



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

FILED

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OFFICE OF FAIR HEARINGS

[REDACTED]

PETITIONER,

AHCA Case No.: 20-FH [REDACTED]

Plan ID No.: [REDACTED]

vs.

AETNA BETTER HEALTH OF FLORIDA, INC.,

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic Fair Hearing on the instant case on January 6, 2021, at [REDACTED]

APPEARANCES

For the Petitioner:

[REDACTED]

Petitioner's Authorized Representative

For the Respondent:

Debra Wingo

Director of Long Term Care

Aetna Better Health of Florida, Inc.

STATEMENT OF ISSUE

The issue is whether Petitioner proved by a preponderance of the evidence that Respondent's decision to deny Petitioner's request for an additional 49 hours weekly of personal care services was incorrect.

PRELIMINARY STATEMENT

PRR0001885

All parties appeared telephonically. Petitioner's Authorized Representative [REDACTED] (" [REDACTED] ") appeared on behalf of the Petitioner.

Debra Wingo, Director of Long Term Care for Aetna Better Health of Florida, Inc. ("Aetna") appeared on behalf of Respondent. Dr. Olunwa Ikpeazu ("Dr. Ikpeazu"), Medical Officer for Aetna appeared as a witness for Respondent. Elaine Bonge, Director of Operations for Aetna, appeared as a witness for Respondent but did not testify.

Chrissie Simmons, Medical Healthcare 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 fourteen (114)-page evidence packet. The evidence packet included: Medicaid Fair Hearing & Appeal Document Checklist; Acknowledgement of Third Party Medicaid Fair Hearing Request, dated December 3, 2020; Notice of Adverse Benefit Determination ("NABD"), dated October 12, 2020; letter from Aetna, dated October 28, 2020; Notice of Plan Appeal Resolution ("NPAR"), dated November 23, 2020; Comprehensive LTSS Plan of Care, with an effective date of September 18, 2020; Florida Department of Elder Affairs 701B Comprehensive Assessment, dated September 18, 2020; Caregiver Supplemental Assessment, dated September 18, 2020; letter from [REDACTED] (" [REDACTED] "), dated June 12, 2020; Florida Medicaid Statewide Managed Care Long-term Care Program Coverage Policy (March 2017) ("LTC Policy"); Florida Medicaid Home Health Visit Services Coverage Policy (November 2016); and Florida Medicaid Personal Care Services Coverage Policy (November 2016) ("PC Policy"). Absent an objection from the Petitioner, the undersigned admitted the page packet into evidence as Respondent's Composite Exhibit 1.

FINDINGS OF FACT

1. Petitioner is an enrolled member of Aetna's Florida Medicaid Managed Medical Assistance plan and Long Term Care plan. See Respondent's Composite Exhibit 1 at page 40. Aetna is a managed care organization contracted by AHCA to provide services to eligible Medicaid recipients in Florida.

2. Petitioner is a ■-year-old female who lives alone in a private residence. *Id.* at 46. Petitioner suffers from dementia, acid reflux/GERD, anemia, general arthritis, high cholesterol, frequent dizziness, heart problems, and incontinence of bowel and bladder. *Id.* at 46 and 51. Petitioner has aides that rotate and provide 24 hour care. *Id.* at 46. Petitioner must be supervised at all times. She has a history of falls, she is highly confused, and she cannot be left alone as a safety precaution. *Id.* at 54. ■ and private aides provide assistance to Petitioner. *Id.* at 49 - 50. ■ assists with shopping and transportation, which amounts to approximately 7 hours per week of support. *Id.* at 64. ■ also provides private aides to ensure that Petitioner receives 24/7 care. *Id.* at 64.

3. Regarding Activities of Daily Living ("ADLs"), Petitioner needs assistance (but not total help) with bathing, dressing, eating, using the bathroom, transferring, and walking/mobility. *Id.* at 49. Regarding the amount of assistance Petitioner has with ADLs, Petitioner always has assistance with bathing, dressing, eating, using the bathroom, transferring, and walking/mobility. *Id.* Petitioner's 701B Assessment states, "[m]ember is highly confused, has a history of falls along with numerous other conditions which compromise her ability to properly/safely perform ADL's." *Id.*

4. Regarding Instrumental Activities of Daily Living (“IADLs”), Petitioner needs total assistance (cannot do at all) with heavy chores, light housekeeping, managing money, preparing meals, shopping, and using transportation. *Id.* at 50. Petitioner needs assistance (but not total help) with using the telephone and managing medication. *Id.* Petitioner always has assistance with heavy chores, light housekeeping, using the telephone, managing money, preparing meals, shopping, managing medication, and using transportation. *Id.*

5. On June 12, 2020, Petitioner’s physician, [REDACTED], wrote a letter stating:

Considering how fragile, prone to falling or being disoriented [Petitioner] is, I urge you to continue with the 24 hour service provided by caregivers your mother has had since August 2018. Furthermore, this support is medically necessary as she needs assistance with bathing, personal hygiene, food intake, etc.

Id. at 66.

6. On October 12, 2020, Respondent issued an NABD denying Petitioner’s request for an additional 49 hours weekly of personal care services and explaining that the requested services are not medically necessary. *Id.* at 11 - 15. The NABD stated:

Aetna Health has reviewed your request for 49 hours of Personal Care Services weekly, which we received on 10/12/2020. After our review, this service has been:

Denied as of 10/12/2020

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.

...

Other authority

The facts that we used to make our decision are:

Your caregiver asked Aetna Better Health of Florida to cover 49 additional hours of Personal Care Services weekly. We will not approve this request because you are receiving enough hours to meet your needs. You are currently getting 21 hours of Personal Care Services weekly and 14 hours of Homemaker Services weekly, for a total of 35 hours of a Home Health Aide weekly. You live alone. We have records dated 10/06/2020 that show you need assistance with bathing, dressing, eating, using the bathroom, and transferring; you use an assistive device (walker) for walking/mobility. You need total assistance with meal preparation, doing laundry, housekeeping, and shopping. You need assistance with managing medicines, managing money, transportation, and using the telephone.

We do not see that you:

- have had any change in your condition.
- do not have enough care.
- are at risk of isolation.
- have had any recent hospitalizations.

You should discuss treatment options with your doctor. Decisions about the care you will have are between you and your doctor. Based on the clinical records we have[,] your care plan will be, [sic] 21 hours of Personal Care Services weekly and 14 hours of Homemaker Services weekly, for a total of 35 hours of a Home Health Aide weekly. We made this decision using clinical records and the Florida Medicaid Handbook Policy for Statewide Medicaid Managed Care Long-Term Care Program.

Id. at 11 – 12.

7. Petitioner requested a plan appeal. *Id.* at 23 - 24. On November 23, 2020, Respondent sent Petitioner an NPAR denying the additional hours of personal care services. *Id.* 32 – 34. The NPAR stated:

On October 26, 2020 we received your timely plan appeal request regarding Aetna Better Health of Florida's Notice of Adverse Benefit Determination dated October 12, 2020, NABD Number [REDACTED], denying 49 hours of Personal Care Services weekly provided to [Petitioner].

On November 22, 2020, after consideration of the information you provided to Aetna Better Health of Florida in support of your plan appeal, Aetna Better Health of Florida hereby denies your plan appeal. As a result, [Petitioner] will not receive 49 hours of Personal Care Services weekly, effective 11/22/2020.

Dr. Avril Anthony-Wilson, MD, Medical Director, Florida Board Certified in Family Medicine reviewed your appeal. Your caregiver asked Aetna Better Health of Florida to cover 49 additional hours of personal care services weekly. We will not approve this request because you are receiving enough hours to meet your needs. You are currently getting 21 hours of personal care services weekly and 14 hours of homemaker services weekly, for a total of 35 hours of a home health aide per weekly. You live alone. We have records dated 10/06/2020 that show you need assistance with bathing, dressing, eating, toileting, and transferring; you use an assistive device (walker) for walking/mobility. You need total assistance with meal preparation, laundry, housekeeping, and shopping. You need assistance with managing medicines, money, transportation, and using the telephone.

We do not see that you:

- [Have had any] change in your condition.
- Do not have enough care.
- No risk of isolation.
- No recent hospitalization.

You should discuss treatment options with your doctor. Decisions about the care you will have are between you and your doctor. Based on the clinical records we have[,] your care plan will be 21 hours of personal care services weekly and 14 hours of homemaker services weekly, for a total of 35 hours of a home health aide weekly. We made this decision using clinical records and the Florida Medicaid Handbook Policy for Statewide Medicaid Managed Care Long-term Care Program.

Id. at 32 - 34.

8. Petitioner is currently authorized to receive 21 hours per week of personal care services and 14 hours per week of homemaker services. *Id.* at 40.

9. On December 1, 2020, Petitioner requested a Fair Hearing due to the denial of additional personal care services. On December 8, 2020, the undersigned scheduled the Fair Hearing for January 6, 2021, at [REDACTED] and all parties were duly notified.

10. At the Fair Hearing, [REDACTED] asserted that Petitioner needs additional personal care services because she is very fragile, disoriented, and in a state of decline. [REDACTED] argued that Petitioner's doctor fully supports the requested services. [REDACTED] asserted that Petitioner currently lives in an independent living facility. [REDACTED] maintained that Petitioner needs round the clock care, and he is paying out of pocket for the additional services that Aetna does not provide. [REDACTED] argued that Aetna has not properly evaluated Petitioner at her residence and that she is paranoid, a fall risk, and experiences confusion. He testified that Petitioner is requesting 12 hours per day of paid services, and he will pay for the rest of the services Petitioner needs.

11. Ms. Wingo asserted that Petitioner's 701B was completed by a certified assessor. She argued that the assessors found that no changes were necessary as of December 2020. Ms. Wingo maintained that the long term care program is intended to be the provider of last resort after the family and natural supports.

12. Dr. Ikpeazu is a board certified pediatrician and Medical Director of Aetna. Dr. Ikpeazu testified that Petitioner needs assistance with most ADLs and all IADLs. She asserted that Aetna calculates the number of hours that are medically necessary and allocates them based on the identified needs. Dr. Ikpeazu calculated that Petitioner needs the following amount of services

on a weekly basis for her ADLs: 4 hours per week for bathing; 2 hours per week for dressing; 6 hours per week for eating; 4 hours per week for using the bathroom; 3 hours per week for transferring; and 1 hour per week for waking and mobility since she uses an assistive device. She asserted that Petitioner's ADLs total 20 hours total per week, and Petitioner receives 21 hours per week of personal care services to cover her personal care needs. For homemaker services, Dr. Ikpeazu calculated that Petitioner requires the following services on a weekly basis: 7.5 hours for meal preparation; 2 hours per week for laundry; 3 hours per week for housekeeping; 1 hour per week for shopping; and 1 hour per week for managing money/medication. Dr. Ikpeazu asserted that Petitioner needs 14 hours per week of homemaker services and is approved for that amount. Dr. Ikpeazu argued that the services must be individualized and not in excess of Petitioner's needs. She further argued that, although Petitioner would like additional personal care services to ensure Petitioner's safety, Medicaid does not reimburse for babysitting services to watch the recipient 24/7.

CONCLUSIONS OF LAW

13. 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).

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

15. 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.

16. 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.).

17. The Florida Medicaid policy that applies to the requested services is the 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:

...

4.2.1.9 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.

18. The 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

...

5.2 Specific Non-Covered Criteria

Florida Medicaid does not reimburse for the following:

...

- Babysitting

PC Policy at pages 3 - 5.

19. In the instant case, Petitioner requested an additional 49 hours of personal care services per week. *See supra* ¶ 6 - 7. As established on the record by the evidence and testimony, Respondent denied Petitioner's request, in part, because the documentation submitted in

support of Petitioner's request failed to establish that the requested services were medically necessary. *See supra* ¶ at 6 - 7.

20. 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* ¶ 17.

21. 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* ¶ 17.

22. The evidence presented in this case does not demonstrate that Petitioner needs an additional 49 hours per week of personal care services. Specifically, the LTC policy 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.” *See supra* ¶ 17. In this case, the Petitioner requires assistance (but not total help) with bathing, dressing, eating, using the bathroom, transferring, and walking/mobility. *See supra* ¶ 3. However, Petitioner currently always has assistance with her ADLs. *See supra* ¶ 3. With regard to IADLs, Petitioner needs total assistance (cannot do at all) with heavy chores, light housekeeping, managing money, preparing meals, shopping, and using transportation. *See supra* ¶ 4. Petitioner needs assistance (but not total help) with using the telephone and managing medication. *See supra* ¶ 4. However, Petitioner always has assistance with her IADLs. *See supra* ¶ 4. The record also indicates that Petitioner has natural supports available to assist with her 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’s son provides natural support by assisting with shopping and transportation, for a total of 7 hours per week, and he hired private aides to ensure that Petitioner receives 24/7 care. See supra ¶ 2. Petitioner is currently approved for a total of 35 hours per week of paid services as follows: 21 hours of personal cares services and 14 hours of homemaker services. See supra ¶ 7. Other than his testimony, ██████ provided no additional evidence at the hearing (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 49 hours of personal care services weekly.

23. As Dr. Ikpeazu testified, the currently approved 35 hours of paid services per week are consistent with the description of Petitioner’s needs identified in Petitioner’s 701B Assessment, and the currently authorized hours of personal care and homemaker services are sufficient to meet Petitioner’s needs. See supra ¶ 2 – 4, and 12. Specifically, Dr. Ikpeazu calculated that Petitioner needs 20 hours weekly of personal care services, and she receives 21 hours. See supra ¶ 12. She further calculated that Petitioner requires 14 hours of homemaker services and receives 14 hours. See supra ¶ 12. Petitioner’s most recent 701B Assessment also indicates that Petitioner always has assistance with her ADLs and IADLs. See supra ¶ 3 and 4. ██████ argued that Petitioner is a fall risk and requires 24/7 supervision as a safety precaution. See supra ¶ 9. However, as Dr. Ikpeazu testified supra ¶ 12, Medicaid does not reimburse for babysitting or supervision, nor do the PC Policy or the LTC Policy include babysitting or supervision in the description of personal care services. See supra ¶ 17 – 18. Petitioner’s physician submitted a letter recommending the continuation of 24/7 services due to Petitioner’s fragility and risk of falling. See supra ¶ 5. The record indicates that Petitioner uses an assistive device for walking,

always has assistance with her ADLs and IADLs, and has private aids and natural support available to her. See supra ¶ 2, 3 and 4. The letter does not identify an unmet need, nor does it explain what specific types or mix of services Petitioner should have. Although Petitioner would like additional personal care services to ensure Petitioner's safety, Medicaid does not reimburse for babysitting services to watch the recipient 24/7. See supra ¶ 12. As previously stated, Petitioner's 35 hours per week of paid services and natural supports are adequate to meet her needs.

24. 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 her aforementioned needs, *supra* ¶ 2 – 4 and 9, are not sufficiently met by her currently authorized services. Given that Petitioner failed to establish that the requested personal care services are warranted in this matter, *supra* ¶ 24 - 25, the requested personal care services are "in excess of [Petitioner's] needs." See supra ¶ 17.

25. In light of the both parties' testimony, Respondent's Composite Exhibit 1, the LTC Policy, the PC Policy, and the Home Health Policy, the undersigned Hearing Officer finds that Petitioner failed to meet her burden of proving that the additional 49 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 additional personal care services is **AFFIRMED**. Petitioner's appeal based on Respondent's **denial** of additional personal care services is **DENIED**.

DONE AND ORDERED this 4th day of February 2021, in Tallahassee, Leon County, Florida.

Laura Gallagher



20-FH [REDACTED]

2021.02.04

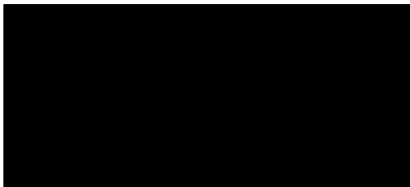
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NOTICE OF A RIGHT TO JUDICIAL REVIEW

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.

Copies Furnished To:



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AHCA Medicaid Hearing Unit
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