



STATE OF FLORIDA
AGENCY FOR HEALTH CARE ADMINISTRATION
OFFICE OF FAIR HEARINGS

FILED

Dec 14, 2020, 8:33 am

OFFICE OF FAIR HEARINGS

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PETITIONER,

AHCA Case No.: 20-FH █

Plan ID No.: █

vs.

SUNSHINE STATE HEALTH PLAN, INC.,

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned Hearing Officer convened a telephonic Medicaid Fair Hearing in the above-styled case on November 18, 2020, at █

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APPEARANCES

For the Petitioner:

█

Petitioner

For the Respondent:

Kizzy Alleyne
Senior Manager
Sunshine State Health Plan, Inc.

STATEMENT OF ISSUE

The issue is whether Petitioner proved by a preponderance of the evidence that Respondent's denial of an additional 14 hours per week of personal care services was incorrect.

PRELIMINARY STATEMENT

All parties and witnesses appeared telephonically. Petitioner appeared for the hearing and provided testimony on his own behalf.

Kizzy Alleyne, Senior Manager for Sunshine State Health Plan, Inc. (“Sunshine”), appeared as a representative for Respondent. Dr. Andrew Russell (“Dr. Russell”), Long Term Care Medical Director for Sunshine, appeared as a witness for Respondent. Vanessa Keyes, Care Coordinator for Sunshine; Louise Jeanty, Quality Improvement Supervisor for Sunshine; and Christina Martin, supervisor for Sunshine appeared on behalf of Respondent but did not testify.

Marielisa Amador, Medical/Health Care Program Analyst for the Agency for Health Care Administration (“Agency” or “AHCA”), appeared for observational purposes.

Petitioner did not submit an evidence package prior to or during the Fair Hearing. Respondent sent to the Office of Fair Hearings and Petitioner a ninety-eight (98)-page hearing packet. The packet included the following documents: the Medicaid Fair Hearing Table of Content; Medicaid Fair Hearing Summary, dated October 29, 2020; Notice of Adverse Benefit Determination (“NABD”), dated September 2, 2020; Long Term Care Person-Centered Care Plan, signed August 27, 2020; Florida Department of Elder Affairs 701B Comprehensive Assessment (“701B Assessment”), dated August 27, 2020; Request for Appeal or Grievance Form, dated September 14, 2020; fax from ██████████, dated September 14, 2020; clinical notes of ██████████ dated ██████████, 2020; NABD, dated September 2, 2020; Expedited Appeal Request Decision, dated September 15, 2020; Standard Appeal Acknowledgement, dated September 15, 2020; Notice of Plan Appeal Resolution, dated October 12, 2020; Sunshine Health Policy and Procedure, LTC (Long Term Care) Ancillary Service Criteria, LT.UM.09; and Florida Administrative Code Rule (“Fla. Admin. Code R.”) 59G-1.010. Absent an objection, the undersigned admitted Respondent’s ninety-eight (98)-page hearing packet into evidence as Respondent’s Composite Exhibit 1.

FINDINGS OF FACT

1. Petitioner is an enrolled member of Sunshine’s Florida Medicaid Managed Medical Assistance plan and Long Term Care plan. See Respondent’s Composite Exhibit 1 at pages 2 and 13. Sunshine is a managed care organization contracted by AHCA to provide services to eligible Medicaid recipients in Florida.

2. Petitioner is a 48-year-old male who lives in a private residence with his wife and daughter *Id.* at 13 and 23. Petitioner suffers from advanced diabetes, severe neuropathy in his extremities, general arthritis, heart problems, and is incontinent of bowel and bladder. *Id.* at 28 – 29.

Petitioner’s 701B Assessment states, in pertinent part, as follows:

[Petitioner] reports that it takes around 2 hours in the morning for bathing and dressing due to his inability to assist with his personal needs. He requires pull up changes throughout the day and must be assisted to use the bathroom for bowel movements daily. In the evenings he requires 2 hours of assistance with getting ready bed later in the evenings for changes and feedings . . . Member is no longer able to eat on his own due to extensive neuropathy in his fingers. He is completely reliant on his wife. Member has a rolling walker but due to extensive pain in his head, he requires assistance with transferring and cannot stand to take more than a few steps.

Id. at 26.

3. Regarding Activities of Daily Living (“ADLs”), Petitioner needs total assistance (cannot do at all) with bathing, dressing, eating, using the bathroom, transferring, and walking/mobility. *Id.* at 26. Regarding the amount of assistance Petitioner has with ADLs, Petitioner has assistance most of the time with bathing, dressing, eating, using the bathroom, transferring, and walking/mobility. *Id.*

4. Regarding Instrumental Activities of Daily Living (“IADLs”), Petitioner needs total assistance (cannot do at all) with heavy chores, light housekeeping, preparing meals, and

shopping. *Id.* at 27. Petitioner needs assistance (but not total help) with managing money, managing medication, and using transportation. *Id.* Petitioner has assistance most of the time with heavy chores, light housekeeping, managing money, preparing meals, shopping, managing medication, and using transportation. *Id.* Petitioner needs no assistance using the telephone. *Id.* Petitioner's wife manages his medications. *Id.*

5. On September 2, 2020, Respondent issued an NABD denying Petitioner's request for an additional 14 hours per week of personal care services, explaining that the requested services are not medically necessary. *Id.* at 4. The NABD stated:

Sunshine Health has reviewed your request for an extra 14 hours per week of personal care (the person who helps bathe and dress you), which were received on 08/27/2020. After our review, this service has been: DENIED as of 09/02/2020.

We made our decision because:

(Check all boxes that apply)

We determined that your requested services are not medically necessary because the services do not meet the reason(s) 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 14 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 24 hours per week of Personal Care Services and 7 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 – 6.

6. Petitioner requested a plan appeal. *Id.* at 54 – 55. On October 12, 2020, Respondent sent Petitioner an NPAR denying 14 additional hours per week of personal care services. *Id.* The NPAR stated as follows:

On October 9, 2020, after consideration of the information you provided to Sunshine Health in support of your plan appeal, Sunshine Health hereby DENIES your plan appeal. As a result, [Petitioner] will not receive an extra 14 hours per week of Personal Care Services, effective October 9, 2020.

The reason for our decision was the request for an additional 14 hours per week of Personal Care (the person who helps bathe and dress you) PDO is denied. Based on the assessment of the member's care needs and household caregiver status, the member's current services are appropriate. This decision was made with Sunshine Health Policy LT.UM.09 Long Term Care Ancillary Service Criteria.

Id. at 60 - 61.

7. With his appeal request, Petitioner submitted clinical notes from his physician, [REDACTED], dated [REDACTED], 2020. The notes state, in pertinent part, as follows:

Pt needs extra 14 hours of personal care due to his advanced medical conditions as described above. Extra hours will improve patient health and much safer at home. Pt has affected the ADLs due to advance long term diabetes complications.

Id. at 45.

8. Petitioner is currently authorized to receive 24 hours per week of personal care services and 7 hours per week of homemaker services. *Id.* at 2. In the NPAR, Sunshine denied an additional 14 hours per week of personal care services, which are at issue in this case. *Id.*

9. On October 23, 2020, Petitioner requested a Fair Hearing due to the denial of additional personal care services. On October 28, 2020, the undersigned scheduled the Fair Hearing for November 18, 2020, at [REDACTED], and all parties were duly notified.

10. At the Fair Hearing, Petitioner asserted that he needs additional personal care services because he suffers from severe medical conditions. Petitioner asserted that he is unable to walk, take a shower, or use the bathroom on his own. He further asserted that he needs assistance with eating, managing medications, and transfers. He testified that he is legally blind and suffers from neuropathy throughout his body. Petitioner stated that his wife is his Patient Directed Option caregiver and took time off of work due to COVID-19 to help him.

11. Dr. Russell stated that Petitioner is currently approved for a total of 31 hours per week of paid services as follows: 24 hours of personal care services and 7 hours of homemaker services. Dr. Russell asserted that the currently authorized level of services is adequate to meet Petitioner's needs. Dr. Russell argued that Petitioner requires personal care assistance but that he is not bed bound or home bound. He argued that Petitioner has no skilled nursing needs, receives no respiratory treatments, has no memory issues, and has not had any recent emergency room visits or hospitalizations. Dr. Russell argued that additional personal care services are not medically necessary because Petitioner lives at home with his wife and daughter who are available to assist with Petitioner's care.

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 section 409.285(2), Florida Statutes (2019). This order is the final administrative decision of AHCA under section 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. The burden of proof in this proceeding is governed by Fla. Admin Code R. 59G-1.100(17)(g), which provides as follows:

The burden of proof is on the party asserting the affirmative of an issue, except as otherwise required by statute. The burden of proof is on the Agency or plan, whichever is applicable, when the issue presented is the suspension, reduction, or termination of a previously authorized service. The burden of proof is on the recipient or enrollee, when the issue presented is the denial or a limited authorization of a service. The party with the burden of proof shall establish its position to the satisfaction of the Hearing Officer by a preponderance of the evidence.

15. Because Petitioner is requesting additional services, Fla. Admin. Code R. 59G-1.100(17)(g) assigns the burden of proof to the 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.).

16. The Florida Medicaid policy that applies to the requested services is the Florida Medicaid Statewide Medicaid Managed Care Long-term Care Program Coverage Policy ("March 2017") ("LTC Policy"). The Agency's LTC Policy has been incorporated, by reference, into Florida Administrative Code Rule 59G-4.192. The LTC Policy provides as follows:

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 Definitions

The following definitions are applicable to this policy. For additional definitions that are applicable to all sections of Rule Division 59G, F.A.C., please refer to the Florida Medicaid definitions policy.

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

...

1.3.5 701-B Comprehensive Assessment

An individualized, complete assessment of an individual's medical, developmental, behavioral, social, financial, and environmental status. The assessment is conducted by a trained individual employed by the Department of Elder Affairs Comprehensive Assessment and Review for Long-Term Care Services (CARES) program or the LTC plan, to determine eligibility for the LTC program based on the need for a nursing facility level of care.

...

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
- Medication management
- Money management
- Personal hygiene
- Transportation
- Using the telephone to take care of essential tasks (examples include paying bills and setting up medical appointments)

...

1.3.14 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.

...

1.3.16 Natural Supports

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

...

2.2 Who Can Receive

Florida Medicaid recipients requiring medically necessary LTC services who are enrolled in a LTC plan and have a nursing facility level of care determined by the CARES program. Some services may be subject to additional coverage criteria as specified in section 4.0.

...

4.0 Coverage Information

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 Specific Criteria

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

- Consistent with the type, amount, duration, frequency, and scope of services specified in an enrollee's authorized plan of care
- Provided in accordance with a goal in the enrollee's plan of care

- Intended to enable the enrollee to reside in the most appropriate and least.

...

4.2.1 Home and Community-Based Supportive Services

The LTC program benefit includes coverage of the following home and community-based supportive services:

...

4.2.1.8 Home Delivered Meals

The provision of nutritionally sound meals delivered to an enrollee's home when an enrollee has difficulty shopping for, or preparing food, without assistance. All meals must provide a minimum of 33 1/3% of the current Dietary Reference Intake. The meals must meet the current Dietary Guidelines for Americans, the United States Department of Agriculture My Pyramid Food Intake Pattern and reflect the predominant statewide demographic.

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 Mixed Services

Mixed services may exceed State Plan limits on those services in accordance with this policy. The Long-term Care benefit includes coverage of the following mixed services:

...

4.2.2.5 Medical Equipment and Supplies

In accordance with Rule 59G-4.070, F.A.C. This service includes the provision of medical equipment and supplies specified in the plan of care, including: devices, controls, or appliances that enable the enrollee to increase the ability to perform activities of daily living; devices, controls, or appliances that enable the enrollee to perceive, control, or communicate with the environment in which he or she lives; items necessary for life support or to address an enrollee's physical conditions, along with ancillary supplies and equipment necessary to the proper functioning of such items; such other durable and non-durable medical equipment not available under the State Plan that is necessary to address enrollee needs, including consumable medical supplies, such as adult diapers; and repair of such items or replacement parts.

...

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.

...

6.0 Documentation

...

6.2 Specific Criteria

In order to receive LTC services, services must be documented on an individualized plan of care based upon a comprehensive needs assessment. The comprehensive assessment includes the completion of the 701-B Comprehensive Assessment and the LTC Supplemental Assessment.

LTC Policy at pages 1-8.

17. The Personal Care Services Coverage Policy (November 2016) (“PC Policy”), which is incorporated by reference in Fla. Admin. Code R. 59G-4.215, states as follows:

1.1 Description

Florida Medicaid personal care services provide medically necessary assistance, in the home or in the community, with activities of daily living (ADL) and age appropriate instrumental activities of daily living (IADL) to enable recipients to accomplish tasks they would normally be able to do for themselves if they did not have a medical condition or disability.

...

1.1.2 Statewide Medicaid Managed Care Plans

Florida Medicaid managed care plans must comply with the coverage requirements outlined in this policy, unless otherwise specified in the AHCA contract with the Florida Medicaid managed care plan. The provision of services to recipients enrolled in a Florida Medicaid managed care plan must not be subject to more stringent coverage limits than specified in Florida Medicaid policies.

...

1.3 Definitions

The following definitions are applicable to this policy. For additional definitions that are applicable to all sections of Rule Division 59G, F.A.C., please refer to the Florida Medicaid definitions policy.

...

1.3.6 Home Health Services

Medically necessary services that can be safely provided to the recipient in their home or in the community that include home health visits (skilled nursing and home health aide services), private duty nursing, and personal care services.

...

4.2 Specific Criteria

Florida Medicaid reimburses for up to 24 hours of personal care services per day, per recipient, in order to provide assistance with ADLs and age appropriate IADLs when the recipient meets the following criteria:

- Has a medical condition or disability that substantially limits their ability to perform ADLs or IADLs and do not have a parent or legal guardian able to provide the required care
- Is under the care of a physician and has a physician's order for personal care services
- Requires more extensive and continual care than can be provided through a home health visit
- Requires services that can be safely provided in their home or the community

PC Policy at pages 3 - 5.

18. The Florida Medicaid Authorization Requirements Policy, June 2016, ("Authorizations Policy") states in pertinent part, as follows:

1.1 Description

This policy contains general requirements for providers to obtain authorization to render Florida Medicaid services, when applicable.

1.1.1 Florida Medicaid Policies

This policy is intended for use by all providers that render services to eligible Florida Medicaid recipients through the fee-for-service delivery system, unless otherwise specified. It must be used in conjunction with Florida Medicaid's general policies (as defined in section 1.3) and any applicable service-specific and claim reimbursement policies with which providers must comply.

...

1.2 Definitions

The following definitions are applicable to this policy. For additional definitions that are applicable to all sections of Rule Division 59G, F.A.C., please refer to the Florida Medicaid definitions policy.

1.3.1 Authorization

The process of obtaining approval for reimbursement of a service based on medical necessity.

1.3.2 Claim Reimbursement Policy

A policy document that provides instructions on how to bill for services.

1.3.3 Coverage and Limitations Handbook or Coverage Policy

A policy document that contains coverage information about a Florida Medicaid service.

1.3.4 General Policies

A collective term for Florida Medicaid policy documents found in Rule Chapter 59G-1 containing information that applies to all providers (unless otherwise specified) rendering services to recipients.

1.3.5 Medically Necessary/Medical Necessity

As defined in Rule 59G-1.010, F.A.C.

1.3.6 Provider

The term used to describe any entity, facility, person, or group that has been approved for enrollment or registered with Florida Medicaid.

1.3.7 Quality Improvement Organization

Entity designated to perform utilization review, quality assurance, and quality improvement activities for Florida Medicaid-covered services rendered by fee-for service providers (also known as the QIO).

...

2.4.3 Modifications

Providers must submit a modification request to the QIO to update the authorization when the recipient requires a different level of service (amount, frequency, duration, or scope) than is currently authorized. Providers must submit additional information documenting the need for the change, including an updated physician's order and plan of care (as applicable) with the request.

Authorizations Policy at pages 1 and 3.

19. The Florida Medicaid Definitions Policy (August 2017) ("Definitions Policy"), which is incorporated by reference in Fla. Admin. Code R. 59G-1.010, defines "medical necessity" as follows:

2.83 Medically Necessary or Medical Necessity

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 severe 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.

20. In the instant case, Petitioner requested an additional 14 hours of personal care services per week. *See supra* ¶ 5 and 6. As established on the record by the evidence and testimony, Respondent denied Petitioner's request, because the documentation submitted in support of Petitioner's request failed to establish that the requested services were medically necessary. *Id.*

21. Section 4.1 of the LTC Policy provides that Florida Medicaid LTC plans cover services that: (a) are determined medically necessary, as defined in the LTC Policy; (b) do not duplicate another service; and (c) meet the criteria as specified in the LTC Policy. *See supra* ¶ 16.

22. Section 4.2.2.6 of the LTC Policy indicates that personal care services are "[t]o 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." *See supra* ¶ 16.

23. The evidence presented in this case does not demonstrate that Petitioner is in need of an additional 14 hours per week of personal care services. Specifically, Fla. Admin. Code R. 59G-1.010^[ND1] requires that a service "[b]e 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." In this case, the Petitioner requires total assistance (cannot do at all) with bathing, dressing, eating, using the bathroom, transferring, and walking/mobility. *See supra* ¶ 3. Further,

Petitioner has assistance most of the time with his ADLs. *See supra* ¶ 3. With regard to IADLs, Petitioner needs total assistance (cannot do at all) with heavy chores, light housekeeping, preparing meals, and shopping. *See supra* ¶ 4. Petitioner needs assistance (but not total help) with managing money, managing medication, and using transportation. *See supra* ¶ 4. Petitioner also has assistance most of the time with his IADLs. *See supra* ¶ 4. The record also indicates that Petitioner has natural supports available to assist with his care and needs. Section 1.3.16 of the LTC Policy provides that natural supports are “[u]npaid supports that are provided voluntarily to the individual in lieu of home and community-based services and supports.” *See supra* ¶ 16. Petitioner resides in the home with his wife and daughter. Petitioner’s wife is his primary caregiver and she does not currently work outside the home. *See supra* ¶ 2 and 10. Petitioner is currently approved for a total of 31 hours per week of paid services as follows: 24 hours of personal cares services and 7 hours of homemaker services. *See supra* ¶ 6, 8 and 11. Other than his testimony, Petitioner provided no additional evidence (i.e., a daily schedule, a schedule of ADLs and IADLs, the amount of time needed for each ADL and IADL) to justify the approval of an additional 14 hours of personal care services weekly. The currently approved 31 hours is also consistent with the description of Petitioner’s needs and time needed to complete ADLs contained in Petitioner’s 701B Assessment. *See supra* ¶ 2.

24. Petitioner’s provider, ██████████, recommended an additional 14 hours weekly of personal care services. *See supra* ¶ 7. ██████████ stated that Petitioner’s ADLs are affected by long term diabetes. *See supra* ¶ 7. However, ██████████ did not describe which of Petitioner’s ADLs require additional support and how much additional time is needed for each ADL. Petitioner’s most recent 701B Assessment also indicates that Petitioner already has assistance “most of the time”

with his ADLs and IADLs. *See supra* ¶ 3 and 4. As Dr. Russell testified, the currently authorized hours of personal care and homemaker services are sufficient to meet Petitioner’s needs. *See supra* ¶ 11.


25. Therefore, considering Petitioner’s currently authorized services, along with the LTC Policy definition for personal care services, homemaker services, and natural support, Petitioner did not demonstrate that his aforementioned needs, *supra* ¶ 2 – 4 and 10, are not sufficiently met by his currently authorized services. Given that Petitioner failed to establish that the requested personal care services are warranted in this matter, *supra* ¶ 23 - 24, the requested personal care services are “in excess of [Petitioner’s] needs.” *See supra* ¶ 11.

26. In light of the both parties’ testimony, Respondent’s Composite Exhibit 1, the LTC Policy, the PC Policy, the Authorization Requirements Policy, the Definitions Policy, the undersigned Hearing Officer finds that Petitioner failed to meet his burden of proving that the additional 14 hours per week of personal care services are medically necessary. Accordingly, the undersigned Hearing Officer finds that Petitioner failed to prove by a preponderance of the evidence that Respondent’s denial of the requested additional personal care services was incorrect.

DECISION

Respondent’s denial of an additional 14 hours per week of personal care services is **AFFIRMED**. Petitioner’s appeal based on Respondent’s denial in this matter is **DENIED**.

DONE AND ORDERED this 14th day of December 2020, in Tallahassee, Leon County, Florida.



Laura Gallagher
20-FH [REDACTED]
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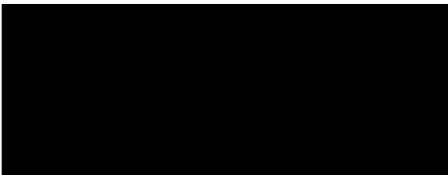
LAURA GALLAGHER, Hearing Officer

**Agency for Health Care Administration
Office of Fair Hearings
2727 Mahan Drive, Mail Stop # 11
Tallahassee, FL 32308-5407
Office: (850) 412-3649
Fax: (850) 487-1423
E-mail: OfficeOfFairHearings@ahca.myflorida.com**

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.

COPIES FURNISHED



**Sunshine State Health Plan, Inc.
SunshineHealth_MFH@centene.com**

**AHCA Medicaid Hearing Unit
MedicaidHearingUnit@ahca.myflorida.com**