

All parties appeared telephonically. Petitioner's Authorized Representative and sister, [REDACTED] ("[REDACTED]"), appeared on behalf of the Petitioner. Petitioner also appeared as witness.

Maria Mojica, Compliance Specialist for Sunshine State Health Plan, Inc. ("Sunshine"), appeared on behalf of Respondent. The following persons attended as witnesses for Respondent: Dr. Bonnie Koreff-Wolf ("Dr. Koreff-Wolf"), Medical Director for Sunshine; Melissa Layne, Senior Manager for Member Appeals for Sunshine; Jacqueline Alvarez Supervisor for Sunshine; and Denise Hyppolite, Care Coordinator for Sunshine.

Suzanne Chillari, Medical/Health Care Program Analyst for the Agency for Health Care Administration ("Agency" or "AHCA"), appeared as an observer.

Petitioner did not introduce any exhibits at the hearing. Prior to the hearing, Respondent sent to the Office of Fair Hearings and Petitioner a one hundred and sixteen (116)-page evidence packet. The evidence packet included a table of contents; a Medicaid Fair Hearing Summary, dated November 6, 2020; the Notice of Adverse Benefit Determination ("NABD"), dated October 1, 2020; a Long Term Care Person-Centered Care Plan, reviewed August, 13, 2020; a second Long Term Care Person-Centered Care Plan, reviewed October 22, 2020; a Florida Department of Elder Affairs 701B Comprehensive Assessment ("701B"), dated August 3, 2020; a second 701B, dated October 22, 2020; Petitioner's plan appeal, dated October 14, 2020; an expedited plan appeal acknowledgment, dated October 15, 2020; a Notice of Plan Expedited Appeal Resolution ("NPAR"), dated October 16, 2020; Sunshine Health Policy and Procedure LT.UM.09, last revised November 2019; and Fla. Admin. Code R. 59G-1.010(166). Absent an objection from the

Petitioner's Authorized Representative, the undersigned admitted the one hundred and sixteen (116)-page evidence packet into evidence as Respondent's Composite Exhibit 1.

FINDINGS OF FACT

1. Petitioner is an enrolled member of Sunshine. Sunshine is a managed care organization contracted by the Agency to provide services to eligible Medicaid recipients in Florida.

2. Petitioner is fifty-two (52)-years old and diagnosed with asthma, occasional dizziness, diabetes, rheumatoid arthritis, degenerating/bulging discs, and depression. Respondent's Composite Exhibit 1 at 40, 49, and 55. Petitioner is five foot and one inch and weighs two hundred and fifty (250) pounds. *Id.* at 42.

3. Petitioner requires total assistance with heavy chores, light housekeeping, managing money, preparing meals, and shopping. *Id.* at 54. Petitioner always has assistance with these tasks. *Id.* Petitioner needs some assistance with managing medication and transportation. *Id.* Petitioner always has assistance with managing her medication and has assistance most of the time using transportation. *Id.*

4. Petitioner requires total assistance for bathing, dressing, using the bathroom, transferring, and walking/mobility. Petitioner always has assistance with bathing, dressing, using the bathroom, and transferring, but rarely has assistance with walking/ mobility. *Id.* at 53

5. Petitioner's sister, [REDACTED], acts as Petitioner's Designated Service Worker ("DSW") through the Participant Option Direction ("PDO") program. [REDACTED] lives with Petitioner and also provides care as a natural support. *Id.* at 59. [REDACTED] does not work outside of the home. *Id.* at 63.

6. Petitioner had a knee replacement which was removed on [REDACTED] 2020, and replaced with an antibiotic loaded spacer. *Id.* at 53. From April 10, 2020, through September 30, 2020, Petitioner received twenty-seven hours per week of Personal Care services. *Id.* at 29. After the end date, Petitioner's Personal Care services reverted to seventeen (17) hours per week, Petitioner's level of services prior to the surgery, with a start date of June 12, 2020, through January 31, 2020. Petitioner requested an additional ten (10) of Personal Care services hours per week, which Respondent denied in an NABD dated October 1, 2020. The NABD explained the basis of the denial as follows:

We determined that your requested services are not medically necessary because the services do not meet either of the reasons checked below: (*See Rule*)

- Meet all of the following criteria for all extended state plan services used for the purposes of maintenance therapy and all other home and community-based services:
 1. 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;
 2. 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
 3. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider;

and one of the following:

1. Enable the enrollee to maintain or regain functional capacity; or
2. Enable an enrollee receiving long-term services and supports to have access to the benefits of community living, to achieve person-centered goals, and live and work in the setting of their choice.

...

The facts that we used to make our decision are: The request for an extra 10 hours per week of Personal Care Services is denied for lack of medical necessity. Based on the assessment, the member's currently approved services are adequate to meet the member's care needs. The member's present care plan includes 17 hours per week of Personal Care Services and 13 hours per week of Homemaker Services. This decision was made with Sunshine Health Policy LT.UM.09 Long Term Care Ancillary Service Criteria.

Id. at 4 through 5.

7. Petitioner requested an expedited plan appeal and received an NPAR dated October 15, 2020, upholding the denial. The NPAR explained as follows:

On October 15, 2020 we received your timely plan expedited appeal request about Sunshine Health's Notice of Adverse Benefit Determination dated October 1, 2020, Notice of Adverse Benefit Determination Number OPFL0193537 denying the request for an extra 10 hours per week of personal care provided to [REDACTED]

On October 15, 2020 after consideration of the information you provided to Sunshine Health in support of your expedited plan appeal, Sunshine Health hereby denies your plan appeal. As a result, [REDACTED] will not receive the request for an extra 10 hours, effective October 15, 2020.

The reason for our decision was: Based on the assessment of the member's care needs and household and caregiver status, the denial of an extra 10 hours/week of Personal Care Services is upheld. The presently approved services are enough to meet the member's care needs.

This decision was made with Sunshine Health Policy LT.UM.09 Long Term Care Ancillary Service Criteria. This decision was made by a Sunshine Health's Medical Director who is Board Certified in Internal Medicine, Geriatric Medicine, and Hospice & Palliative Care.

Id. 78.

8. [REDACTED] requested an expedited Fair Hearing on behalf of Petitioner on October 16, 2020. On November 6, 2020, after receiving a valid Designation of Authorized Representative, the undersigned issued an Order Scheduling Fair Hearing by Telephone and Prehearing Instructions, setting the hearing for November 9, 2020, at [REDACTED]

9. During the hearing, Petitioner testified that she is unable to bathe herself due to her weight, bulging discs, and her knee's condition. She also testified that she utilizes a continuous passive motion ("CPM") machine on her leg for three (3), two (2)-hour sessions every day, totaling six hours per day, which must be supervised and adjusted, usually two to three times per

session, by [REDACTED]. Petitioner testified that, prior to acting as her full-time caregiver, [REDACTED] had a job outside of the home.

10. [REDACTED] testified that as of [REDACTED] 2020, Petitioner has received a new knee replacement to replace the one removed on [REDACTED] 2020. [REDACTED] added that Petitioner can now bear some weight on her leg that received the knee replacement and no longer receives an intravenous antibiotic.

11. During the hearing, Dr. Koreff-Wolf testified that Respondent denied Petitioner's request because Respondent disagrees with the 701B that Petitioner needed total assistance with bathing because Petitioner has use of her arms. Dr. Koreff-Wolf also testified the requested services are not medically necessary because Petitioner is now weight bearing on her leg that received the knee replacement and that [REDACTED] does not need to constantly supervise Petitioner's use of the CPM machine.

CONCLUSIONS OF LAW

12. The Agency's Office of Fair Hearings has jurisdiction over the subject matter of this proceeding and the parties pursuant to Fla. Stat. § 409.285(2). This order is the final administrative decision of AHCA under Fla. Stat. § 409.285(2)(a).

13. This hearing was held as a *de novo* proceeding pursuant to Fla. Admin. Code R. 59G-1.100(17)(b).

14. Because Petitioner is requesting a new service, Fla. Admin Code R. 59G-1.100(17)(g) assigns the burden of proof to Petitioner. The standard of proof in an administrative hearing is a preponderance of the evidence. The preponderance of the evidence standard requires proof by "the greater weight of the evidence". Black's Law Dictionary at 1201, 7th Ed.

15. The Florida Medicaid Statewide Medicaid Managed Care Long-term Care Program Coverage Policy (March 2017) (“LTC Policy”), incorporated by reference in Fla. Admin. Code R. 59G-4.192, governs Long-Term Care services available under Florida Medicaid. The LTC Policy provides the following with respect to Homemaker services and Personal Care services:

1.1 Description and Program Goal

Under the Statewide Medicaid Managed Care Long-Term Care (LTC) program, managed care plans (LTC plans) are required to provide an array of home and community-based services that enable enrollees to live in the community and to avoid institutionalization.

...

1.3.1 Activities of Daily Living (ADLs)

ADLs include:

- Bathing
- Dressing
- Eating (oral feedings and fluid intake)
- Maintaining continence (examples include taking care of a catheter or colostomy bag or changing a disposable incontinence product when the recipient is unable to control bowel or bladder functions)
- Toileting
- Transferring

...

1.3.9 Instrumental Activities of Daily Living (IADLs)

When necessary for the recipient to function independently, including:

- Grocery shopping
- Laundry
- Light housework
- Meal preparation
- Money Management
- Personal hygiene
- Transportation
- Using the telephone to take care of essential tasks (examples include paying bills and setting up medical appointments)

...

1.3.16 Natural Supports

Unpaid supports that are provided voluntarily to the individual in lieu of home and community-based services and supports.

...

4.1 General Criteria

Florida Medicaid LTC plans cover services that meet all of the following:

- Are determined medically necessary, as defined in this rule
- Do not duplicate another service
- Meet the criteria as specified in this policy

...

4.2.1.1 Adult Companion Care

The provision of non-medical care, supervision when necessary to protect the health, safety, and well-being of the enrollee, or social enrichment of a functionally impaired enrollee. This includes assistance or supervision with meal preparation, laundry, and light housekeeping tasks incidental to the care and supervision of the enrollee.

...

4.2.1.9 Homemaker Services

The provision of general household activities (such as meal preparation) and routine household care (including laundry and pest control) by a trained homemaker, when the individual regularly responsible for these activities is temporarily absent or unable to manage these activities.

...

4.2.2.6 Personal Care

In accordance with Rule 59G-4.215, F.A.C., for enrollees under the age of 21 years. To provide assistance with ADLs and IADLs, including assistance with preparation of meals, and housekeeping chores which are incidental to the care furnished or are essential to the health and welfare of the enrollee. The scope and nature of these services do not otherwise differ from personal care services furnished to persons under the age of 21 years.

16. The LTC Policy also addresses medical necessity:

1.3.14 Medically Necessary or Medical Necessity

For the purposes of this policy, the service must meet either of the following criteria:

(a) Nursing facility services and mixed services must meet the medical necessity criteria defined in Rule 59G-1.010, F.A.C.

(b) All other LTC supportive services must meet all of the following:

- 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
- 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
- Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient’s caretaker, or the provider

And, one of the following:

- Enable the enrollee to maintain or regain functional capacity; or
- Enable the enrollee to have access to the benefits of community living, to achieve person-centered goals, and to live and work in the setting of his or her choice.

17. The Definitions Policy, incorporated by reference in Fla. Admin. Code R. 59G-1.010, defines “Medically Necessary” or “Medical Necessity” as follows:

The medical or allied care, goods, or services furnished or ordered must meet the following conditions:

- Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate pain
- 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
- Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational
- 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
- Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient’s caretaker, or the provider

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.

18. The NABD denied Petitioner’s request for additional Personal Care services on the basis that the requested hours are not medically necessary. *Supra* ¶ 6. As provided in the LTC Policy, Personal Care services are intended to provide assistance with ADLs and IADLs, including assistance with preparation of meals, and housekeeping chores which are incidental to the care furnished or are essential to the health and welfare of the enrollee. *Supra* ¶ 15.

19. The evidence shows that [REDACTED] lives with Petitioner and acts as her DSW. *Supra* ¶ 5. As testified to by Petitioner, [REDACTED] left her previous job to act as Petitioner's caregiver. *Supra* ¶ 9. Dr. Koreff-Wolf testified that Respondent denied Petitioner's request after reviewing the 701B and determining that Petitioner did not require total assistance to bathe herself. *Supra* ¶ 10. Dr. Koreff-Wolf also testified that the services requested by Petitioner were not medically necessary considering that Petitioner is able to bear some weight on her leg that received the knee replacement and that [REDACTED] does not need to constant supervise Petitioner's use of the CPM machine. *Id.* Petitioner testified that she cannot bathe herself without total assistance due to her health conditions and that she needs constant supervision while using the CPM machine. *Supra* ¶ 9.

20. The component of medical necessity at issue is whether Petitioner's request is 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. *Supra* ¶ 15. Petitioner currently receives seventeen (17) hours per week of personal care services. [REDACTED] spends forty-two hours per week supervising Petitioner's use of the CPM machine, but only adjusts Petitioner two to three times per two-hour session. As testified to by Dr. Koreff-Wolf, [REDACTED] does not need to be present watching Petitioner use the machine, but [REDACTED] must be present to assist Petitioner as needed. The evidence does not demonstrate that the type of activity described in this circumstance is an IADL or ADL, or a housekeeping chore contemplated in the definition of Personal Care. The function performed by [REDACTED] is supervisory in nature and may be more consistent with Adult Companion Care. Despite Petitioner showing that she has less functionality with respect to bathing than the 701B reflects, and has not regained full functioning of her leg,

Petitioner has still not shown that a total of twenty-seven (27) hours per week of personal care services is medically necessary.

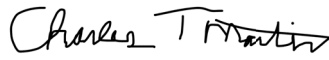
21. The availability of natural supports is considered in addressing this component of medical necessity, even when the Personal Care services would otherwise be medically necessary. *Id.* Here, Petitioner's sister lives with her, acts as her paid caregiver, and provides a significant amount of care to Petitioner beyond the hours approved by the Plan. The record does not indicate that [REDACTED] is an unwilling participant in Petitioner's care. [REDACTED] is not required to be Petitioner's DSW and home health aide services are available to meet Petitioner's Personal Care needs. Even if Petitioner made use of a home health aide service, Petitioner has still not shown that the additional hours requested are not in excess of her needs given the availability of her sister as a natural support to meet Petitioner's needs in the absence of Plan provided care. Petitioner has not met the burden of proof to show that the Personal Care services requested are medically necessary.

22. Accordingly, the undersigned concludes that Petitioner has not proved by a preponderance of the evidence that Respondent's denial of ten (10) hours of Personal Care services was incorrect.

23. **IT IS HEREBY ORDERED AND ADJUDGED:**

Respondent's denial is **AFFIRMED**. Petitioner's appeal based on Respondent's denial is **DENIED**.

DONE and ORDERED this 12th day of November, 2020, in Tallahassee, Leon County, Florida.



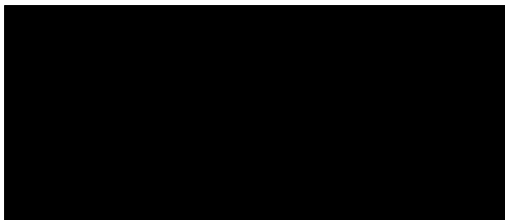
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NOTICE OF A RIGHT TO JUDICIAL REVIEW

A PARTY WHO IS ADVERSELY AFFECTED BY THIS FINAL ORDER IS ENTITLED TO JUDICIAL REVIEW, WHICH SHALL BE INSTITUTED BY FILING THE ORIGINAL NOTICE OF APPEAL WITH THE AGENCY CLERK OF AHCA, AND A COPY, ALONG WITH THE FILING FEE PRESCRIBED BY LAW, WITH THE DISTRICT COURT OF APPEAL IN THE APPELLATE DISTRICT WHERE THE AGENCY MAINTAINS ITS HEADQUARTERS OR WHERE A PARTY RESIDES. REVIEW PROCEEDINGS SHALL BE CONDUCTED IN ACCORDANCE WITH THE FLORIDA APPELLATE RULES. THE NOTICE OF APPEAL MUST BE FILED WITHIN 30 DAYS OF THE RENDITION OF THE ORDER TO BE REVIEWED.

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