

Deborah Havey-Levey, Program Integrity Manager for UnitedHealthcare of Florida, Inc. (“United”), appeared for the Fair Hearing as a representative for Respondent. Dr. Sloan Karver, MD (“Dr. Karver”), Long-term Care (“LTC”) Medical Director for UnitedHealthcare of Florida, Inc. (“United”), appeared for the Fair Hearing as a witness for Respondent.

Sheila Gonzalez, Medical Health Care Program Analyst and Fair Hearing Liaison for the Agency for Health Care Administration (“Agency” or “AHCA”), appeared for the Fair Hearing as an observer.

Petitioner introduced an evidence packet containing forty-one (41) pages, which was admitted into evidence as Petitioner’s Composite Exhibit 1. Petitioner’s Composite Exhibit 1 includes the following: Petitioner’s Authorized Representative’s correspondence (dated March 29, 2021); Petitioner’s Authorized Representative’s correspondence (dated March 29, 2021); an Authorization for the Use and Disclosure of Protected Health Information (“PHI”) (signed on [REDACTED] 2021); a Designation of Authorized Representative for Medicaid Fair Hearing Participation (“DAR”) (signed on [REDACTED] 2021); a prescription from [REDACTED] [REDACTED] [REDACTED] (dated [REDACTED] 2021); prescriptions from [REDACTED] (dated [REDACTED] 2021, [REDACTED] 2021, [REDACTED] 2021, and [REDACTED] 2021); [REDACTED] [REDACTED] medical records (dated [REDACTED] 2020); a consultation form from [REDACTED] [REDACTED] (dated [REDACTED] 2020); a consultation form from [REDACTED] (dated [REDACTED] 2020); Orthopedics Trauma Follow Up note; a PT [“Physical Therapy”] Daily Treatment Note (dated [REDACTED], 2020); OT [“Occupational Therapy”] Daily Treatment Note (dated [REDACTED], 2020); ST [“Speech Therapy”] Daily Treatment Note (dated [REDACTED], 2020); and Medicare Summary Notice (undated).

Petitioner introduced an additional evidence packet containing sixty-nine (69) pages, which was admitted into evidence as Petitioner's Composite Exhibit 2. Petitioner's Composite Exhibit 2 includes the following: Petitioner's Authorized Representative correspondence (dated April 14, 2021); Petitioner's Authorized Representative's correspondence (dated [REDACTED] 2021); Medical records from [REDACTED] (dated [REDACTED] 2021); a prescription from [REDACTED] (dated [REDACTED] 2021); prescriptions from [REDACTED] (dated [REDACTED] 2021, [REDACTED] 2021, [REDACTED] 2021, [REDACTED] 2021); Medical records from [REDACTED] [REDACTED] (dated [REDACTED] 2020); a consultation form from [REDACTED] (dated [REDACTED] 2020); a consultation form from [REDACTED] (dated [REDACTED] 2020); Orthopedics Trauma Follow Up note; a PT Daily Treatment Note (dated [REDACTED], 2020); OT Daily Treatment Note (dated [REDACTED], 2020); ST Daily Treatment Note (dated [REDACTED], 2020); Medicare Summary Notice (undated); an Authorization for the Use and Disclosure of Protected Health Information (signed on March 29, 2021); a Designation of Authorized Representative for Medicaid Fair Hearing Participation (DAR); a Time Statement from Dade-County Public Schools (dated April 13, 2021); and Claim Details from Medicare (dated February 24, 2021 and March 17, 2021).

Respondent introduced an evidence packet containing two hundred and forty-five (245)-page evidence packet, which was admitted into evidence as Respondent's Composite Exhibit 1. Respondent's Composite Exhibit 1 includes the following: a Statement of Matters; a Notice of Adverse Benefit Determination ("NABD") (dated February 9, 2021); a CSP – General Request Form (dated February 15, 2021); a Plan Appeal Acknowledgement letter in Spanish (dated February 16, 2021); Respondent's email correspondence; letter from Respondent (dated

February 16, 2021); Respondent's document tracking information; a fax cover sheet (dated February 25, 2021); Medical records from [REDACTED] (dated [REDACTED] 2021); prescriptions from [REDACTED] (dated [REDACTED] 2021, and [REDACTED] 2021, [REDACTED] 2021, [REDACTED] 2021, [REDACTED] 2021, and [REDACTED] 2021); a Print HSC History - HSR Production Environment; a Florida Department of Elder Affairs: 701B Comprehensive Assessment ("701-B Comprehensive Assessment") (dated January 5, 2021); two copies of Respondent's Appeal Review notes; a Notice of Plan Appeal Resolution ("NPAR") (dated February 24, 2021); Respondent's correspondence (dated March 1, 2021); an NPAR (dated March 1, 2021); Respondent's cover letter (dated March 3, 2021) in Spanish; Respondent's correspondence (dated March 1, 2021) in Spanish; an NPAR (dated March 1, 2021) in Spanish; Respondent's correspondence (dated March 4, 2021) in Spanish, an NPAR (dated February 24, 2021) in Spanish; an Exhibit 2 (References) Cover Page – Long Term Care; Florida Administrative Code Rule ("Fla. Admin. Code R.") 59G-1; the Florida Medicaid Statewide Medicaid Managed Care Long-term Care Program Coverage Policy ("LTC Policy") (March 2017); the Florida Medicaid Authorization Requirements Policy (June 2016); the Florida Medicaid Personal Care Services Coverage Policy (November 2016); the Florida Medicaid Private Duty Nursing Services Coverage Policy (November 2016); the Home Health Visit Services Fee Schedule (January 2017); a Personal Care Services Fee Schedule (January 2017); a Private Duty Nursing Services Fee Schedule (January 2017); AHCA's Participant Direction Option (PDO) Manual; Florida Medicaid Hospice Services Coverage Policy (June 2016); 42 C.F.R. §441.480; 42 C.F.R. 418 Subpart C – Conditions of Participation: Patient Care; Florida Statute ("Fla. Stat.") § 400.6105 (2018); Fla. Stat. § 400.609 (2018); Fla. Stat. § 400.462 (2018); and Fla. Stat. § 409.910 (2018).

FINDINGS OF FACT

1. Petitioner receives Medicaid services through United. *See* Respondent's Composite Exhibit 1, page 13. United is a Medicaid Managed Care organization contracted by AHCA to provide services to eligible Medicaid recipients in the State of Florida. Petitioner is also enrolled into Medicare. *See* Petitioner's Composite Exhibit 1, pages 22-41.

2. As of the date of the Fair Hearing, Petitioner is sixty-six (66) years old and resides in the community with the following people: Petitioner's Authorized Representative; Petitioner's son-in-law; and Petitioner's grandchildren. *See* Respondent's Composite Exhibit 1, pages 42-43, 62. Petitioner currently experiences the following physical health conditions: acid reflux/gastroesophageal reflux disease ("GERD"); allergies; high blood pressure; high cholesterol; diabetes; frequent bowel and bladder incontinence, vascular dementia, and aphasia. *Id.* at 27, 48-49, and Petitioner's Composite Exhibit 2, page 3. On [REDACTED] 2020, Petitioner suffered from a catastrophic stroke on her dominant side, a brain hemorrhage, and a broken right hip. *See* Petitioner's Composite Exhibit 2, page 2 and 18. Following hospitalization and hip replacement surgery, Petitioner was discharged from an Assisted Living Facility ("ALF") in [REDACTED] 2021. *Id.* at 27, 45. Petitioner has shown increased independence during bed to chair/commode transfers. *Id.* at 27. Petitioner receives Speech Therapy services. *Id.* Petitioner is cognitively impaired, forgetful or easily confused more than half the days in the last month, is unable to stay alone, and needs supervision. *Id.* at 44, 51, and Petitioner's Composite Exhibit 2, page 2. Petitioner has not been diagnosed with a mental condition or psychiatric disorder by a health professional. *Id.* at 50. Petitioner is prescribed medication to be taken on a daily basis. *See* Respondent's Composite Exhibit 1 at 54. Petitioner uses a wheelchair and a walker for walking. *Id.* at 62-63. She

fell twice in the six months preceding the 701-B Comprehensive Assessment. *Id.* at 45. In [REDACTED] 2021, [REDACTED] signed prescriptions for Home Health services, Physical Therapy services, Occupational Therapy services, Speech Therapy services, and Wound Care services. *Id.* at 32-33. On [REDACTED] 2021, [REDACTED] signed a prescription for, “Home health RN for assistance ADLs, medications, bathing, monitor for pressure ulcers after right hip fracture on weekdays for the next 3 months.” See Petitioner’s Composite Exhibit 1, page 5. As testified to by Petitioner’s Authorized Representative, the right hip fracture was due to experiencing a stroke that resulted in hospitalization and admission into a rehabilitation facility.

3. Petitioner needs total assistance with Activities of Daily Living (“ADLs”) that includes bathing, dressing, eating, using the bathroom, transferring, and walking/mobility. See Respondent’s Composite Exhibit 1, page 46. Petitioner needs total assistance with Instrumental Activities of Daily Living (“IADLs”) that includes heavy chores, light housekeeping, using the telephone, managing money, preparing meals, shopping, managing medication, and using transportation. *Id.* at 47. As testified to by Petitioner’s Authorized Representative at the hearing, Petitioner cannot perform any ADLs or any IADLs on her own. [REDACTED] a neurologist, declared, “[Petitioner] requires home health services. . . needs help with all of her ADLs. She cannot be left without supervision.” See Petitioner’s Composite Exhibit 2, page 3. [REDACTED] also declared that Petitioner’s “vascular dementia, with significant cognitive impairment” further complicates Petitioner’s care. *Id.* Petitioner is not independent and is at high risk of falls. *Id.* at 5. Petitioner requires a special diet due to her medical conditions. *Id.* Petitioner cannot perform most ADLs. *Id.* at 6.

4. Petitioner's Authorized Representative is also Petitioner's primary caregiver. See Respondent's Composite Exhibit 1, pages 56-57. As testified to by Petitioner's Authorized Representative at the hearing, Petitioner's Authorized Representative works full-time outside of the home, as a social worker for [REDACTED]. *Id.* and Petitioner's Composite Exhibit 2 at 60-62. Petitioner's Authorized Representative does not have anyone to assist with providing care. See Respondent's Composite Exhibit 1 at 56. Petitioner's Authorized Representative currently spends 40 hours per week providing care for the Petitioner. *Id.* at 57. As testified to by Petitioner's Authorized Representative at the hearing, she experiences "a lot of strain" providing care to the Petitioner while caring for her own children. Petitioner's Authorized Representative works Monday through Friday, 8:00 a.m. to 4:00 p.m., and Petitioner's Authorized Representative's children (3 years old and 6 years old) attend an after-school program due to her work schedule. *Id.* at 39-40. Petitioner's Authorized Representative's husband (who is also Petitioner's son-in-law) also has full-time employment. *Id.* at 40. Petitioner's Authorized Representative's caregiving responsibilities for her two children and work responsibilities with [REDACTED] prevent her from providing natural support in the form of Personal Care services. Petitioner's Authorized Representative's primary responsibility outside of employment is caregiving for her two children. Petitioner's Authorized Representative wakes up at 4:30 a.m. or 5:00 a.m. during the week to prepare the Petitioner for Adult Day Health Care.

5. At the time of the request, Petitioner currently receives nine (9) hours per day of Adult Day Health Care services for five (5) days per week, including transportation to and from the Adult Day Health Care center. *Id.* at 63. This was confirmed by Dr. Karver at the hearing.

6. On February 9, 2021, United issued an NABD denying Petitioner's request for twenty-five (25) hours per week of Personal Care services. *Id.* at 5-9. The NABD states the following, in pertinent part:

UnitedHealthcare Community Plan has reviewed your request for 25 hours a week of personal care, which we received on February 8, 2021. After our review, this service has been:

DENIED as of February 9, 2021.

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 either of the reason(s) checked below: *(See Rule)*

- Meet all of the criteria as defined in Rule 59G-1.010(166), F.A.C., for all nursing facility services and mixed services; OR
- 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: **Your assessment tells us you help for bathing, dressing, toileting, transferring and making meals. You live with your family. I have approved 5 (9 hour) days a week of day care with transportation. In my clinical opinion, this with your natural supports will meet your needs.**

...

Sincerely,
Sloan B. Karver, MD ["Dr. Karver"]
Long term Care Medical Director
UnitedHealthcare Community Plan

Id. at 5-9. (Emphasis added).

7. On February 24, 2021, United issued an NPAR denying Petitioner's plan appeal. *Id.* at 76-78. The NPAR states the following, in pertinent part:

On February 24, 2021, after consideration of the information you provided to UnitedHealthcare Community Plan in support of your plan appeal, UnitedHealthcare hereby denies your plan appeal. As part of our review we look at information you or your provider gave us. We also look at your benefits. Based on our review of your appeal, we have determined that the service you requested will not be approved.

John Szafranski, MD, specializing in Family Medicine, reviewed the appeal. This doctor did not make the original decision. The decision was based on Florida Administrative Code 59G-1.010(166).

We looked at your records. **We have decided that what you asked for cannot be approved. This does not meet Florida Medicaid rules. You asked for personal care. You would like 25 hours a week. We cannot approve this because it is not medically needed. Based on my professional judgment, these hours are more than you need. We looked at your home assessment. This helps to show us how much help you need. The health plan is approving 0 hours a week. You have family who can help some. This should meet your personal care needs. Also, you have another paid service for help. This is adult day health care 5 days a week 9 hours per day. That is why we cannot approve what you asked for.** Please talk about this with your doctor.

...
Sincerely,
John Szafranski, M.D. ["Dr. Szafranski"]
Medical Director
Appeals and Grievances
UnitedHealthcare Community and State
Board Certified in Family Medicine

Id. at 76-78. (Emphasis added).

8. On March 1, 2021, United issued a corrected NPAR denying Petitioner’s plan appeal. *Id.*

at 76-78. The NPAR states the following, in pertinent part:

On February 24, 2021, after consideration of the information you provided to UnitedHealthcare Community Plan in support of your plan appeal, UnitedHealthcare hereby denies your plan appeal. As part of our review we look at information you or your provider gave us. We also look at your benefits. Based on our review of your appeal, we have determined that the service you requested will not be approved.

John Szafranski, MD, specializing in Family Medicine, reviewed the appeal. This doctor did not make the original decision. The decision was based on Florida Administrative Code 59G-1.010(166).

We looked at your records. We have decided that what you asked for cannot be approved. This does not meet Florida Medicaid rules. You asked for personal care. You would like 25 hours a week. We cannot approve this because it is not medically needed. **Based on my professional judgment, these hours are more than you need. We looked at your home assessment. This helps to show us how much help you need. The health plan is approving 0 hours a week. You have family who can help some. This should meet your personal care needs. Also, you have another paid service for help. This is adult day health care 5 days a week 9 hours per day. That is why we cannot approve what you asked for.** Please talk about this with your doctor.

...

Sincerely,
John Szafranski, M.D. [“Dr. Szafranski”]
Medical Director
Appeals and Grievances
UnitedHealthcare Community and State
Board Certified in Family Medicine

Id. at 85-87. (Emphasis added).

9. On March 3, 2021, Petitioner’s Authorized Representative timely requested a Fair Hearing to contest Respondent’s denial of twenty-five (25) hours per week of Personal Care services. On March 30, 2021, the undersigned scheduled the hearing to be conducted by telephone for April 26, 2021, at [REDACTED].

10. At the hearing and under oath, Petitioner's Authorized Representative testified that Respondent's 701-B Comprehensive Assessment and Appeal Review notes contains incorrect information and do not give a full assessment of Petitioner's medical condition and natural support. Petitioner's Authorized Representative presented the recommendations of Petitioner's providers, who have personally evaluated the Petitioner, as evidence that the requested services are medically necessary. Petitioner needs the requested services to be rendered during the week in the afternoons after returning from the Adult Day Health Care service facility.

11. At the hearing and under oath, Respondent denied Petitioner's request for Personal Care services after determining that the requested services were not medically necessary. Respondent based their medical necessity determination on Petitioner's needs and current LTC services. Respondent determined that Petitioner's currently approved Adult Day Health Care services are sufficient to meet Petitioner's needs. Respondent reviewed the letters of recommendation from Petitioner's medical providers. Respondent expects Petitioner's family to provide some level of natural support in addition to the Adult Day Health Care services that are approved. Respondent did not provide any evidence regarding the amount (in the form of hours) that natural support is to be provided or any evidence that Petitioner's family can provide natural support.

CONCLUSIONS OF LAW

12. Pursuant to Fla. Stat. § 409.285(2) (2019), the Agency's Office of Fair Hearings has jurisdiction over the subject matter of this proceeding and the parties. This order is the final administrative decision of AHCA. See Fla. Stat. § 409.285(2)(a).

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

14. The burden of proof in this proceeding is governed by Fla. Admin. Code R. 59G-1.100(17)(g), which provides as follows:

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

(Emphasis added).

15. 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.).

16. The LTC Policy, incorporated by reference in Fla. Admin. Code R. 59G-4.192, establishes the provision and coverage of LTC services under Florida Medicaid. See Respondent’s Composite Exhibit 1, pages 134-155. The LTC Policy provides as follows, in pertinent part:

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:

...

4.2.1.2 Adult Day Health Care

The provision of social and health related therapeutic services and activities, self-care training, nutritional services, and respite, in accordance with Chapter 429, Part III, F.S. Nutritional meals are included as part of this service when the enrollee is at the adult day health care center during meal times. This service includes medical screening emphasizing prevention and continuity of care, including routine blood pressure checks and diabetic maintenance checks. Physical, occupational, and speech therapies indicated in the enrollee's plan of care are furnished as components of this service. Nursing services, which include periodic evaluation, medical supervision of self-care services directed toward activities of daily living, and personal hygiene are also a component of this service.

...

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:

...

4.2.2.6 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.

Respondent's Composite Exhibit 1, pages 134-155. (Emphasis added).

17. The Florida Medicaid Definitions Policy ("Definitions Policy") (August 2017), which is incorporated by reference in Fla. Admin. Code R. 59G-1.010, defines the commonly used terms, Medical Necessity and Medically Necessary, 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. (Emphasis added).

18. The evidence admitted and testimony presented established that Respondent denied Petitioner's request for twenty-five (25) hours per week of Personal Care services based on

medical necessity in accordance with the LTC Policy. *See supra* ¶ 6. Specifically, Respondent determined that Petitioner's current LTC services and Petitioner's natural support were sufficient to meet Petitioner's needs. *See supra* ¶ 6-8, 11. In addition, Petitioner's Authorized Representative argued that Petitioner's current LTC services and Petitioner's natural support are not sufficient to meet Petitioner's needs because Adult Day Health Care services are rendered during the day, and Petitioner has minimal to no natural support during the weekday evenings when she returns home from the Adult Day Health Care. Petitioner's Authorized Representative is requesting the Personal Care services to be rendered on weekday evenings. Petitioner's Authorized Representative expressed no need for additional care on the weekends.

19. 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* ¶ 16. The LTC Policy covers Personal Care services that are determined to be medically necessary. *See supra* ¶ 16. 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* ¶ 16-17. 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* ¶ 17. Based on the record, *supra* ¶ 6-8, 11, Respondent determined that Petitioner did not meet the following medical necessity standard: Services 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. This standard is incorporated in section 2.83 of the Definitions Policy's criteria for Medical Necessity. *See supra* ¶ 17. Based on the NABD, Respondent used the incorrect medical necessity criteria to make the initial decision

regarding Petitioner's request. *See supra* ¶ 6. The NABD used the medical necessity criteria set forth in section 1.3.14(b) of the LTC Policy. *See supra* ¶ 6. However, Respondent should have applied the medical necessity criteria set for in 1.3.14(a) of the LTC Policy and section 2.83 of the Definitions Policy. *See supra* ¶ 16-17.

20. The record indicates that the Petitioner requires total assistance with all ADLs and IADLs, and cannot perform these tasks on her own. *See supra* ¶ 3. Petitioner experiences vascular dementia and aphasia, which further complicate Petitioner's care. *See supra* ¶ 2-3. On [REDACTED] 2020, Petitioner suffered from a catastrophic stroke on her dominant side, a brain hemorrhage, and a broken right hip. *See supra* ¶ 2. Following hospitalization and hip replacement surgery, Petitioner was discharged from an ALF in [REDACTED] 2021. *See supra* ¶ 2. Petitioner needs help with all of her ADLs, and cannot be left without supervision. *See supra* ¶ 3. Petitioner does not have a need for Personal Care services during the weekday as she attends an Adult Day Health Care facility for 9 hours per day, Monday through Friday. *See supra* ¶ 10. Petitioner has no other LTC services approved at the time of the Fair Hearing. *See supra* ¶ 5. The record indicates that the Petitioner does not have a need for Personal Care services during the weekday prior to attending the Adult Day Health Care facility, as Petitioner's Authorized Representative provides care to the Petitioner in the form of natural support. *See supra* ¶ 4, 10. The record indicates that the Petitioner does not have a need for Personal Care services overnight, as Petitioner resides with Petitioner's Authorized Representative and Petitioner's son-in-law. *See supra* ¶ 2. Petitioner's Authorized Representative provided no testimony that the Petitioner has a need for Personal Care services on the weekends. *See supra* ¶ 10. Following, the record indicates that the Petitioner needs total assistance with ADLs in the evenings when she returns from the Adult Day

Health Care facility. *See supra* ¶ 3-4, 10. Petitioner's Authorized Representative is unable to assist the Petitioner with ADLs during weekday evenings as she has caregiving responsibilities for her two children (both under the age of 10 years) that take priority. *See supra* ¶ 4, 10. In addition, both Petitioner's Authorized Representative and her husband work full-time outside of the home. *See supra* ¶ 4, 10. Respondent did not dispute Petitioner's Authorized Representative's assessment of her ability to provide natural support on weekday evenings. Instead, Respondent argued that the Petitioner should enroll into an ALF. However, Petitioner's Authorized Representative chooses to enable the Petitioner to live in the community and to avoid institutionalization. Further, the LTC Policy has no limitation that bars the Petitioner from receiving the LTC services while residing in the community and also has no requirement that the Petitioner be institutionalized should they require near 24-hour care. *See supra* ¶ 16. Respondent presented the following two (2) Medical Directors who determined that Petitioner's request is in excess of their needs based on Petitioner's Adult Day Health Care services and Petitioner's natural support: Dr. Karver who issued the NABD; Dr. Szafranski who issued the NPAR; and again, Dr. Karver who testified at the hearing. *See supra* ¶ 6-8, 11. Respondent's two Medical Directors based their determination on Petitioner's needs, Petitioner's LTC services, and Petitioner's natural support. *See supra* ¶ 6-8, 11. However, the record indicates that Respondent had an incorrect assessment of Petitioner's natural support during weekday evenings, which is the foundation of Petitioner's request. Respondent attributed this incorrect assessment of Petitioner's natural support to a lack of consistent communication with Petitioner's Authorized Representative, while Petitioner's Authorized Representative argued that she can only communicate during work hours by text message or e-mail, and Respondent only requested

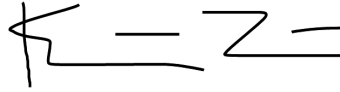
communication by telephone. Although both parties agree on Petitioner's needs for assistance with ADLs and IADLs, the record indicates that Respondent's assessment of Petitioner's natural support was incorrect. Regardless of who is to blame for the inconsistent communication, Petitioner's Authorized Representative presented credible testimony that Petitioner needs the requested Personal Care services to enable the Petitioner receiving long-term services and supports to have access to the benefits of community living. Thus, the record supports that the Petitioner has an unmet need of twenty-five (25) hours per week for assistance with ADLs and IADLs during weekday evenings (5 hours per weekday evening). Upon consideration of the aforementioned facts, Petitioner's Authorized Representative has established that the requested twenty-five (25) hours per week of Personal Care services for assistance with ADLs and IADLs are not in excess of the Petitioner's needs. Thus, the Petitioner has met the section 2.83 of the Definition Policy's criterion at issue for medical necessity.

21. Accordingly, in light of both parties' sworn testimony, Petitioner's Composite Exhibit 1, Petitioner's Composite Exhibit 2, Respondent's Composite Exhibit 1, and the applicable rules and policies, the undersigned Hearing Officer finds that Petitioner has proved by a preponderance of the evidence that Respondent's denial of Petitioner's request for twenty-five (25) hours per week of Personal Care services was incorrect.

DECISION

Respondent's denial of twenty-five (25) hours per week of Personal Care services is **REVERSED**. Petitioner's request for relief is hereby **GRANTED**.

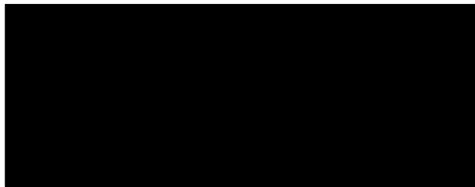
DONE and ORDERED this 18th day of May, 2021, in Tallahassee, Leon County, Florida.



Digitally signed by
Kristopher León
Reason: 21-FH [REDACTED]
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KRISTOPHER LEÓN, Hearing Officer
Agency for Health Care Administration
Office of Fair Hearings
2727 Mahan Drive, Mail Stop # 11
Tallahassee, FL 32308-5407
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