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

APPEAL NO. 07F-03891

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 August 15, 2007, at 2:00 p.m., in Fort Lauderdale, Florida. The hearing was rescheduled from July 17, 2007, at the respondent's request. The petitioner was not present. She was represented by her mother . The Agency was represented by Sheila Samuels, registered nurse specialist. Present on the telephone from Kepro was Dr. Robert Buzzio, physician, and George Smith, review operations supervisor.

ISSUE

At issue is the Agency's May 25, 2007 action of reducing the petitioner's skilled home nursing services from 12 hours daily 7 days per week to 8 daily hours 7 days per week. The Agency has the burden of proof.

FINDINGS OF FACT

The petitioner is a child, date of birth [illegible] She has been receiving skilled home nursing services of 12 hours daily 7 days per week. Included in the evidence is a copy of a Recipient Denial Letter, dated May 25, 2007, stating that 240 hours of skilled home nursing services were denied, and 480 hours were approved for her from June 1, 2007 to July 30, 2007. Included in the evidence is a copy of a Recipient Reconsideration Denial Upheld notice dated June 15, 2007. This notice informed the petitioner that the denial of the 240 hours of skilled home nursing services was upheld, and that 480 hours was approved, which is 8 hours daily 7 days per week, effective June 1, 2007.

The notices sent to the petitioner explained that it was determined by Kepro that the medical care of the skilled home nursing services of 480 hours was determined to be medically necessary. Included in the evidence is a copy of a Kepro Internal Focus Review Findings report on the petitioner, dated May 21, 2007, stating that she was diagnosed with a short gestation, which was a 24 week gestation, disorders of phosphorus metabolism, newborn hemolytic disease, isoimmunization nec, primary apnea of newborn, and respiratory distress syndrome in newborn.

Included in the evidence is a copy of a Kepro Synopsis of Case report, concerning the reconsideration, dated June 5, 2007, recommending that the petitioner be provided with 480 hours of skilled home nursing services, and her mother can provide more independent care because she is not working. This was after a second board certified pediatrician reviewed the petitioner's medical records.

There was an additional reconsideration done on June 14, 2007, by the second board certified pediatrician, upholding the initial denial, and approving 8 hours daily 7 days per week of skilled home nursing services. At the hearing, the petitioner's mother asserted that she was planning to start school, but has not started yet. According to her, she plans to attend school Monday, Wednesday, and Friday, and is also looking for work. According to Robert Buzzio at the hearing, he agrees with the reduction of the skilled home nursing services for the petitioner.

CONCLUSIONS OF LAW

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 59G4.290 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. The petitioner was receiving skilled home nursing services of 12 hours daily 7 days per week, and it was determined that these services would be reduced to 8 hours daily 7 days per week, which is 480 hours from June 1, 2007 to July 30, 2007.

The Agency's determination takes into account what is medically necessary for the petitioner, and her mother's availability to help care for her. The physician that testified at the hearing agrees that the petitioner needs skilled home nursing care, and he agrees with the pediatric physician's determination of reducing the skilled home nursing services from 12 hours daily to 8 hours daily. After careful consideration, it is determined that the Agency's action to reduce the skilled home nursing services, is upheld.

DECISION

This 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 31st day of August, 2007,

in Tallahassee, Florida.

Stuart Imberman

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

Copies Furnished To: [illegible], Petitioner
Gail Wilk, Area 10 Medicaid Adm.

Karen Kinser, Nursing Consultant

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

APPEAL NO. 07F-03143

PETITIONER,

Vs.

CASE NO. 1243237481

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

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on July 26, 2007, at 10:45 a.m., in Riviera Beach, Florida. The petitioner was not present. Representing the petitioner was Stephen Hall, attorney. Appearing as witnesses were: , social services director; , social services assistant; and , nurse supervisor, all from Nursing and Rehabilitation Center. Representing the respondent was Terry Verduin, District 9 legal. Appearing as a witness was Idali Hilgenfeldt, specialist II.

An original hearing was convened September 9, 2006 on this matter. The Final Order of October 23, 2006 found the petitioner was not disabled for Institutional Care Program (ICP) Medicaid eligibility.

When this Final Order was appealed to the 4th District Court of Appeals, the respondent determined that the recording of the hearing was not clear enough so it requested that jurisdiction be relinquished pending the outcome of this hearing.

ISSUE

The petitioner is appealing the respondent's action to deny her Medicaid benefits in the Institutional Care Program (ICP) Medicaid on the basis that she did not meet the disability criteria. The petitioner has the burden of proof.

FINDINGS OF FACT

1. The petitioner is a fifty-seven year old (D[illegible]) resident of a nursing facility in [illegible] County, Florida. An application for Institutional Care Program (ICP) Medicaid benefits was submitted, on her behalf, May 23, 2006.
2. The petitioner had been admitted to the facility June 2005 following a two week stay at the psychiatric pavilion of [illegible]. The petitioner had been Baker Acted after a breakdown. She was and continues to be delusional and confused.
3. Because the petitioner was not 65 years old, she did not meet the aged criteria for eligibility. The respondent, therefore, completed a disability package and sent it to the District Medical Review Team (DMRT).
4. The DMRT completed their findings, based upon the medical information submitted, June 22, 2006. The DMRT notified the respondent that the petitioner did not meet the disability requirement for the Program because it felt the

"impairment is no longer severe at time of adjudication but not expected to last twelve months". This is noted by the code N34.

5. Based upon the DMRT's denial, the respondent denied the petitioner's application for ICP benefits.
6. As of the hearing date, applications were submitted to Social Security for both a disability determination and for Supplemental Security Income (SSI). Social Security denied both, not on the question of disability, but for assets exceeding their eligibility limits.
7. The petitioner established a special needs (qualified disabled) trust. However, because no disability determination was ever made, Social Security counts the funds in the trust as an asset.
8. The petitioner is disputing the findings of the DMRT. The petitioner has been diagnosed with Schizophrenia, Major Depression, Dementia, and hypertension. She receives medication for all diagnoses to include Risperdal, Lexapro, and Exelon.
9. Concerning her activities of daily living (ADLs), the petitioner ambulates but with no direction. She needs guidance for almost all her responsibilities. She cannot do sequential tasks. She requires help with her bathing, feeding, and dressing. She has poor memory. She has a flat affect.
10. It is noted that she does not initiate conversation. There has been no improvement in her conditions and there are signs of worsening, particularly the dementia. She needs nursing assistance to take her medications.

11. The petitioner was last employed as a tax attorney. And according to her treating psychiatrist [redacted] "Ms. West is permanently disabled and unable to work".

CONCLUSIONS OF LAW

Fla. Admin. Code 65A-1.710 (1) sets forth the rules of eligibility for elderly and disabled individuals. 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 42 U.S.C. § 1396a(m), and 20 C.F.R. § 404.1505 **Basic definition of disability**. The regulation states in part:

> (a)The law defines disability as the inability to do any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months. To meet this definition, you must have a severe impairment(s) that makes you unable to do your past relevant work (see Sec. 404.1560(b)) or any other substantial gainful work that exists in the national economy.

42 C.F.R. § 435.541 **Determinations of disability** states in part:

> (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 Sec. 435.911 on the same issues presented in the Medicaid application. A determination of eligibility for SSI payments based on disability that is made by SSA automatically confers Medicaid eligibility, as provided for under Sec. 435.909.
>
> (b) Effect of SSA determinations. (1) Except in the circumstances specified in paragraph (c)(3) of this section--

> (i) An SSA disability determination is binding on an agency until the determination is changed by SSA.
>
> (c) Determinations 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....

Authority is given to the respondent to have the DMRT make a determination of disability.

The hearing officer evaluated the petitioner's claim of disability using the sequential evaluation as set forth in 20 C.F.R. § 404.1520. The first step is to determine whether or not the individual is working. The petitioner is not working and, therefore, meets the first step.

The second step is to determine whether or not the individual has a severe impairment that will last more than twelve months. Documentation provided shows that the petitioner's condition(s) meet the second step requirement.

The third step is to determine whether or not the individual's impairment(s) meets or equals a listed impairment in appendix 1 of the subpart of the Social Security Act. Among the petitioner's conditions is that of schizophrenia. Reviewing 12.00 Mental Disorders:

> A. Introduction. The evaluation of disability on the basis of mental disorders requires documentation of a medically determinable impairment(s), consideration of the degree of limitation such impairment(s) may impose on your ability to work, and consideration of whether these limitations have lasted or are expected to last for a continuous period of at least 12 months. The listings for mental disorders are arranged in nine

diagnostic categories: ...schizophrenic, paranoid and other psychotic disorders (12.03)....

12.03 Schizophrenic, Paranoid and Other Psychotic Disorders:

Characterized by the onset of psychotic features with deterioration from a previous level of functioning.

The required level of severity for these disorders is met when the requirements in both A and B are satisfied, or when the requirements in C are satisfied.

A. Medically documented persistence, either continuous or intermittent, of one or more of the following:

1. Delusions or hallucinations; or

2. Catatonic or other grossly disorganized behavior; or

3. Incoherence, loosening of associations, illogical thinking, or poverty of content of speech if associated with one of the following:

a. Blunt affect; or

b. Flat affect; or

c. Inappropriate affect;

or

4. Emotional withdrawal and/or isolation;

AND

B. Resulting in at least two of the following:

1. Marked restriction of activities of daily living; or

2. Marked difficulties in maintaining social functioning; or

3. Marked difficulties in maintaining concentration, persistence, or pace; or

4. Repeated episodes of decompensation, each of extended duration;

OR

C. Medically documented history of a chronic schizophrenic, paranoid, or other psychotic disorder of at least 2 years' duration that has caused more than a minimal limitation of ability to do basic work activities, with symptoms or signs currently attenuated by medication or psychosocial support, and one of the following:

1. Repeated episodes of decompensation, each of extended duration; or

2. A residual disease process that has resulted in such marginal adjustment that even a minimal increase in mental demands or change in the environment would be predicted to cause the individual to decompensate; or

3. Current history of 1 or more years' inability to function outside a highly supportive living arrangement, with an indication of continued need for such an arrangement.

Upon reviewing the medical information provided, the petitioner's schizophrenic condition alone would qualify her as having a disabling condition. She meets the conditions set forth in A, B, and C. Combining the additional medical problems only accentuates the underlying disabling existence.

DECISION

The appeal is granted and the petitioner is found to be disabled. However, she must meet all the respondent's other criteria to be ICP eligible.

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-

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

APPEAL NO. 07F-03538

PETITIONER,

Vs.

CASE NO. 1253196699

FLORIDA DEPARTMENT OF
CHILDREN AND FAMILIES
DISTRICT: 07 Orange
UNIT: 88999

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned-hearing officer convened an administrative hearing in the above matter on July 12, 2007, at 11:10 a.m., in Orlando, Florida. The petitioner did not appear. [redacted] petitioner's representative, appeared on the petitioner's behalf. [redacted], benefits coordinator of [redacted] and Nick Barton, executive director of Aged Pooled Special Needs Trust, appeared as witnesses for the petitioner. Reginald Schofield, economic self-sufficiency specialist supervisor, appeared and represented the respondent-Department.

ISSUE

At issue is the respondent's action of January 2, 2007, denying the petitioner's application for Institutional Care Program Medicaid (ICP) for failure to follow through in

establishing eligibility. Also at issue is the respondent's delay in processing the petitioner's application dated March 30, 2007, for ICP Medicaid.

FINDINGS OF FACT

1. The parties stipulated to the following facts:
2. The petitioner submitted an application for Institutional Care Program (ICP) Medicaid on November 30, 2006.
3. The respondent issued a notice dated December 4, 2006, to the petitioner requesting the return of several items. The deadline date for submission of these items was December 14, 2006. The notice also informed that the petitioner had a total of 30 days by which to submit all of the information before it issued a denial for failure to provide the verification.
4. The petitioner submitted all requested information on December 15, 2006.
5. The petitioner submitted additional asset information to the respondent that was not officially requested but was informative in nature on December 22, 2006.
6. On January 2, 2007, the respondent's eligibility specialist denied the petitioner's application for failure to follow through in establishing eligibility.
7. The petitioner's representative made several contacts following the denial to check on the status of the case and find out on what basis the respondent denied the case. The representative received no response.
8. On February 15, 2007, the petitioner's representative met with the respondent's representative who informed her that the application was denied and that a new application needed to be filed regardless of the fact that the previously requested information was submitted in December 2006.

9. On February 22, 2007, the petitioner's representative filed a written hearing request with the respondent to appeal the January 2, 2007, denial. This hearing request was never forwarded to the Office of Appeal Hearings.
10. Due to the volume of difficulties experienced in trying to get the petitioner's application approved, the petitioner's representative filed another application on March 30, 2007. The same documentation requested with the prior application was again requested and in addition, verification of the petitioner's monthly Veteran's Benefit payment was needed. The representative provided this verification.
11. In May 2007, the respondent acknowledged that all information was received but that the case was awaiting disability approval by the District Medical Review Team (DMRT).
12. The petitioner's representative filed another hearing request directly with the Office of Appeal Hearings which was received on June 11, 2007.
13. At the hearing, the petitioner argued that the respondent mishandled the application and is well over the time standard allowed for application processing. The respondent has a duty to act on the application immediately.
14. The respondent conceded that it made errors in the handling and processing of the petitioner's application dated November 30, 2006, including improper denial and causing delay. The respondent forwarded the petitioner's file to the District Medical Review Team (DMRT) on July 3, 2007, for determination of disability for ICP Medicaid. The petitioner met all others factors of eligibility for the program and the application was currently pending for the DMRT's approval or denial of

the factor of disability. Once the DMRT issues a decision, the respondent will issue an approval or denial of the Medicaid application.

CONCLUSIONS OF LAW

Fla. Admin. Code 65A-1.205 states in relevant part:

> **Eligibility Determination Process** [emphasis original]...(1)(c) Time standards for processing applications vary by public assistance program. The time standard begins with the date on which the department or an outpost site receives a signed and dated application and ends with the date on which benefits are made available or a determination of ineligibility is made. For the Medicaid program, the time standard ends on the date an eligibility notice is mailed. Applications must be processed and determinations of eligibility made within the following time frames:...Medical Assistance and State Funded Programs for individuals who apply on the basis of disability...90 days...All days counted after the date of application are calendar days. Applicant delay days do not count in determining non-compliance with the time standard. See paragraph (e) of this rule...(e) There are situations of non-agency processing delays due to unusual circumstances for Medicaid disability-related applications. Unusual circumstances that might affect the timely processing of Medicaid are determined and documented in accordance with 42 CFR subpart 435.911 and include applicant delay, physician delay and emergency delay as defined below. Unusual circumstances are considered non-agency processing delays and the calendar time passing during such delay(s) is not counted as part of the 90-day time standard for determining the timeliness of Medicaid eligibility decisions based on disability...1. Applicant delay is defined as the time attributed to the applicant who fails to keep any scheduled appointment or to provide requested and required eligibility information...2. Physician delay is defined as the time attributed to a physician when medical evidence or when a medical examination is requested and is not provided timely...3. Emergency delay is defined as time attributed to other situations beyond the agency's control. These delays are situations such as disasters, unexpected office closure(s) and systems inaccessibility or unavailability...

The respondent is under a duty to approve or deny a disability-related application by the 90th day from the date of the application. The above provision indicates there are certain types of acceptable delay that can occur during the processing of an application which cause it to be approved or denied untimely. None of the types of delay described

above apply to this case. The findings show that the respondent's own actions caused delay in the processing of the petitioner's application for ICP Medicaid dated November 30, 2006. The respondent must act upon the petitioner's application, dated November 30, 2006, promptly.

DECISION

The appeal is granted. The respondent's denial of the application dated November 30, 2006, is reversed. The DMRT has had sufficient time to issue a decision on the factor of disability and in the event that its decision is still pending upon receipt of this order, the DMRT is ordered to issue a decision within 10 days.

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 30th day of August, 2007, in Tallahassee, Florida.

Jeannette Estes

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

Copies Furnished To

Petitioner

7 DPOES: Janet DeChristopher

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

APPEAL NO. 07F-03454

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 July 20, 2007, at 2:35 p. m., at the West Dade Service Center, in Miami, Florida. The petitioner was not present, but was represented by his mother, The respondent was represented by Erica Woodard, registered nurse specialist, Agency For Health Care Administration (AHCA). Present as witnesses for the respondent, via the telephone, was Dr. Robert Buzzio, physician reviewer, from KePRO and George Smith, review operations supervisor with KePRO. Ron Ruel, RN, was present observing the hearing.

ISSUE

At issue is the respondent's action of May 29, 2007, to deny the petitioner 240 hours of Home Health Aide (HHA) services, for the period of May 5, 2007 through July 3, 2007, due to medical necessity. The respondent has the burden of proof.

FINDINGS OF FACT

1. The petitioner, who was eight years of age at time of review, has a condition called Hunter Syndrome, a genetic disorder with progressive mental and physical deterioration.

2. On behalf of the petitioner, ... Health Service, a home health care provider, requested authorization for 240 HHA hours for the certification period May 5, 2007 through July 3, 2007. The provider indicates that the petitioner requires constant supervision. He attends school Monday through Friday 7:00 a.m. to 5:00 p.m. The primary caregiver (mother) works ten hours daily. The provider provides HHA for personal care daily from 5:00 p.m. to 9:00 p.m.

2. KePRO has been authorized to make Prior (service) Authorization Process decisions for the respondent. The Prior Authorization Process was completed for the petitioner by KePRO.

3. On May 29, 2007 a physician consultant reviewed the petitioner's request and made the following determination: "Mom is at home by the time pt returns from school. Mom seems to be able to care for the pt as she does so in the absence of CNA services..." The physician consultant denied the request for service as medical necessity had not been demonstrated.

4. The provider requested a reconsideration and submitted additional medical information.

5. On June 5, 2007, a different physician consultant reviewed the information and denied the request stating: "I agree partially with physician consultant and suggest to modify the denial for assistant service. The care and needs of this recipient could be

provided by regular Home Health HHA visits in less than two hours, therefore I suggest to uphold this denial for paraprofessional HHA services and request provider to submit a request for HHA visits to address the ADL needs and care for this recipient."

6. On June 6, 2007, the petitioner was notified of the above decision.

7. The petitioner's representative expressed that she works for ten hours, does all the household chores and cares for her son, but she needs rest.

8. Dr. Buzzeo responded that the program that AHCA provides does not support respite care, and rest is considered respite care. Dr. Buzzeo explained that the reason for the denial was because the petitioner is at school from 7:00 a.m. to 5:00 p.m. and the mother is available at home after 5:00 p.m. to provide care to the petitioner. Dr. Buzzeo notes that if the caregiver needs help, this can be done on a HHA visit of less than two hours per day.

CONCLUSIONS OF LAW

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

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

Fla. Stat. ch. 409.901(4) **Home Health Care Services** states in part:

> The agency shall pay for nursing and home health aide services, supplies, appliances, and durable medical equipment, necessary to assist a recipient living at home.

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

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

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

Fla. Admin. Code 59G-4 **Home Health Services** states in part:

(1) This rule applies to all home health agencies licensed under Chapter 400, Part IV, 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, October 2003, incorporated by reference, and the Florida Medicaid Provider Reimbursement Handbook, CMS-1500, which is incorporated in Rule 59G-4.001, F.A.C. Both handbooks are available from the Medicaid fiscal agent.
(3) When terminating, reducing, or denying private duty nursing or personal care services, Medicaid will provide written notification to the recipient or the recipient's legal guardian. The notice will provide information and instructions regarding the recipient's right to request a hearing.

The Home Health Services Coverage and Limitations Handbook (October 2003) explains service requirements for Home Health Aide Visit Service on page 2-14, stating in part:

Home health aide services may be reimbursed only when they are:
- Ordered by the attending physician;
- Documented as medically necessary; ...

Home health aide services help maintain a recipient's health or facilitate treatment of the recipient's illness or injury. The following are examples of home health aide services reimbursed by Medicaid:

- Assisting with the change of a colostomy bag;
- Assisting with transfer or ambulation;
- Reinforcing a dressing;
- Assisting the individual with prescribed range of motion exercises that have been taught by the RN;
- Assisting with an ice cap or collar;
- Conducting urine test for sugar, acetone or albumin;
- Measuring and preparing special diets;
- Providing oral hygiene;
- Bathing and skin care; and
- Assisting with self-administered medication.

The respondent, through KePRO, took action on May 29, 2007, to deny the petitioner 240 hours of HHA for the period of May 5, 2007 through July 3, 2007, as medical necessity had not been demonstrated. This decision was based on the information as provided by the petitioner's service provider and the petitioner's medical necessity need of the request for the service.

After considering the evidence, the Fla. Admin. Code Rule and all of the appropriate authorities set forth in the findings above, the hearing officer affirms the respondent's action.

DECISION

This appeal is denied 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 3rd day of August, 2007,

in Tallahassee, Florida.

Alfredo Fernandez

Alfredo Fernandez
Hearing Officer
Building 5, Room 203
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Copies Furnished To: [redacted] Petitioner
Judith Rosenbaum, Prog. Adm., Medicaid Area 11
Sharon Lang
Mary Wheeler
Karen Kinser, Nursing Consultant

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

APPEAL NO. 07F-02817

PETITIONER,

Vs.

AGENCY FOR HEALTH CARE ADMINISTRATION
DISTRICT: 11 Dade
UNIT: AHCA

RESPONDENT.
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FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned-hearing officer on July 18, 2007, at 10:58 a.m., at the Caleb Service Center, in Miami, Florida. The petitioner appeared by telephone at her request and represented herself. The Agency was represented by Donna Pollins, senior human services program specialist, Agency for Health Care Administration (AHCA). On the telephone was Deborah Parthemore, operations manager with KePRO; Dr. Frank Castrina, medical director from KePRO; Elizabeth Mesa, case manager from Maxmed and Rosty Batista, Medicaid coordinator for Maxmed. Mary Wheeler and Theresa Ashey were also present via the telephone observing the hearing. Blanca Alvarez Buylla served as an interpreter. The record was left open for a total of fourteen additional days in order for the petitioner to submit additional information. Additional information was submitted within the time frame allotted.

ISSUE

At issue is the Agency's action of March 12, 2007, to deny the petitioner's request for Home Health Aide (HHA) visit one time a day for the period of January 16, 2007 through March 16, 2007, because the documentation submitted by the agency (provider) does not support the medical necessity for the visit frequency of the services requested. The petitioner has the burden of proof.

FINDINGS OF FACT

1. The petitioner, who was 59 years of age at time of review, has severe and numerous medical problems that require medical services as provided through the Agency for Health Care Administration's (AHCA) Medicaid State Plan. The petitioner's condition(s) are outlined in Respondent Composite Exhibit 1. AHCA will be further addressed as the respondent.

2. KePRO has been authorized to make Prior (service) Authorization Process decisions for the respondent. The Prior Authorization Process was completed for the petitioner by KePRO.

3. On January 16, 2007, the provider, Maxmed Inc. requested 59 hours of HHA visits, one time a day, Monday through Sunday.

4. The plan of care submitted by the provider indicates in part that the petitioner suffers from urinary incontinence, has transmetatarsal amputation to left foot and right great toe and requires assistance with ADL's and personal care.

5. The respondent's witness indicated that after review of the information provided to KePRO regarding the medical needs of the petitioner, a KePRO physician consultant

determined that the HHA visits could not be authorized because there was not sufficient documentation regarding why the petitioner was unable to participate in her own care.

6. A reconsideration of the above decision was requested. All information pertinent to the case was reviewed by a KePRO reconsideration physician consultant who upheld the original denial of the requested service.

7. On March 27, 2007, the provider notified KePRO that the information previously submitted concerning the caregiver who works long hours was a misunderstanding with another patient. The provider explained that the petitioner's caregiver is her mother, who takes responsibility of making decision as to care/treatment, but not the person performing bathing, dressing and other kind of assistance for patient.

8. At the hearing, the petitioner explained that she brought to the provider her plan of care by her doctor showing her medical condition and the amputation that she had on both of her feet. The petitioner purported that she had two thromboses and has the same skin/circulatory condition in her hands that does not allow her to do her own personal care.

9. The respondent's witness responded that there was no information sent to KePRO saying that she had circulatory problems with her arms or her hands, or a skin condition of her hands.

10. On August 1, 2007, the hearing officer received a letter from the petitioner's treating physician. This letter by Dr. Elizabeth Mesa, dated July 30, 2007, states in part: "Mrs. [redacted] eficiency is also affecting her upper extremities leading to decrease sensation, coldness, claudication of hands, which incapacitates her to provide own