.

3. Management and monitoring medication regime on a daily basis:

a. For drugs whose dosage requirements may rapidly change;

b. For drugs prone to cause adverse reactions, severe side effects or unfavorable reactions; and

c. For residents with unstable conditions.

4. Levin tube and gastrostomy feedings; excluding feedings performed by residents, family members, or friends.

5. Administration of medical gases, aerosolized medication or oxygen which is started, monitored and regulated by professional staff.

6. Naso-pharyngeal and tracheotomy aspiration, excluding tracheotomy care in self-care residents.

7. Insertion, replacement, and sterile irrigation of catheters when:

a. Medically necessary or required for reasons other than to maintain satisfactory catheter functioning and dryness;

b. The medical need is documented by the physician;

c. Continuous irrigation, frequent insertion, special care or observation is required because of bleeding, infection, obstruction, or heavy sediment formations; and

d. Care of a recently inserted supra-pubic catheter, inserted within 2-4 weeks, is required.

8. Colostomy and ileostomy care:

a. When medically necessary and required during early postoperative period;

b. During the period of initial self-care training; or

c. When complications are present and documented in the medical record.

18. Based on the above criteria, the Department concluded that the petitioner no longer meets the MW requirements and introduced Fla. Admin. Code 59G-4.290, Respondent Exhibit 7, as evidence.

19. The Department proceeded to explain the different levels of services and their eligibility criteria and introduced Fla. Admin. Code 59G-4.180, Respondent Exhibit 7, which governs Intermediate Care Services.

(c) Intermediate care services level II is limited health related care and services required by an individual who is mildly incapacitated or ill to a degree to require medical supervision. Individuals requiring this level of care shall:

1. Be ambulatory, with or without assistive devices,

2. Demonstrate independence in activities of daily living, and

3. Not require the administration of psychotropic drugs on a daily or intermittent basis or exhibit periods of disruptive or disorganized behavior requiring 24-hour nursing supervision.

(d) Examples of services, in addition to medical supervision, that qualify as intermediate care level II:

1. Administration of routine oral medication;

2. Assistance with mobilization, helping a resident maintain balance when transferring from bed to chair and providing necessary help when climbing steps or manipulating wheelchair in difficult places;

3. Assistance with bathing, that is, assembling towels, soap, and other necessary supplies, helping the recipient in and out of the bathtub or shower, turning the water on and off, adjusting water temperature, washing and drying portions of the body which are difficult for the recipient to reach and being available while the recipient is bathing himself;

4. Assistance with dressing, that is, helping the recipient to choose and to put on appropriate clean clothing, and fastening hooks, buttons, zippers and ties;

5. Assistance with meals, that is, helping with cutting up food and pouring beverages;

6. Assistance with grooming, that is, helping the recipient to shave, wash, comb and curl hair, and to clean and file fingernails and toenails. Fingernails or toenails should not be cut by the recipient unless approved by the physician;

7. Provision of social and leisure services which are arranged for and

individually designed to reduce isolation and withdrawal and to enhance communication and social skills;

8. Self-administration of medical gases, or alm edications, subcutaneous medication after a regimen of therapy has been established and self-administration approved by the physician;

9. Ongoing medical and social evaluations to determine the point when a recipient's progress has reached the stage at which medical and related needs can be met appropriately outside of the nursing facility or through alternative placement or services;

10. Application of dressings and treatments prescribed by the physician for small or superficial areas requiring a dressing;

11. Application of elastic stockings, when prescribed, if the recipient cannot manage independently;

12. Administration of oxygen or intermittent positive pressure breathing when prescribed by the physician and performed by the recipient;

13. Assistance with colostomy care, that is, helping the recipient care for permanent colostomy which the recipient ordinarily cares for;

14. Routine measurement and recording of vital signs and weights, including being alert to symptoms and readings corresponding to abnormal conditions of the residents;

15. Routine restorative and rehabilitation procedures, that is, the encouragement and incorporation of range of motion exercises in the daily activities schedule.

20. The Department explained that the petitioner's services are currently provided under an Intermediate Care Services Level II and that the petitioner no longer meets the criteria. The petitioner's witness insisted that her client sometimes refused services due to privacy issues. She fervently argued that these services are necessary for her client to maintain her quality of life and delay institutionalization. She referred to her client's EARS provided through the Lifeline as being very significant if an emergency should arise. The Department expressed concerns regarding potential medical emergencies, but explained they are bound by Federal regulations which they must follow. The petitioner's witness argued that termination of services could reverse her client's documented improvements and could deteriorate her condition. The Department explained back in 2003 the petitioner did not meet the Level of care, but was issued an

exception, Respondent Exhibit 3, solely based on medical necessity, namely the cost of the drugs associated with her treatments. The Department pointed out that she is only taking one prescribed medication for her MS she is not eligible for another exception. The Department explained that the petitioner could try to get services from Community Care for the Elderly (CCE). The petitioner's witness expressed concern about the long wait and the Department agreed to contact the agency head on their behalf to facilitate that transaction.

21. The Department's online Integrated Pub Policy Manual passage 1440.1300, states in part:

> To qualify for…Home and Community Based Services (HCBS)…the individual must meet special institutional eligibility criteria, including "appropriate placement."
> Appropriate placement means than 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.
>
> For Home and Community Based Services (HCBS), to be appropriately placed, a person must be in need of waiver services and be enrolled in the waiver as documented by form CF-ES 2515 with an appropriate case manager.
> **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. (**emphasis added**)**

22. Respondent Exhibit 6 shows that the petitioner does not meet the Level of Care based on current medical/personal needs.

23. Florida Administrative Code 65A-1.701, defines programs available to certain

individuals and states in part:

> (1) Aged and Disabled Adult Waiver Program/Home and Community-Based Services (ADA/HCBS): A Home and Community-Based Services (HCBS) waiver program for aged and disabled individuals in need of skilled or intermediate nursing care services.

24. The Findings of Fact show that the petitioner was previously enrolled and receiving services from the HCBS Waiver Program by [redacted] case management agency from November 3, 2007 to present. During those years she had made significant progress in achieving a certain level of independence and medical stability. Based on the petitioner's most recent Assessment instrument report (DOEA Form 701B) and her most current Medical Certification for Nursing Facility/Home and community-Based Services Form (AHCA Medserv 3008) from the petitioner's primary care physician (PCP), the Department concluded that the petitioner no longer meets the Level of Care. After reviewing the above-cited regulations and the testimonies of both parties, the undersigned concludes that the Department action to terminate/cancel the petitioner's eligibility for HCBS Medicaid Waiver coverage is correct.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the petitioner's appeal is denied and the Department's action upheld.

NOTICE OF RIGHT TO APPEAL

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

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

DONE and ORDERED this _____ day of _____, 2011,

in Tallahassee, Florida.

_____
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