



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

**FILED**

May 07, 2021, 10:45 am

OFFICE OF FAIR HEARINGS

[REDACTED]

PETITIONER,

AHCA Case No.: 21-FH [REDACTED]

Plan ID No.: [REDACTED]

vs.

SUNSHINE STATE HEALTH PLAN, INC.,

RESPONDENT.

\_\_\_\_\_ /

[REDACTED]

PETITIONER,

AHCA Case No.: 21-FH [REDACTED]

Plan ID No.: [REDACTED]

vs.

SUNSHINE STATE HEALTH PLAN, INC.,

RESPONDENT.

\_\_\_\_\_ /

[REDACTED]

PETITIONER,

AHCA Case No.: 21-FH [REDACTED]

Plan ID No.: [REDACTED]

vs.

SUNSHINE STATE HEALTH PLAN, INC.,

RESPONDENT.

\_\_\_\_\_ /

**FINAL ORDER**

Pursuant to notice, the undersigned convened a telephonic Fair Hearing on the instant case on February 16, 2021, at [REDACTED]. The hearing was continued and subsequently

reconvened on March 3, 2021, at [REDACTED] Petitioner's Authorized Representative did not appear, and the hearing reconvened a final time on April 13, 2021, at [REDACTED].

**APPEARANCES**

For the Petitioner: [REDACTED]  
Petitioner's Authorized Representative

For the Respondent: Maria Mojica  
Compliance Specialist  
Sunshine State Health Plan, Inc.

**STATEMENT OF ISSUE**

The first issue is whether Petitioner proved by a preponderance of the evidence that Respondent's decision to deny Petitioner's request for an additional ten (10) hours per week of personal care services was incorrect.

The second issue is whether Petitioner proved by a preponderance of the evidence that Respondent's decision to deny Petitioner's request for five (5) hours of hours of respite care services was incorrect.

The third issue is whether Petitioner proved by a preponderance of the evidence that Respondent's decision to deny Petitioner's request for an additional three (3) hours of hours of homemaker services was incorrect.

**PRELIMINARY STATEMENT**

All parties appeared telephonically. Petitioner's Authorized Representative and daughter, [REDACTED] appeared on behalf of the Petitioner. [REDACTED] [REDACTED] also Petitioner's daughter, appeared as a witness for Petitioner.

Maria Mojica, Compliance Specialist for Sunshine State Health Plan, Inc. ("Sunshine") appeared on behalf of Respondent. Cynthia Morasaki, Long Term Care Supervisor for Sunshine;

Louise Jeunty, Quality Improvement Supervisor for Sunshine; Joan Maurice, Care Coordinator for Sunshine; Katherine Colonge, Long Term Care Coordinator for Sunshine; and Dr. Michael Gervasi (“Dr. Gervasi”), Medical Director for Sunshine, attended as witnesses for Respondent.

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

Prior to the hearing, Respondent sent to the Office of Fair Hearings and Petitioner a one hundred (100)-page evidence packet. The evidence packet included: a table of contents; a Medicaid Fair Hearing Summary, dated January 26, 2021; a Notice of Adverse Benefit Determination (“NABD”), dated September 9, 2020; a Long Term Care Person-Centered Care Plan, signed February 2, 2020; a second Long Term Care Person-Centered Care Plan, signed February 11, 2021; a Florida Department of Elder Affairs 701T Non-Community Placement Assessment (“701T”), dated [REDACTED] 2019; second 701T, dated [REDACTED] 2020; Petitioner’s plan appeal with an attached picture, dated October 21, 2020; a Standard Appeal Acknowledgment, dated October 28, 2020; a Notice of Plan Appeal Resolution (“NPAR”), dated November 23, 2020; Sunshine Health Policy and Procedure LT.UM.09, last revised November 2019; and Florida Administrative Code Rule (“Fla. Admin. Code R.”) 59G-1.010(166). Absent an objection from the Petitioner, the undersigned admitted the one hundred (100)-page evidence packet into evidence as Respondent’s Composite Exhibit 1.

Petitioner submitted an email to the Office of Fair Hearings, dated March 22, 2021, in response to the Order to Show Cause for non-appearance. Petitioner’s email was admitted on the undersigned’s motion without objection from the parties as Petitioner’s Exhibit 1.

## FINDINGS OF FACT

1. Petitioner is an enrolled member of Sunshine State Health plan, Inc. (“Sunshine”). Respondent’s Composite Exhibit 1 at 2. Sunshine is a managed care organization contracted by the Agency to provide services to eligible Medicaid recipients in Florida. *See Id.*
2. Petitioner is eighty (80) years old and diagnosed with high blood pressure, congestive heart failure, frequent bladder and bowl incontinence, partial paralysis on her right side, muscle weakness, depression, dementia, and asthma. *Id.* at 42 and 45-46. Petitioner currently lives in a nursing facility. *Id.* at 42.
3. With regards Activities of Daily Living (“ADLs”), Petitioner requires some assistance with bathing, dressing, eating, using the bathroom, and transferring. *Id.* at 44. Petitioner needs total assistance with mobility and uses a wheelchair. *Id.* Petitioner does not need assistance with eating. Petitioner receives assistance with her ADLs from the nursing facility staff. *Id.*
4. With regards to Instrumental Activities of Daily Living (“IADLs”), Petitioner requires total assistance with heavy chores, light housekeeping, managing money, preparing meals, shopping, managing medication, and using transportation. *Id.* Petitioner does not require assistance with using the telephone. *Id.* Petitioner receives assistance with her IADLs from the nursing facility staff with the exception of managing money which is handled by Petitioner’s Power of Attorney. *Id.*
5. Petitioner wishes to transition from the nursing facility and requested the following home health services: forty-five (45) hours per week personal care services; ten (10) hours per week of homemaker services; five (5) hours of respite care services; and five (5) hours per week of adult

companion care services. *Id.* at 5 and 43. Respondent partially denied Petitioner's request. *Id.* at

5. The NABD dated September 9, 2020, explained the basis of the partial 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 the addition of 45 hours per week of Personal Care Services, 10 hours per week of Homemaker Services, 5 hours per week of In Home Respite Care Services and 5 hours per week of Companion Care Services is partially approved.

Based on the assessment of the member's care needs and household and caregiver status, Sunshine Health will approve 21 hours per week of Personal Care Services and 3 hours per week of Homemaker Services and will deny the remaining requested 24 hours per week of Personal Care Services, 7 hours per week of Homemaker Services, 5 hours per week of In Home Respite Care Services, and 5 hours per week of Companion Care Services. The updated care plan approved by Sunshine Health will include 21 hours per week of Personal Care Services and 3 hours per week of Homemaker Services. This decision was made with Sunshine Health Policy LT.UM.09

*Id.*

6. The pertinent portion of Sunshine’s Long Term Care Ancillary Criteria (“LT.UM.09”) provides as follows:

**B. Medical Necessity Determination**

To assist in determining the medical necessity of any ancillary services, the clinical criteria established in this policy will be applied. Any decision to deny, reduce, suspend, or terminate services must be made by a Sunshine Health Medical Director as outlined in the policy Medical Necessity Review FL.UM.02.01 and Use of Clinical Criteria FL.UM.02 Sunshine Health will respond to requests within the timelines as outlined in the policy Timeliness of UM Decisions FL UM 05.

**C. Criteria for Type of Service:**

Criteria for each of the benefits noted in the Policy section will be used when reviewing the medical necessity of any ancillary services. In addition, the Medical Necessity Review policy FL.UM.02.01 is considered when determining medical necessity of ancillary services. The Florida Coverage Policies and Limitations Handbooks are used to determine benefits, any benefit limitations, and additional criteria. The ancillary services of this policy are intended to augment and support the existing informal care and community services being provided to allow the member to remain safely in their home.

**1. Determinants for Services**

When considering the level of support the member requires and which of the ancillary services may support the member’s cognitive, functional, environmental, and social needs, several elements are to be considered. The review for the medical necessity of the ancillary services includes consideration of the member’s support needed due to ADL deficits, living situation, and supervision needs.

- a) Activities of Daily Living (ADL’s)/Instrumental Activities of Daily Living (IADL’s)
  - Independent where member is able to provide the task without support, with or without assistive devices
  - Minimal functional impairment where the ADL’s require one of the following:
    - Supervision
    - At least minimal assistance
    - Member ambulates with assistance of a person or a device
    - Member transfers require at least minimum assistance
  - Moderate functional impairment where two of the follow apply:
    - Member has ADLs requiring at least minimal assistance
    - Member ambulates with assistance of a person or device
    - Member transfers require at least minimum assistance

- Maximum and persistent functional impairment without available caregiver support where all of the following exist:
  - Member has ADLs requiring total assistance
  - Member is non-ambulatory
  - Member transfers require one (1) to two (2) person assist
  - Member's treating physician has certified that member meets Maximum functional impairment.

b) Living situation consideration

- Lives alone
- Lives with family (with consideration of the number of days and hours that family members are not available to assist the member).
- Lives with non-family (with consideration of the number of days and hours that nonfamily members are not available to assist the member).

c) Supervision needs, including:

- Wandering risk: Member has already been found to leave their home unsafely and/or is unable to find their way back.
- Confused/disoriented and at risk to themselves: Member is confused and/or disoriented to the point that they are unable to perform functional activities, and if they do are at risk of harm to themselves.
- Member has a cognitive impairment that prevents them from knowing when or how to carry out personal care tasks and caregivers are not able to provide the services. The member is incapable of learning despite efforts to train in the care tasks. The member has memory deficits, which prevent them from managing care tasks.
- Member is unable to call for help, even with a personal emergency response unit. Member's medical status will not permit the member to all for help, even with assistance of a personal emergency response unit.

...

d) Available Supports

- No assistance needed or Always has assistance
- Has assistance most of the time
- Rarely has assistance
- Never has assistance

Services in Place

- Provided by Sunshine Health
- Provided by other Provider insurance

The criteria for each ancillary service is described below:

...

**6. Homemaker Services**

Homemaker provides assistance with essential shopping, light housework

laundry, and meal preparation. These services are provided to members who exhibit a functional deficit that impairs their ability to complete these tasks and lack an available support system. Services are provided to support member's health, safety, and ensure basic standards are met. Services are provided by a trained homemaker when the individual regularly responsible for these services is temporarily absent or unable to manage these activities.

**Approval Criteria**

Homemaker Service reviews include four (4) criteria:

- a) Instrumental Activity of Daily Living (IADL) limitations
- b) Living situation
- c) Supervision needs
- d) Available Supports

...

**7. Personal Care Services**

A service that provides assistance with eating, bathing, dressing and personal hygiene, and other activities of daily living. The service includes assistance with preparation of meals, but does not include the cost of meals. The service may also include housekeeping tasks such as bed making, dusting and vacuuming, which are incidental to the care furnished or are essential to the health and welfare of the member, rather than the member's family. Personal care services include the following:

- a. Assistance to the member to complete personal hygiene (bathing, grooming, mouth care, etc.)
  - b. Assistance with bladder and bowel requirements that include assisting the member to and from the bathroom or with bedpan routines
  - c. Assisting the member in following through with physician orders
- The Personal Care provider cannot not administer any medications, but may bring medications to the member and remind the member to take the medicine at specific times
- d. Assisting with food, nutrition, and diet activities, including preparing meals, when required and other incidental services, (i.e. housekeeping chores) essential to the health and welfare of the member
  - e. Performing household services (changing bed linen or arranging furniture), when such services are essential to the member's health and comfort.

Personal Care workers must be supervised by a registered nurse, licensed to practice nursing in Florida and who conducts a supervisory home visit every 60 days to observe the personal care worker. The services may be provided in the member's home or other location.

**Approval Criteria**

Personal Care Services reviews include four (4) criteria:

- a) Activity of Daily Living (ADL) limitations
- b) Living situation
- c) Supervision needs
- d) Available Supports

...

### **9. Respite Care**

In-home Respite Care services are to provide short-term, temporary relief to the informal, unpaid caregiver in order to support and preserve the primary caregiving relationship. The service provides general supervision, meal preparation, and hands-on assistance with personal care that are incidental to supervision during the period of service delivery. Respite services can be provided on a planned or emergency basis and shall only be furnished in the member's home. The provider must be awake during the provision of respite services and the services shall not be provided overnight. Member must reside in a non-facility based setting with his or her informal, unpaid primary caregiver.

#### **Approval Criteria**

To be considered for In-Home Respite Services, a member must have a primary caregiver as defined below, have a qualifying trigger diagnosis, and meet the minimal criteria for the four (4) dimensions of determination as discussed here.

- a) A primary caregiver is defined as any person who lives with the member and regularly provides or arranges help as needed with Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs). This person may or may not be related by birth or marriage.

- b) Trigger diagnosis include:

1. Advanced Alzheimer's disease & dementia
2. Advanced Parkinson's disease
3. Multiple Sclerosis
4. ALS
5. Congestive Heart Failure
6. COPD
7. Cancer
8. End Stage Renal disease
9. TBI
10. Other diagnosis as deemed medically necessary by Medical Director

- c) Four (4) Dimensions of Determination

1. Level of functioning for safety reasons
  - Independent-
  - Supervision-
  - Minimal Assistance- ADL's require one of the following:
  - Moderate Assistance- ADLs require two of the following:

- Total Assistance- ADL's require total hands on assistance

See Section C.1.c for more details

2. Caregiver Stress – defined by responses for caregiver assessment questions on the 701B

- Minimal Stress
- Moderate Stress
- Major Stress
- Sudden Absence
  - a. Defined by documented absence of caregiver due to medical emergency

3. Informal Supports

- Alone
- Lives with caregiver
- Lives with caregiver and others
- Lives with 2 caregivers

4. Services in Place

- Sunshine Health provided
- Provided by other provider/insurance

Exclusions and Limitations for In-Home Respite Services include but are not limited to:

1. Service must be provided at member's residence.
2. Member must reside in a non-facility based setting.
3. Member resides with his or her informal, unpaid primary caregiver.
4. In-home Respite Care services provides short-term, temporary relief to the informal, unpaid caregiver.
5. In-home Respite Care provides relief to member's primary caregiver when member care is causing stress for caregiver.
6. Service is provided when caregiver is absent.
7. The service is not provided when other family members resides in the home who are able to provide care.
8. Respite services can be provided on a planned or emergency basis.
9. The provider must be awake during the provision of respite services, and the services shall not be provided overnight.
10. In-home Respite Care services provided by Sunshine Health may not duplicate services that are provided under by another provider.
11. Services are to substitute the care that is provided by the caregiver, independent of the other services being provided to the member.

12. Provision of services provided during the respite period are within the respite provider's scope of practice.

*Id.* at 73-75, 80, 86-87, and 93-95.

7. Respondent issued an NPAR dated November 12, 2020, partially upholding the denial of Petitioner's request for additional personal care services, homemaker services, and respite care services. *Id.* at 62. The NPAR explained as follows:

On October 22, 2020, we received your timely plan appeal request about Sunshine Health's Notice of Adverse Benefit Determination dated September 9, 2020, Notice of Adverse Benefit Determination Number [REDACTED] partially denying, the 24 hours per week of personal care (the person who helps bathe and dress you), 7 hours per week of homemaking services (the person who cleans for you), 5 hours per week of respite care (the care given at your home to gives your caregiver a break), 5 hours per week of companion care ( the person who helps wathec [sic] over you), provided to [REDACTED]

On November 21, 2020, after consideration of the information you provided to Sunshine Health in support of your plan appeal, Sunshine Health hereby partially approves your plan appeal. As a result, [REDACTED] will receive the 14 hours per week of personal care, 4 hours per week of homemaking services, will not receive the 5 hours per week of companion care, and the 5 hours per week of respite care, effective November 21, 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 the remaining requested services is now partially overturned. Sunshine Health will now approve an extra 14 hours/week of Personal Care Services (and will continue to deny the remaining requested 10 hours/week of Personal Care Services), and will now approve an extra 4 hours/week of Homemaker Services (and will continue to deny the remaining requested 3 hours/week of Homemaker Services), and will continue to deny the 5 hours/week of in-home Respite Care Services, and will continue to deny the 5 hours/week of Companion Care Services.

This decision was made with Sunshine Health Policy LT.UM.09 Long Term Care Ancillary Service Criteria.

*Id.* at 62.

8. [REDACTED] requested a Fair Hearing on behalf of Petitioner on January 19, 2021. On February 1, 2021, the undersigned issued an Order Consolidating and Scheduling Fair Hearing by Telephone and Prehearing Instructions, setting the hearing for February 16, 2021, at [REDACTED]. The hearing was continued rescheduled for March 3, 2021, at [REDACTED]. [REDACTED] Petitioner's Authorized Representative did not appear at the rescheduled hearing. The undersigned issued a Third Order Scheduling Fair Hearing by Telephone and Prehearing Instructions, setting the hearing for April 13, 2021, at [REDACTED]. After addressing the non-appearance of Petitioner's Authorized Representative at previously scheduled date of the hearing, the hearing proceeded to the merits of Petitioner's Fair Hearing request.

9. During the hearing, [REDACTED] asserted that she is seeking enough home health services to meet Petitioner's needs while she is at work. [REDACTED] added that she works from 7:30 a.m. to 3:30 p.m. as a teacher assistant and then until 6:00 p.m. at child aftercare. [REDACTED] explained that she is willing to adjust her schedule to care for Petitioner who would be transitioned into her home.

10. Dr. Gervasi, medical director for Sunshine, opined that the services approved for Petitioner's transition to [REDACTED] home are sufficient to meet Petitioner's needs and consistent with the level of total home health services Petitioner's Authorized Representative had been seeking for Petitioner.

## CONCLUSIONS OF LAW

11. 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).

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

13. Because Petitioner is requesting additional services, 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.

14. 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, establishes and regulates Long-Term Care services available under Florida Medicaid.

The LTC Policy provides the following:

### **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.

...

#### **4.2.1.15 Respite Care**

The provision of services on a short-term basis due to the absence of, or need to relieve, the enrollee's natural supports on a planned or an emergency basis.

...

#### **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.

15. 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.

16. The Florida Medicaid 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.

### **Denial of Personal Care Services**

17. Respondent denied Petitioner's request for an additional (10) hours of personal care services. *Supra* ¶ 7. On the NABD, Respondent indicated that the respite care services were not medically necessary but did not identify which component of medical necessity the denial was based on. *Supra* ¶ 5.

18. The 701B shows that Petitioner currently resides in a nursing facility and that with the exception of managing money Petitioner's needs for assistance with IADLs and ADLs are met by the staff at the nursing facility. *Supra* ¶¶ 2-4. Dr. Gervasi testified that in his opinion Petitioner's current approved services are sufficient to transition Petitioner from the nursing facility. *Supra* ¶ 10. [REDACTED] testified that while she works from 7:30 a.m. to 6:00 p.m. she is willing to alter her schedule to accommodate Petitioner's transition into her home. *Supra* ¶ 9. The NPAR shows that Petitioner is currently approved to receive forty-two (42) hours of home health services consisting of thirty-five (35) hours of personal care services per week and seven (7) hours of homemaker services per week pending Petitioner's transition to [REDACTED] home. *Supra* ¶ 7.

19. 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* ¶ 14. The personal care services requested by Petitioner must 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.” *Supra* ¶ 16. In this case [REDACTED] and [REDACTED] offered testimony as to their desire to remove Petitioner from the nursing facility and their dissatisfaction with Petitioner living there. However, Petitioner offered no evidence as to why the remaining personal care services at issue are necessary to meet Petitioner’s needs with her IADLs and ADLs. Even if [REDACTED] were unable to alter her current work schedule Petitioner would be alone for approximately ten and a half hours per week or slightly above two hours per day. Petitioner has not shown how Petitioner’s need for assistance with IADLs and ADLs cannot be met if Petitioner is alone for approximately more than two hours per day. Furthermore, [REDACTED] testified that she was willing to alter her work schedule to accommodate Petitioner’s transition into her home which reduces the time Petitioner would otherwise be alone. Dr. Gervasi’s testimony did not add any additional explanation as to the Respondent’s rationale behind the denial but is still credible. Thus, Petitioner has not met the burden of proof to show that the personal care services requested are “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.”

### **Denial of Respite Care Services**

20. Respondent denied Petitioner's request for five (5) hours of respite care services. *Supra* ¶ 7. On the NABD, Respondent indicated that the respite care services were not medically necessary but did not identify which component of medical necessity the denial was based on. *Supra* ¶ 5.

21. As provided in the LTC Policy, respite care services are to provide services on a short-term basis due to the absence of, or need to relieve, the enrollee's natural supports on a planned or an emergency basis. *Supra* ¶ 14. The respite care services requested must 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." *Supra* ¶ 15. As discussed in the section addressing the denial of personal care services Petitioner's evidence was limited to removing Petitioner from the nursing care facility. Petitioner offered no evidence that any of Petitioner's natural supports would be temporarily unavailable or otherwise need relief upon transition into [REDACTED] home. As such, Petitioner has not met the burden of proof to show that The respite care services requested must 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."

### **Denial of Homemaker Services**

22. Respondent denied Petitioner's request for an additional three (3) hours of homemaker services. *Supra* ¶ 7. On the NABD, Respondent indicated that the homemaker services were not medically necessary but did not identify which component of medical necessity the denial was based on. *Supra* ¶ 5.

23. As provided in the LTC Policy, homemaker services are intended to provide assistance with general household activities (such as meal preparation) and routine household care (including laundry and pest control). *Supra* ¶ 14. The homemaker services requested by Petitioner must 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.” *Supra* ¶ 15. As discussed in the previous sections Petitioner did not offer evidence as to where Petitioner would still need assistance with general household activities Petitioner is already approved to receive forty-two hours (42) of home health services as well as transition into [REDACTED] home. Based on the services in place it appears that Petitioner’s needs for homemaker services are met between available natural supports and her service approved pending her departure from the nursing facility. Accordingly, Petitioner has not shown that the homemaker services requested are “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.”

### **Conclusion**

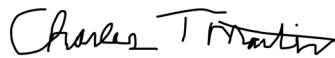
24. Upon consideration of the testimony provided, evidence submitted, and applicable policies, the undersigned concludes the following: Petitioner has not proved by preponderance of the evidence that Respondent’s decision to deny Petitioner’s request for an additional ten (10) hours per week of personal care services was incorrect. Petitioner has not proved by a preponderance of the evidence that Respondent’s decision to deny Petitioner’s request for five (5) hours of hours of respite care services was incorrect. Petitioner has not proved by a

preponderance of the evidence that Respondent's decision to deny Petitioner's request for an additional three (3) hours of hours of homemaker services was incorrect.

**IT IS THEREFORE ORDERED AND ADJUDGED THAT:**

Respondent's denial of an additional ten (10) hours of personal care services per week is **AFFIRMED**. Petitioner's appeal based on the denial of an additional ten (10) hours of personal care services per week is **DENIED**. Respondent's denial of five (5) hours of respite care services per week is **AFFIRMED**. Petitioner's appeal based on the denial of five (5) hours of respite care services per week per week is **DENIED**. Respondent's denial of an additional three (3) hours of homemaker services per week is **AFFIRMED**. Petitioner's appeal based on the denial of an additional three (3) hours of homemaker services per week is **DENIED**.

**DONE and ORDERED** this 7th day of May, 2021, in Tallahassee, Leon County, Florida.



Charles Martin  
21-FH0[REDACTED] 21-FH[REDACTED] & 21-  
FH[REDACTED]  
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**CHARLES MARTIN, 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**  
**Email: 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 To:**



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**SunshineHealth\_MFH@centene.com**

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