



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

FILED

May 03, 2021, 8:38 am

OFFICE OF FAIR HEARINGS

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PETITIONER,

AHCA Case No.: 21-FH █

Plan ID No.: █

vs.

SUNSHINE STATE HEALTH PLAN, INC.,

RESPONDENT.

_____ /

█

PETITIONER,

AHCA Case No.: 21-FH █

Plan ID No.: █

vs.

SUNSHINE STATE HEALTH PLAN, INC.,

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned Hearing Officer convened a consolidated telephonic Fair Hearing in the above-styled case on April 6, 2021, at █

APPEARANCES

For the Petitioner:

█
Petitioner

For the Respondent:

Maria Mojica
Compliance Specialist
Sunshine State Health Plan, Inc.

PRR0002607

STATEMENT OF ISSUE

The first issue is whether Petitioner proved by a preponderance of the evidence that Respondent's denial of additional Personal Care services (an additional 114 hours per week) was incorrect.

The second issue is whether Petitioner proved by a preponderance of the evidence that Respondent's denial of additional Consumable Medical Supplies (an additional tube of Barrier Cream per month) was incorrect.

PRELIMINARY STATEMENT

All parties and witnesses appeared for the Fair Hearing telephonically. Petitioner appeared for the Fair Hearing and provided testimony. [REDACTED] [REDACTED] Petitioner's wife, appeared for the Fair Hearing as a witness for the Petitioner.

Maria Mojica, Compliance Specialist for Sunshine State Health Plan, Inc. ("Sunshine Health"), appeared for the Fair Hearing as a representative for Respondent. The following persons appeared for the Fair Hearing as witnesses for Respondent: Carmen Guerrero, Supervisor of Case Management for Sunshine Health; Dr. John Carter ("Dr. Carter"), Long-term Care ("LTC") Medical Director for Sunshine Health; Sarah Borosky, LTC Care Coordinator for Sunshine Health; and Louise Jeanty, Supervisor of Quality Improvement for Sunshine Health.

Linda Latson, Registered Nurse Specialist and Fair Hearing Liaison for the Agency for Health Care Administration ("Agency" or "AHCA"), appeared for the Fair Hearing as an observer.

Petitioner did not introduce any exhibits at the Fair Hearing. Respondent introduced an evidence packet containing one hundred and twenty-five (125) pages, which was admitted into evidence as Respondent's Composite Exhibit 1. Respondent's Composite Exhibit 1 includes the

following: a Table of Contents; the Medicaid Fair Hearing Summary (dated March 11, 2021); a Notice of Adverse Benefit Determination (“NABD”) (dated November 16, 2020); a Long Term Care Person-Centered Care Plan (“Plan of Care”) (signed by Care Manager on October 29, 2020); a Plan of Care (signed by Care Manager on December 23, 2020); a Florida Department of Elder Affairs: 701B Comprehensive Assessment (“701B Comprehensive Assessment”) (dated October 29, 2020); a 701B Comprehensive Assessment (dated December 23, 2020); a fax transmission sheet (dated January 7, 2021); a fax cover sheet (dated December 30, 2020); a Standard Appeal Acknowledgment letter (dated January 11, 2021); a Notice of Plan Appeal Resolution (“NPAR”) (dated February 5, 2021); Sunshine Health Policy and Procedure: LTC Ancillary Service Criteria (LT.UM.09) (“LTC Ancillary Service Criteria”); Sunshine Health Policy and Procedure: LTC Durable Medical Equipment (“DME”)/ Supplies / Orthotics & Prosthetics (O&P) Criteria (LT.UM.10) (“LTC DME Criteria”); and the Florida Administrative Code Rule (“Fla. Admin. Code R.”) 59G-1.010 (166).

FINDINGS OF FACT

1. As of [REDACTED] 2018, Petitioner is an enrolled member of Sunshine Health’s LTC Program. See Respondent’s Composite Exhibit 1, page 2. Sunshine Health is a Medicaid Managed Care organization contracted by the Agency to provide services to eligible Medicaid recipients in the State of Florida.

2. Petitioner is 50 years old and resides in the community with her spouse, [REDACTED] *Id.* at 52. Petitioner uses the following DME: power wheelchair, shower chair, bed rails, bedside commode, Hoyer lift, and a grabber. *Id.* at 54. Petitioner experiences the following physical health conditions: occasional dizziness; frequent bowel and bladder incontinence; full paralysis; generalized weakness; and dysphagia. *Id.* at 57-58. Petitioner also uses a battery operated

bladder implant. *Id.* As testified to by the Petitioner and Dr. Carter at the hearing, the Petitioner experiences Multiple Sclerosis (“MS”). *Id.* at 24. Petitioner’s last two 701B Comprehensive Assessments indicate that Petitioner has experienced bed sores, in the form of pressure ulcers, in the past, but she is not currently experiencing them. *Id.* at 39 and 57.

3. Petitioner needs assistance (but not total help) with activities of daily living (“ADLs”) such as bathing, dressing, eating, using the bathroom, and transferring. *Id.* at 55. Petitioner uses an assistive device for walking/mobility. *Id.* Petitioner needs total assistance with instrumental activities of daily living (“IADLs”) such as heavy chores, light housekeeping, managing money, preparing meals, and shopping. *Id.* at 56. Petitioner needs assistance (but not total help) with using transportation. *Id.* Petitioner needs supervision or prompt with managing medication. *Id.* As testified to by the Petitioner at the hearing, Petitioner requires total assistance with ADLs and IADLs.

4. Petitioner’s primary care giver is [REDACTED]. *Id.* at 65. [REDACTED] is on a lifting restriction and unable to care for the Petitioner at night due to back surgery. *Id.* at 66. As testified to by [REDACTED] at the hearing, she experiences caregiver fatigue and experiences loss of sleep from being Petitioner’s primary caregiver and can no longer render ADLs and IADLs for Petitioner. [REDACTED] has a history of previous back surgery and is awaiting another back surgical procedure. In the past, [REDACTED] rendered multiple transfers per night on the Petitioner. [REDACTED] experienced falls attempting to lift and transfer the Petitioner. [REDACTED] has been unemployed since June 2020. [REDACTED] cannot lift more than 10 lb. and has inability to bend at the waist. [REDACTED] was unaware that her medical records were needed to make a medical necessity determination regarding Petitioner’s request for additional Personal Care services.

5. On November 9, 2020, Sunshine Health received Petitioner's request for the following LTC services: an additional 114 hours per week of Personal Care services and additional tube monthly of barrier cream. *Id.* at 2.

6. On November 16, 2020, Sunshine Health issued an NABD denying Petitioner's request for additional LTC services and medical supplies. *Id.* at 5-10. The NABD states as follows:

Sunshine Health has reviewed your request for an additional 1 tube monthly of Barrier Cream (a cream you put on your skin to protect it), an additional 1 case monthly of Briefs (underwear you can throw away after use) and additional 114 hours weekly of Personal Care Services (the person who helps bathe and dress you), which we received on 11/09/2020. After our review, this service has been:

PARTIALLY DENIED as of 11/16/2020.

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 114 hours per week of Personal Care Services, an extra 1 tube per month of Barrier Cream, and an extra 1 case per month of Briefs is partially approved.

The member's present care plan includes:

- **36 hours per week of Personal Care Services**
- **6 hours per week of Homemaker Services**
- **12 hours per week of Companion Care Services**
- **1 tube per month of Barrier Cream**
- **1 case per month of Briefs.**

Based on the assessment of the member's care needs and household and caregiver status, Sunshine Health will approve the temporary addition of 57 hours per week of Personal Care Services for 8 weeks, to begin on the date of the caregiver's surgery and will approve an extra 1 case per month of Briefs. Sunshine Health will deny the remaining requested 57 hours per week of Personal Care Services and extra 1 tube per month of Barrier Cream.

...

Sincerely,

Bonnie S. Koreff-Wolf, MD ["Dr. Koreff-Wolf"]

Medical Director

Id. at 5-10. (Emphasis added).

7. On December 30, 2020, Petitioner submitted a letter to Sunshine explaining the rationale for her request for additional services in this case. *Id.* at 26. The letter states as follows:

I am appealing the decision which denied the request for 24-hour care now as requested by my physician, [REDACTED]. He is my neurologist who treats my Secondary Progressive Multiple Sclerosis (SPMS). He is not only a neurologist who treats MS but knows me and my specific needs very well.

Sunshine determined my request was not medically necessary because the services did not meet the reasons checked in the letter. I don't understand the decision since my SPMS is a debilitating disease and I believe I meet all the necessary criteria.

I appreciate the 8 weeks of 96 extra hours of personal care approved which my wife/caregiver has her surgery, but I need the care not was well due to my inability to care for myself.

Below are some of the reasons I need the additional 114 hours:

- To be repositioned when I spasm
- Turned every few hours to prevent bed sores

- To take medicine in the middle of the night
- Brief changes throughout the night hours
- Safety reasons – I cannot be left alone

Please reconsider your decision and grant me the necessary fulltime 24-hour care no as my doctor originally requested.

Id.

8. On February 5, 2021, Sunshine issued an NPAR partially approving Petitioner's plan appeal. *Id.* at 78-80. The NPAR states as follows:

On January 7, 2021, we received your timely plan appeal request about Sunshine Health's Notice of Adverse Benefit Determination dated November 19 2020, Notice of Adverse Benefit Determination Number [REDACTED], PARTIALLY DENYING, the request for an additional 1 tube monthly of barrier cream (a cream you put on your skin to protect it), an additional 1 case monthly of briefs (underwear you can throw away after use) and additional 114 hours weekly of personal care services (the person who helps bathe and dress you) provided to [Petitioner].

On February 4, 2021, 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, [Petitioner] will not receive an additional 1 tube monthly of barrier cream (a cream you put on your skin to protect it), an additional 1 case monthly of briefs (underwear you can throw away after use) and will receive the additional 114 hours weekly of personal care services (the person who helps bathe and dress you), effective February 4, 2021.

The appeal to overturn the denial of remainder 21 hours per week of Personal Care Services for 8 weeks is APPROVED for medical necessity. Sunshine Health will approve the temporary addition of 21 hours per week of Personal Care Services for 8 weeks, to begin on the date of the caregiver's surgery. Further assessment by case manager can be made at this time. Sunshine Health will deny extra 1 tube per month of Barrier Cream.

The updated care plan approved by Sunshine Health will include:

- **36 hours per week of Personal Care Services**
- **114 hours per week of Personal Care Services for 8 weeks beginning the date of the caregiver's surgery**
- **6 hours per week of Homemaker Services**
- **12 hours per week of Companion Care Services**

- **1 tube per month of Barrier Cream**
- **2 cases per month of Briefs**

This decision was made with Sunshine Health Policy LT.UM.09 Long Term Care Ancillary Service Criteria, and Sunshine Health Policy LT.UM.10 LTC (Long Term Care) Durable Medical Equipment (DME)/Supplies/Orthotics & Prosthetics (O&P) Criteria.

This decision was made by a Medical Director who is Board Certified Physician in Family Medicine.

...

Sincerely,

Dr. Sapnalaxmi Amin ["Dr. Amin"]

Medical Director

Id. at 78-80. (Emphasis added).

9. In making a medical necessity determination in the NABD and in the NPAR, Sunshine Health relied upon the LTC Ancillary Service Criteria. *Id.* at 85-115. The LTC Ancillary Service Criteria states as follows regarding Personal Care services:

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 minimum 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:

...

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

See Section C.1 for more detail

Covered Personal Care services may include:

- a) Bathing - Assistance with bathing, including washing, rinsing, and drying the body or body parts.
 - Member's ability to transfer in and out of the tub or shower
 - Amount of time it takes the member to transfer in and out of the tub or shower
 - Ability of member to prepare the shower or run the bath water

- Ability of member to use any assistive devices, such as a grab-bar or shower chair
 - Ability of member to use a sponge or wash cloth to clean himself/herself
 - How many times per week does the member bathe, consider that:
 - Incontinence episodes resulting in the need for a bath
 - Daily bathing of the elderly is not recommended due to damage that occurs to the skin from the water and the soap
 - Bathing more than once per day is a personal preference and not a necessity.
 - Full bath (bathtub, shower, or bed bath) or partial sponge bath (washing of face, underarms, and private areas).
 - A bed bath for members who are bed bound and cannot get out of the bed to be bathed in a shower or tub
- b) Dressing and Grooming - Dressing assistance includes the laying out, taking off, putting on, and fastening of clothing and footwear, and includes:
- Member's ability to choose their own clothes, put them on, and put on socks and shoes
 - Ability to put clothes, socks, and shoes on if someone lays out the clothes
 - Ability to button, zipper, tie, or buckle clothes or shoes
 - Ability to successfully use assistive devices in dressing, such as reachers, sock pullers, or shoehorns
 - Ability to dress self in the morning or evening to get ready for bed

Grooming includes assessment of member's ability to:

- Comb or brush hair
- Shave
- Complete oral hygiene, including brushing teeth, remove dentures/partials, clean dentures/partials, and replace dentures/partials
- Trim and clean fingernails and toenails
-

- c) Eating and Feeding Considerations – Eating/Feeding is the process of a member getting oral nourishment from a receptacle (dish, plate, cup, glass, bottle, etc.) into their body after it is cooked or prepared for eating. (This does not include tube feeding as that is considered a skilled task.)

Includes an assessment of the member's ability to:

- Cut foods into appropriate size pieces
- Move food or drink from the serving receptacle to their mouth

Support for eating considers the number of meals per day that the member eats.

Note: Assistance with the preparation of meals is considered as part of Meal Preparation

- d) Toileting Considerations
 - Taking off and putting on of clothing and/or diapers,
 - Post-toilet hygiene
 - Use of equipment, such as a urinal or bedpan
 - Emptying of urinal or bedpan
 - Cleaning of a catheter or ostomy bag
 - Reminders or a toileting schedule

- e) Transferring Considerations - Transferring is the member's ability to move horizontally and/or vertically between the bed, chair, wheelchair, commode, etc. It includes an assessment of the member's:
 - Ability to use any mechanical devices such as a walker, cane, handrails, or wheelchair to assist with transfers
 - Ability to safely transfer without the assistance of another person
 - Ability to physically participate in the transfer by pivoting, holding on, or bracing themselves to assist the caregiver

- f) Mobility Considerations – Mobility is the extent of the member's purposeful movement within their residence. It includes an assessment of the member's:
 - Ability to purposely move about his/her residence independently with or without the use of assistive devices, this includes the ability of a member to move around in a wheelchair
 - Movements being unsafe without the assistance of another person in ambulating
 - Muscle weakness, unstable gait or unstable balance

...

Exclusions and Limitations for Personal Care 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. The provider must be awake during the provision of personal care services.
4. If services are required overnight, member must live alone and one of the following conditions must apply:
 - a. Member requires frequent repositioning due to wounds
 - b. Severe incontinence requiring multiple overnight changes and cleaning
5. Services provided by Sunshine Health may not duplicate services that are provided under by another provider.
6. Escort Services

Respondent's Composite Exhibit 1, pages 85-115.

10. In making a medical necessity determination in the NABD and in the NPAR, Sunshine Health also relied upon the LTC DME Criteria. *Id.* at 85-115. The LTC DME Criteria states as follows regarding Consumable Medical Supplies:

B. Medical Necessity Determination

Sunshine Health's utilization management department will respond to physician requests within the timelines as outlined in the policy Timeliness of UM Decisions and Notifications, FL UM 05.00. Any decision to deny, reduce, suspend or terminate services must be made by a Sunshine Health Medical Director as outlined in the policy Use of Clinical Criteria FL.UM.02.00

1. Durable Medical Equipment (DME), Supplies, Orthotics and Prosthetics

Sunshine Health's Utilization Management Department will use the Interqual® criteria or other criteria in the DME and O&P Criteria policy CP.MP.107 If the DME/Supplies or O&P item requested is not covered by criteria in that policy, the following criteria will be used:

- Medical Necessity Review and Continuity of Care policy FL.UM.02.01
- Agency for Healthcare Administration, Durable Medical Equipment and Medical Supplies Coverage and Limitations Handbook
- Current AHCA Medicaid contract

To assist in determining the medical necessity of any DME/supply or O&P, the clinical criteria established in this policy will be applied.

2. Incontinence Supplies

Prior authorization is required for diapers, gloves, perineal wipes, emollients and absorbent products used to manage incontinence in individuals covered by Sunshine Health LTC product. Coverage determinations are based on an assessment of the individual's unique clinical needs as documented in the clinical information submitted by the requesting provider and/or the current 701B assessment completed by the LTC Care Coordinators. The 701B assessment is used to identify the member's level of incontinence, functional status as measured through Activities of Daily Living (ADL) and Instrumental Activities of Daily Living (IADL), and level of caregiver support.

Sunshine Health does not require a physician's prescription to review, approve or deny a request for standard incontinence supplies found on the Florida Medicaid Fee Schedule. Sunshine Health covers items for LTC members listed on the fee

schedules for Medicaid Recipients “ Under the Age of 21 Years” and “All Medicaid Recipients”, even when the member is over the age of 21. Diapers, gloves, perineal wipes, emollients and absorbent products may be considered medically necessary in the management of incontinence associated with a broad range of medical conditions including, but not limited to neurological conditions, congenital anomalies, injuries to the pelvic region, injuries to the spinal cord, fistula, bowel prolapse and infections. Consideration is always given to the unique needs of a given individual.

Criteria to support need for incontinence products

Upon review of the 701B assessment, Sunshine Health will consider but is not limited to the following:

- Member must have current incontinence of the bladder and/or bowel; and/or
- Member must have one of the following limitations in their Activities of Daily living:
 - Using the bathroom (toileting, hygiene, cleaning) and/or Walking/Mobility and/or Transferring:
 - Needs supervision or prompt
 - Needs assistance without a caregiver
 - Needs assistance with a caregiver
 - Needs total assistance without a caregiver
 - Needs total assistance with a caregiver

Sunshine Health may approve up to the amount allowed on the Medicaid fee schedule depending on the member’s level of incontinence.

The clinical reviewer takes into consideration the individual needs of the member, which includes assessment and identification of the individual’s specific medical, mobility and psychosocial needs. The assessment includes the frequency in which a member may need an incontinence diaper/brief changed and considers the health and lifestyle of the member wearing them. An independent individual with limited functional deficits may be able wear an incontinence diaper/brief longer than someone who is frail and bedridden. Most adults with incontinence need to change their diaper between 5-8 times a day.

Diapers/briefs should be changed as soon as they become soiled or wet. If a bedbound individual does not wet diapers or briefs often, or has small leakage, consideration may be given to alternating between pads and diapers. The frequency and volume of urinary and bowel incontinence should be identified in order to select the appropriate type and amount of incontinence supplies. The goal is to promote skin integrity. The impact of a brief allowing good air circulation, must be considered as this can lead to skin irritation and rashes.

Respondent's Composite Exhibit 1, pages 116-124.

11. On February 24, 2021, Petitioner timely requested a Fair Hearing to contest Respondent's denial of additional Personal Care Services and additional Consumable Medical Supplies. On March 10, 2021, the undersigned scheduled the Fair Hearing to be conducted by telephone on April 6, 2021, at [REDACTED]

12. At the hearing and under oath, Petitioner testified that she requested the additional tube of Barrier Cream because she uses adult diapers daily, and applies the Barrier Cream to her body after every diaper change. Petitioner requires assistance with ADLs and IADLs while awake, and requires multiple transfers and diaper changes per night while asleep. Petitioner alleged that she experiences bed sores; however, no medical documentation was submitted to corroborate the allegation. Due to her paralysis, Petitioner is unable to use the Personal Emergency Response System (PERS) given to her by Sunshine Health.

13. At the hearing and under oath, Ms. Mojica testified that the Petitioner will receive 24 hours per day of combined LTC services for the duration of eight (8) weeks while [REDACTED] recovers from her upcoming back surgery.

14. At the hearing and under oath, Dr. Carter testified that he reviewed Petitioner's case and denied Petitioner's request based on medical necessity. Dr. Carter is board-certified in Internal medicine, Geriatric medicine, and Hospice & Palliative medicine. Dr. Carter also serves as a home care doctor. Dr. Carter determined that Petitioner's request for an additional tube of Barrier Cream was in excess of Petitioner's needs and not medically necessary because Sunshine Health received no documentation that the Petitioner experiences bed sores or ulcers. Dr. Carter determined that Petitioner's request for an additional Personal Care services was in excess of

Petitioner's needs and not medically necessary because Respondent did not receive any documentation from [REDACTED] regarding an ongoing inability to care for Petitioner after having the back surgery.

CONCLUSIONS OF LAW

15. Pursuant to Florida Statute ("Fla. Stat.") § 409.285(2) (2019), the Agency's Office has jurisdiction over the subject matter of this proceeding and the parties. This Final Order is the final administrative decision of AHCA. *See* Fla. Stat. § 409.285(2)(a).

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

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

18. Pursuant to Fla. Admin Code R. 59G-1.100(17)(g), the burden of proof is 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.

(Emphasis added).

19. The Florida Medicaid Statewide Medicaid Managed Care Long-term Care Program Coverage Policy ("LTC Policy") (March 2017), incorporated by reference in Fla. Admin. Code R.

59G-4.192, establishes the provision and coverage for LTC services available under the Florida Medicaid program. 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.

...

4.1 General Criteria

Florida Medicaid covers services that meet all of the following:

- Are determined medically necessary;
- Do not duplicate another service; and
- Meet the criteria as specified in the 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 restrictive setting

...

4.2.1 Home and Community-Based Supportive Services

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

4.2.1.1 Adult Companion Care

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

4.2.1.9 Homemaker Services

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

...

4.2.2 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.

20. The Florida Medicaid Definitions Policy (“Definitions Policy”) (August 2017), incorporated by reference in Fla. Admin. Code R. 59G-1.010, defines the commonly used terms, Medically Necessary or 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.

Respondent’s denial of Personal Care services

21. Based on the record, Respondent issued an 8-week limited authorization of an additional 57 hours per week of Personal Services. This was due to Petitioner’s wife and caregiver, [REDACTED], expecting to undergo back surgery in the near future. Petitioner is requesting a permanent authorization of an additional 114 hours per week of Personal Care services. The evidence admitted and testimony presented established that Respondent denied Petitioner’s request for an additional 114 hours per week of Personal Care services based on medical necessity. See supra ¶ 6-8. Specifically, Respondent determined that, based on the assessment of the member’s care needs and household and caregiver status, Petitioner’s request is in excess

of their needs. *See supra* ¶ 6-8. Petitioner argued that the request for additional Personal Care services should be approved because ██████████ cannot provide natural support presently, and will not be able to render any natural support even after an 8-week recovery period post-surgery.

22. Both the NABD and the NPAR disclosed that the adverse action taken against Petitioner's request for additional Personal Care services was based on the LTC Ancillary Service Criteria. *See supra* ¶ 6-and 8. The LTC Ancillary Service Criteria for Personal Care services weighs the following four (4) criteria: (a) ADL limitations; (b) Living Situation; (c) Supervision needs; and (d) Available supports. *See supra* ¶ 9. In addition, Respondent's internal criteria mandates that if Personal Care services are required overnight, member must live alone and one of the following conditions must apply: Member requires frequent repositioning due to wounds; or Severe incontinence requiring multiple overnight changes and cleaning. *See supra* ¶ 9. The record indicates that Petitioner does not live alone and does not frequent repositioning due to wounds. *See supra* ¶ 2. Petitioner has multiple transfers at night, but the record does not indicate that this is due to bed sores or ulcers. *See supra* ¶ 4. The record does support that Petitioner has severe incontinence requiring multiple overnight changes and cleaning. *See supra* ¶ 2-4. Respondent's 701B Comprehensive Assessment indicates that Petitioner needs assistance (but not total help) with ADLs, and uses an assistive device for walking/mobility. *See supra* ¶ 3. Petitioner receives multiple transfers per night. *See supra* ¶ 4. Petitioner is fully paralyzed, *supra* ¶ 2, and at the hearing Petitioner argued that she requires maximum assistance with ADLs. Although Petitioner sent Sunshine a letter asserting that 24-hour care was requested by her neurologist, ██████████, *supra* ¶ 7, Petitioner submitted no documentation from her treating physician certifying that the Petitioner meets maximum functional impairment. *See supra* ¶ 14. Petitioner lives with her

spouse and caregiver, who is not currently employed. See supra ¶ 2, 4. However, ██████████ cannot presently render assistance with ADLs, is on a lifting limitation, and is expecting back surgery. Petitioner is unable to call for help by physically using a personal emergency response unit such as PERS. See supra ¶ 12. However, there is no evidence that the Petitioner cannot call out (verbally) for help or alert ██████████ (verbally) she needs assistance. Petitioner is currently authorized to receive the following support services: 36 hours per week of Personal Care services, 6 hours per week of Homemaker services, and 12 hours per week of Adult Companion Care services. See supra ¶ 6-7. In addition to the Petitioner's Plan of Care, Respondent granted the Petitioner a limited authorization of Petitioner's request for an additional 114 hours per week of Personal Care services beginning on the date of the caregiver's surgery, which has not yet been used by the Petitioner. See supra ¶ 3. The undersigned considered Petitioner's and ██████████'s testimony with respect to Sunshine's internal criteria, and the Definitions Policy criteria for medical necessity with respect to Personal Care services.

23. Personal Care services 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 ¶ 19. The LTC Policy covers Personal Care services that are determined to be medically necessary. See supra ¶ 19. Under the LTC Policy, Mixed services such as Personal Care services must meet the medical necessity criteria defined in Fla. Admin. Code R. 59G-1.010. See supra ¶ 19. To be medically necessary, the requested Personal Care services must meet the five criteria set forth in section 2.83 of the Definitions Policy. See supra ¶ 20.

24. With respect to the medical necessity standard at issue, the record indicates that Petitioner requires a significant amount of assistance with ADLs and Petitioner's primary care caregiver (and wife) cannot presently provide care for the Petitioner due to back problems that will be addressed in an upcoming surgery. In response to Petitioner's primary caregiver being presently unable to render care, Respondent granted a limited authorization of an additional 114 hours per week of Personal Care services to address [REDACTED]'s inability to render care. Thus, Respondent determined that the Petitioner will require 24-care for 8 weeks after [REDACTED] has surgery. The undersigned found Petitioner's testimony regarding her limitations and needs to be credible as well as finding [REDACTED] testimony regarding her inability to render hands-on care to be credible as well. Thus, at this time, Petitioner requires significant assistance with ADLs and does not have any natural support regarding her need for assistance with ADLs. Although the Petitioner has a Plan of Care that includes 54 hours per week of LTC services, the record indicates that the Petitioner requires 24-hour assistance with ADLs. This is based on Petitioner's complete paralysis, Petitioner's requirement of multiple transfers during the day and night, Petitioner's inability to use PERS, Petitioner's frequent bowel and bladder incontinence during the day and night, and Respondent's limited authorization. Upon consideration of the record, it appears that Respondent based their limited authorization decision on speculation that [REDACTED] will be able to return to caregiving responsibilities after her surgery. To contradict Respondent, Petitioner and [REDACTED] speculated that even after having the back surgery [REDACTED] will still be unable to render natural support for ADLs. Although both arguments are uncorroborated, Petitioner bears the burden in this case. Simply, Petitioner is required to prove that their argument is based on factual findings, not speculation. [REDACTED] may be able to

return to her caregiving responsibilities and she may not. However, the record is unclear on this important factor. Should the health of [REDACTED] not improve to the extent that she can continue rendering natural support (primarily assistance with ADLs), then such Petitioner is not barred from submitting a new authorization request to extend the limited authorization of 24-hour care. However, presently the record does not indicate that a permanent authorization of 114 hours per week of Personal Care services is furnished in a manner not primarily intended for the convenience of the recipient or the recipient's caretaker. Upon consideration of the aforementioned facts, Petitioner has not established that the additional 114 hours per week of Personal Care services for assistance with ADLs and IADLs is not in excess of the Petitioner's needs. Thus, the Petitioner has not met the Definition Policy's criterion at issue for medical necessity.

25. Accordingly, upon consideration of the evidence admitted into the record, the parties' sworn testimony, and the aforementioned applicable laws and policies, the undersigned concludes that Petitioner has not proved that an additional 114 hours per week of Personal Care services is medically necessary. The undersigned finds that Petitioner did not prove by a preponderance of the evidence that Respondent's denial of a permanent addition of 114 hours per week of Personal Care services was incorrect.

Respondent's denial of Consumable Medical Supplies

26. Based on the record, Respondent denied Petitioner's request for an additional tube of Barrier Cream based on their medical director's medical necessity determination. See supra ¶ 6-8. Specifically, Respondent determined that the request for an additional tube of Barrier Cream was in excess of Petitioner's needs. See supra ¶ 6-8. At the hearing, Dr. Carter explained that an

additional tube of Barrier Cream was in excess of Petitioner's needs and not medically necessary because Sunshine Health received no documentation that the Petitioner experiences bed sores or ulcers. *See supra* ¶ 10. Although Petitioner provided a letter to Sunshine explaining that she needs to be "[t]urned every few hours to prevent bed sores," *supra* ¶ 7, Petitioner provided no documentation of current bed sores from her treating physician. *See supra* ¶ 10. Further, Petitioner's last two 701B Comprehensive Assessments indicate that Petitioner has experienced bed sores, in the form of pressure ulcers, in the past, but she is not currently experiencing them. *See supra* ¶ 2.

27. Medical Equipment and Supplies are covered if they are determined to be medically necessary. *See supra* ¶ 19. Under the LTC Policy, Mixed services such as Medical Equipment and Supplies must meet the medical necessity criteria defined in Fla. Admin. Code R. 59G-1.010. *See supra* ¶ 19. To be medically necessary, a service must meet the criteria set forth in the section 2.83 of the Definitions Policy. Based on the record, Respondent denied an additional tube of Barrier Cream for not meeting the following medical necessity standard: Services must be individualized, specific, consistent with symptoms or diagnosis of illness or injury and not be in excess of the patient's needs. *See supra* ¶ 6-8. This criterion is stated in section 1.3.14(b) of the LTC Policy. *See supra* ¶ 20.

28. The record indicates that Petitioner did not prove by a preponderance of the evidence that an additional tube of Barrier Cream is not in excess of their needs at this time. The record indicates that Barrier Cream is used to treat ulcers and/or bed sores. Although the Petitioner alleged that she experiences bed sores, Respondent's 701B Comprehensive Assessment indicates that the Petitioner's has a history of bed sores, but does not currently experience bed sores or

ulcers. Petitioner provided no documentary evidence to corroborate her allegations, which would have been paramount to meeting her burden in this case. Although the Petitioner desires to use Barrier Cream every time she changes her incontinence briefs, Petitioner failed to prove that it is necessary to use Barrier Cream every time she changes her incontinence briefs. The record does not show that it is medically necessary to when changing incontinence briefs. Thus, the Petitioner does not meet criterion number two for medical necessity, according to section 2.83 of the Definitions Policy.

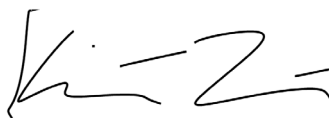
29. Accordingly, upon consideration of the evidence admitted into the record, the parties' sworn testimony, and the aforementioned applicable laws and policies, the undersigned concludes that Petitioner failed to prove that an additional tube of Barrier Cream is medically necessary. The undersigned finds that Petitioner did not prove by a preponderance of the evidence that Respondent's denial of additional Consumable Medical Supplies was incorrect.

DECISION

Respondent's denial of additional Personal Care services is **AFFIRMED**. Petitioner's request for relief is hereby is **DENIED**.

Respondent's denial of additional Consumable Medical Supplies is **AFFIRMED**. Petitioner's request for relief is hereby is **DENIED**.

DONE and ORDERED this 3rd day of May, 2021, in Tallahassee, Leon County, Florida.



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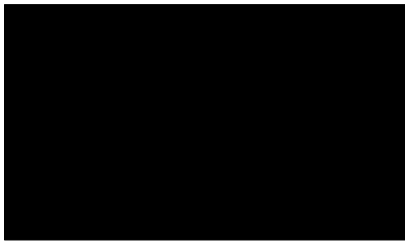
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NOTICE OF A RIGHT TO JUDICIAL REVIEW

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

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