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

[redacted]

PETITIONER,

APPEAL NO. 07N-00119

Vs.

[redacted]

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer at the [redacted] in Winter Garden, Florida, at 3:45 p.m. on August 22, 2007. The petitioner was not present but was duly represented by her daughter, [redacted] and her granddaughter, [redacted] Also present on behalf of the petitioner were [redacted] Hospice team manager, and [redacted] social worker. The respondent was represented by [redacted], administrator. Testimony on behalf of the respondent was also available from [redacted] social service director; [redacted] residential care coordinator; and [redacted] director of nursing.

ISSUE

At issue was whether or not discharge from the nursing facility was correct due to facility's inability to meet the needs of the petitioner. The respondent had the burden of proof.

FINDINGS OF FACT

1. The petitioner entered the [redacted] nursing facility on May 12, 2007 from an assisted living facility. Health problems included dementia and memory impairment. Health problems of that nature are undisputed.

2. The [redacted] facility does not have a locked section to provide for security of individuals with disorientation or dementia - related wandering. The facility has recently been refurbished, but changes did not include provision of a locked area.

3. The petitioner is ambulatory and unrestrained. She has difficulty finding her own room and in avoiding entry to other residents' rooms. By May 14, 2007 she was found wandering into others' rooms and was easily redirected by staff (Respondent's Exhibit 2, nursing section). On May 30, 2007 progress notes reflected the wandering and "socially inappropriate behavior" (social service notes). In June 2007 those notes and care plan reflected her behavior of "rummaging through" belongings of others. In other words, without invitation, she enters the rooms of other residents.

4. Some other residents are not comfortable about that behavior and grievances have been registered (Respondent's Exhibit 2, grievance section). Provision of a landmark to help her identify her own area helped for a time, but not as an ongoing tool. By August 13, 2007 she continued to wander and "became agitated when redirected..." (nursing notes).

5. On July 3, 2007, with a determination that the facility could not meet her needs, and that she needed a more secure location, notice of discharge intent was issued (Respondent's Exhibit 1). That notice was accompanied by the attending physician's authorization for discharge to [redacted] That location is east of [redacted] and is in the same county. [redacted] has a locked unit to provide security for such residents. It is a licensed facility. This is undisputed, although the family did not prefer the area where [redacted]s located. The respondent planed to achieve relocation to the new location by August 2, 2007.

6. Her family is committed to visiting with the petitioner and involving her in their lives and vice versa. Location proximity is important to the family. The family wants the petitioner to be located close to them in an area where they feel safe visiting. Petitioner's Exhibit 1 reflected some of their concerns. Key family members work, have difficulty traveling and also face serious health problems. The family has participated in care planning.

7. The family wants additional time to handle the relocation problem, and is primarily able to address this matter on the weekends or outside of work hours. There is another facility in [redacted] that has a secure unit and another facility in another county just west of the area. Agreement to and placement for relocating had not been achieved by the family as of date of hearing.

8. When the hearing was registered, the undersigned directed that review be conducted by the Agency for Health Care Administration (AHCA). While such a review may have been conducted, it is not necessarily controlling for hearing purposes and was not available as of hearing. If results were received before the final order was

complete, the undersigned agreed to provide copies of the review to the parties and afford opportunity to respond. AHCA review results were received and were shared under separate order, with opportunity for and instructions for response. Response was not necessary nor received. The review did not change facts developed at hearing.

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;
>
> (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. ...

(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...

Based on all evidence and testimony presented, it is concluded the current facility cannot adequately meet the security or personal welfare needs of the petitioner, as described in the notice. Discharge to a more secure section of a facility such as [redacted], in a community not too far away would be appropriate, as also set forth in the notice under challenge. Due to wandering and behavior concerns, another location which would provide greater security is not only preferable, it is needed for the welfare of the petitioner.

While the family might prefer a close location, more time for research and visiting other facilities, and would prefer certain other aspects of favorable accommodations, such are not controlling factors under regulation. The regulations do not permit a longer period of time for research or planning and do not provide for individual preferences as

to sections of the community. To some extent, preparation time may be afforded by the thirty day advance time set forth in the notice.

Upon careful review of all facts and regulatory guidelines, if the location for intended discharge has a secure section and is appropriately licensed, such a location would be a permissible location for discharge. [redacted] meets standards for discharge. Therefore, it is concluded that discharge planning and orientation to the facility named in the notice may proceed.

DECISION

The appeal is denied and the discharge notice is upheld.

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 September, 2007, in Tallahassee, Florida.

J W Alper
Hearing Officer
Building 5, Room 203
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
850-488-1429

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

[redacted]

PETITIONER,

APPEAL NO. 07N-00106

Vs.

CASE NO. 1253702551

[redacted]

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on August 21, 2007, at 9:15 a.m., in Lauderhill, Florida. The petitioner was not present. He was represented by his daughter [redacted] The respondent was represented by [redacted] administrator of [redacted] Also present from the facility was [redacted] business office manager, and [redacted] social services director. Also present was [redacted] chairman of the Broward County Long Term Care Ombudsman Council.

ISSUE

At issue is the [redacted] Care Center's action of June 5, 2007, to discharge the petitioner for not paying the cost of care in the facility.

FINDINGS OF FACT

As of the time of the hearing, the petitioner resided at the [redacted] in Lauderhill, Florida. The petitioner was provided with a Nursing Facility Transfer and Discharge Notice, dated June 5, 2007, informing him that he would be discharged from the facility due to non-payment of care in the facility. At the hearing, the petitioner's representative asserted that she did not disagree with the discharge of the petitioner from the facility. She also agreed that the petitioner owes money to the facility.

Included in the evidence are copies of Notice Of Case Action forms from the Department dated March 15, 2007, to the petitioner informing him that he was approved for Institutional Care Program Medicaid benefits. He was informed that his patient responsibility to the facility is $2,373.86 monthly. Included in the evidence are copies of statements sent from the facility to the petitioner's representative informing her of the facility charges from April 2007 to August 2007. According to a statement dated August 1, 2007, the balance due as of that time was $12,136.79.

CONCLUSIONS OF LAW

The jurisdiction to conduct these hearings is conveyed to the Department by Federal Regulations appearing at 42 C.F.R. § 431.200. These hearings differ from most hearings conducted by the Department's hearing staff, as the Department is not party to the proceedings. The matter is a private dispute between two parties and not a circumstance where the individual's substantial interest has been affected by the Department's action.

In accordance with the Federal Regulations at 42 C.F.R. § 483.12 (a):

> (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.

At the hearing, the petitioner's representative asserted that she did not disagree with the discharge of the petitioner from the facility. She also agreed that the petitioner owes money to the facility, which was $12,136.79 as of August 1, 2007. It is determined that the facility's action to discharge the petitioner, is upheld.

DECISION

The appeal is denied, and the [redacted] action to discharge the petitioner is affirmed.

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 12th day of September, 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: [redacted] Petitioner

[redacted] Respondent

Agency for Health Care Administration

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

[redacted]

APPEAL NO. 07N-00108

PETITIONER,

Vs.

CASE NO.

[redacted]

RESPONDENT.

_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on August 10, 2007 at 11:20 a.m., at the [redacted] in Jacksonville, Florida. The petitioner was not present. However, she was represented by her daughter, [redacted] at the hearing. The nursing facility was represented by [redacted] Administrator and [redacted] Director of Nursing.

ISSUE

The petitioner wishes to appeal the respondent's action for failing to readmit the petitioner to the facility after an emergency admission to a hospital.

FINDINGS OF FACT

The petitioner was admitted to the nursing home in 2004. On December 28, 2006, the petitioner was transferred to the [redacted] due to a

medical emergency. The petitioner remained in the hospital for 13 days. There was no evidence submitted that would show the transfer was not a medical emergency. The petitioner was provided with a Resident Transfer Form when she was transferred to the hospital. The petitioner was discharged from the hospital on January 9, 2007 and she is currently a patient at another nursing home facility. The petitioner would like to return to the [redacted] facility as soon as possible. The respondent stated that there have not been beds available for the petitioner. The petitioner believes that other beds have become available but not offered to the petitioner to allow her to return.

CONCLUSIONS OF LAW

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

> This subpart--
> (c) Implements sections 1919(f)(3) and 1919(e)(7)(F) of the Act by providing an appeals process for any person who--
> (1) Is subject to a proposed transfer or discharge from a nursing facility...

Additionally 42 C.F.R. §483.12(a)(1) states in part:

> 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.

The need for a transfer notice is addressed at 42 C.F.R. §483.12(a) as follows:

> (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...
> (5) Timing of the notice.
> (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;..
> (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (a) (2)(i) of this section; or...

These regulations only provide for a hearing of actions to transfer or discharge a resident. The petitioner does not challenge the transfer to the hospital. The issue before this tribunal is whether the respondent is obligated to maintain a bed for more than eight days after an emergency transfer to a hospital. This is referred to as a bed-hold policy. The respondent's bed-hold policy states that the bed will not be paid by Medicaid for more than eight days. After that, the resident will be re-admitted to the first available Medicaid bed. The petitioner's stay in the hospital was longer than eight days.

The petitioner was properly noticed of the policy and given a transfer form. The issue of the transfer is not the issue that is being challenged. Rather is it the failure of the respondent to readmit the petitioner after her hospital stay. Therefore, this is not an issue of a transfer or a discharge. As such, there is no jurisdiction for this hearing officer to entertain this matter. Concerns relating to the respondent's bed-hold policy and admitting or readmitting a resident would more properly be addressed to the Agency for Health Care Administration (AHCA) for resolution.

The petitioner was transferred to a hospital based on a medical emergency. The regulations at 42 C.F.R. §483.12 requires the facility to issue a notice of transfer at the time of transfer, or as soon as possible thereafter. In this case, the nursing facility has complied with this policy. As such, the transfer was correct under the regulations.

DECISION

This appeal is denied as the action to transfer the resident was in accordance with controlling regulations.

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 12th day of September, 2007, in Tallahassee, Florida.

James Abdur-Rahman
Hearing Officer
Building 5, Room 203
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
850-488-1429

Copies Furnished To: [redacted] Petitioner
[redacted], Respondent
Agency for Health Care Administration

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

APPEAL NO. 07F-03858

PETITIONER,

Vs.

CASE NO. 1260149072

FLORIDA DEPARTMENT OF
CHILDREN AND FAMILIES
DISTRICT: 14 Polk
UNIT: 88119

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on July 20, 2007, at 11:07 a.m. in Lakeland, Florida. The petitioner was not present. He was represented by his legal counsel Connie Durrance. The respondent was represented by Jerome Major, district counsel. Present as witnesses for the petitioner were his son and power of attorney, his daughter, ; his daughter and family friend, s. Present as witnesses for the respondent were Shirley Johnson, supervisor; and Clare Short, economic self-sufficiency specialist.

ISSUE

At issue is the June 11, 2007 action by the respondent denying the petitioner's application for benefits through the Institutional Care Program due to his failure to follow through in establishing eligibility.

FINDINGS OF FACT

1. On April 4, 2007, the petitioner filed a Request for Assistance to apply for benefits through the Institutional Care Program. He was represented by his son and power of attorney, [redacted]. The petitioner resided in a nursing home. He has a spouse in the community. The couple does not have any mutual children.
2. The respondent issued a notice requesting information with a return deadline date of April 19, 2007. On May 10, 2007, the respondent denied the petitioner's application for failure to return requested information. One of the items he failed to return was verification of the income and assets of the community spouse. On May 16, 2007, the application was reopened following the recommendation of a program specialist with the Department.
3. On May 17, 2007, the respondent issued another request for information. The respondent requested information on the income and resources of the community spouse, proof of the balance in shared accounts, proof of the market value of the home, and proof of the health insurance premium. There was a question of the validity of the transfer of the couple's home to the community spouse's daughter in February 2007. The deadline date to return the information was May 19, 2007.
4. The validity of the transfer of the homestead was resolved. However, the petitioner failed to return verification of the community spouse's income and assets owned

singly or with the petitioner. On June 8, 2007, the respondent denied the petitioner's application for failure to return requested information.

5. The petitioner was diagnosed with early stage dementia over four years ago. He was hospitalized on February 28, 2007 due to swollen legs, extreme fluid build up on his feet, and fluid in one of his lungs. Prior to his hospitalization, family noticed his rapid deterioration in that he was disheveled, appeared heavily medicated, and could not carry on a sensible conversation.
6. During his hospitalization, his son and power of attorney noted his community spouse's lack of interest in the petitioner's care. She did not want to take responsibility for or discuss his long term care needs. On March 6, 2007, the petitioner was discharged from the hospital to a nursing facility,
7. During his nursing home stay, physicians determined that the petitioner was no longer capable of acting in his best interests and make decisions. His son was his health care surrogate and power of attorney. The nursing facility determined that he could be discharged home with services in the community. His community spouse would not agree to provide his care in their home. In addition, she was uncooperative in providing necessary information for his application for Medicaid. Attempts by the son to obtain information resulted in instructions to cease any contact with the community spouse by the community spouse's son-in-law who is a police officer.
8. The POA/son explained the status of his father's marriage to the respondent. It is not in dispute that he discussed his inability to obtain the cooperation of the community spouse in providing further information regarding any shared resources

with a program specialist and an eligibility specialist with the Department. The son provided copies of two separate emails from the community spouse documenting her refusal to cooperate in providing information.

9. According to the son, the couple experienced a bankruptcy and their only resource was their home where the community spouse currently resides. The son was able to provide a copy of a bank statement showing deposits reflecting the community spouse's income, but she has since removed the petitioner's name from the account.

10. The petitioner submitted an Assignment of Rights to Support form signed by the son (POA) and his two sisters. This assigns any interests he has to the state in exchange for Institutional Care Program benefits. An investigation into obtaining a divorce to separate the couple legally discovered that it is a lengthy procedure involving forming a guardianship.

CONCLUSIONS OF LAW

The Fla. Admin. Code at 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 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 (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.

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 evidence establishes that the petitioner's community spouse has not taken responsibility for his care. Moreover, the evidence establishes that she has not cooperated in any efforts to obtain Medicaid to pay for his care in the nursing facility.

The respondent does not dispute that the son reported the difficulties in obtaining the requested information from the community spouse and the fact that their marriage was estranged.

It is clear that the community spouse is resistant to the eligibility process for Medicaid and could even be considered separated from her community spouse. Any assets owned by the community spouse can be considered unavailable to the petitioner due to the failure of the community spouse to cooperate in establishing eligibility. The respondent did not offer the petitioner any exception to providing information on the community spouse or an opportunity to sign an Assignment to Rights to Support. Subsequently, the petitioner signed this form and offered it to the respondent. According to the above-cited rules, the respondent can disregard any assets owned by the petitioner but controlled by the community spouse.

DECISION

This appeal is granted. The respondent's action denying the petitioner's application is reversed. The respondent should reevaluate the petitioner's eligibility for benefits based the known income and assets available to the petitioner.

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 20th day of September, 2007,

in Tallahassee, Florida.

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

Copies Furnished To: [redacted], Petitioner
14 DPOES: Ellen Schultz
Jerome Major, Esquire
Connie Durrance, Esquire

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

APPEAL NO. 07F-04226

PETITIONER,

Vs.

AGENCY FOR HEALTH
CARE ADMINISTRATION
DISTRICT: 01 Escambia
UNIT: AHCA

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on September 5, 2007, at 8:40 a.m., in Pensacola, Florida. The petitioner was not present but was represented by her mother, [redacted]. The Agency was represented by Cindy Henline, medical health care program analyst, Agency for Health Care Administration (AHCA). Testifying on behalf of the Agency, via speakerphone, was Dr. Rakesh Mittal, KePRO South. Observing the hearing was George Smith, review operations supervisor, KePRO and Mary Wheeler, review operations manager, KePRO.

The hearing record was held open for 14 days or until September 19, 2007 to allow the respondent to submit additional evidence which was received and entered as Respondent's Exhibit 3.

ISSUE

The petitioner is appealing AHCA's action of July 13, 2007 to reduce Private Duty Nursing (PDN) from a request of 1440 hours to 480 for the time period of July 10, 2007 through September 7, 2007 based on the contention that the intensity or level of medical care requested was not medically necessary.

FINDINGS OF FACT

1. The petitioner (date of birth [redacted]) is a Medicaid recipient. The petitioner has been receiving PDN services under Medicaid. A request for 1,440 hours of PDN was submitted by the provider, Maxim Healthcare Services, Inc., for the period of July 10, 2007 through September 7, 2007.

2. Prior to the action under appeal, the petitioner was authorized to receive 16 hours per day, seven days per week of PDN. The petitioner's mother is unemployed. The provider's request for PDN indicated that the child's biological father was in the home every day and night except one when nursing staff were present. In addition, both parents are trained caregivers. The petitioner's mother testified that the biological father does not reside in the home and "drops" in without notice.

3. Requests for PDN are reviewed with a contract provider who completes prior authorization for the requested service. That contract provider is KePRO. The request for services is submitted by the home health care provider, in this case, Maxim Healthcare Services, Inc. The requests are for 60 day time periods. All communication is sent between KePRO and the provider until a decision is reached. KePRO reviews

the written request for services to determine if the number of hours requested are medically necessary. If additional information is needed, KePRO contacts the provider. Once services, as in this case, were rejected or modified, a notice is sent to the recipient's family.

4. KePRO received the request for 1,440 hours of PDN submitted by the provider, Maxim Healthcare Services, Inc. A KePRO Registered Nurse Reviewer (RNR) completed a screening of the Plan of Care submitted on July 6, 2007 and suspended the case as the "Plan of Care (POC) was signed outside of the 21 day range from the start date of the certification period." On July 9, 2007, the provider submitted an updated POC signed by the attending physician, Dr. Julia Niebauer. The request was for night nursing only, from 11 p.m. to 7 a.m., seven days per week or 480 hours (Respondent's Composite Exhibit 2, Section C and Respondent's Exhibit 3).

5. At AHCA's direction, the RNR used modified InterQual Criteria and a Pediatric Home Care Guide for Private Duty Nursing (PDN) Hourly Utilization to review the request for PDN services. Using that documentation, a Utilization Form was developed. The Utilization Form assigns point values to physical conditions of the petitioner and level of care that is anticipated. KePRO concluded that based on the points the petitioner was scored, a physician's review was required.

6. The case was then referred to a Board Certified Pediatric Specialty Physician Consultant. A Board Certified Pediatrician reviewed the case and made the following determination: "1 y/0 with unspecified congenital anomalies, failure to thrive. Has trach,

on ventilator at bedtime; requires nebulizer treatment and sat checks...Lives with mother who does not work and question of whether Dad is living in the home/may or may not be working. Nurse Reviewer Recommendation---:approve 480 hours for 11 p.m. to 7 a.m. every day so Mom can sleep; deny 960 hours. Updated request is for 480 hours, 8 hours per day, 7 days per week." (Respondent's Composite Exhibit 2, Section C). The determination of the physician consultant was sent to Maxim Healthcare Services, Inc. on July 12, 2007 and July 13, 2007. Based on the documentation, the pediatric consultant denied 960 hours and approved 480 hours of the 1,440 requested hours of PDN.

7. The documentation indicated a request for the petitioner with congenital anomalies of the larynx, trachea, bronchus, and failure to thrive. The petitioner is developmentally intact. The petitioner has a tracheostomy and g-tube. In addition she is on a ventilator, especially at night when sleeping and during nap time. She requires suctioning of the tracheostomy as needed to clear secretions. She requires medication administration and tube feedings when she fails to take enough nutrition. The provider informed KePRO that the "patient has been stable for the past 60 days. She has had no hospitalization and no episodes of respiratory distress during this certification period. The Patient is off her ventilator for several hours at a time during the day but stays on continuous when sleeping. Patient has required no supplemental oxygen. Patient receives bottle feedings by mouth. If ordered amount is not taken in during the day