

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



FILED

May 17, 2021, 9:23 am

OFFICE OF FAIR HEARINGS

[REDACTED]

PETITIONER,

AHCA Case No.: 21-FH [REDACTED]

Plan ID No.: [REDACTED]

vs.

UNITEDHEALTHCARE OF FLORIDA, INC.,

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned Hearing Officer convened a telephonic Medicaid Fair Hearing on April 20, 2021, at [REDACTED]

APPEARANCES

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

For the Respondent: Deborah Havey-Levy
Program Integrity Manager
UnitedHealthcare of Florida, Inc.

STATEMENT OF ISSUE

The issue is whether Petitioner proved by a preponderance of the evidence that Respondent's denial of 32 additional hours per week of personal care services was incorrect.

PRELIMINARY STATEMENT

All parties and witnesses appeared telephonically. [REDACTED] [REDACTED]
Petitioner's Designated Authorized Representative and daughter, appeared for the hearing provided testimony on Petitioner's behalf.

Deborah Havey-Levy (“Ms. Havey”), Program Integrity Manager for UnitedHealthcare of Florida, Inc. (“United”), appeared as a representative for Respondent. Dr. Sloan Karver, (“Dr. Karver”) Long Term Care (“LTC”) Medical Director for United appeared as witnesses for Respondent.

Doris Rivera (“Ms. Rivera”), Fair Hearing Liaison for the Agency for Health Care Administration (“Agency” or “AHCA”), appeared as an observer.

Alejandra, translator number 25678, with Language Line Solutions appeared at the hearing and provided translation services for Petitioner’s Authorized Representative.

Prior to the hearing, Petitioner did not submit an evidence packet to the Office of Fair Hearings and Respondent. Petitioner offered no documents in evidence.

Prior to the hearing, Respondent sent to the Office of Fair Hearings and Petitioner a 209-page evidence packet. The packet included the following documents: a Medicaid Fair Hearing Statement of Matters; an address page; a blank page; a Notice of Adverse Benefit Determination (“NABD”), dated February 2, 2021; Respondent’s CSP – General Request Form; Respondent’s letter to Petitioner, dated February 8, 2021; the Florida Department of Elder Affairs 701B Comprehensive Assessment, reflecting an assessment date of January 27, 2021; Respondent’s internal file on Petitioner; Respondent’s Appeal Review notes; a blank page; an address page; a blank page; a Notice of Plan Appeal Resolution (“NPAR”), dated February 16, 2021 (in English and Spanish); the Exhibit 2 (References) Cover Page – Long Term Care (“LTC”); Florida Administrative Code Rule (“Fla. Admin. Code R.”) 59G-1; the Florida Medicaid Managed Care Long-term Care Program Coverage Policy, March 2017 (“SMMC LTC Policy”); Florida Medicaid Authorization Requirements Policy (June 2016); the Florida Medicaid Personal Care Services Coverage Policy,

November 2016 (“PC Policy”); the Florida Medicaid Private Duty Nursing Services Coverage Policy, November 2016 (“PDN Policy”); the Participant Direction Option Manual; the Florida Medicaid Hospice Services Coverage Policy, June 2016; 42 C.F.R. 418, Subpart C – Conditions of Participation: Patient Care; and section 409.910 (2018) of the Florida Statutes (“Fla. Stat.”). Absent an objection from Petitioner, the undersigned admitted Respondent’s 209-page evidence packet into evidence as Respondent’s Composite Exhibit 1.

FINDINGS OF FACT

1. Petitioner is an enrolled member of United’s LTC program. *See* Respondent’s Composite Exhibit 1, page 41. United is a managed care organization contracted by the Agency to provide services to eligible Medicaid recipients in Florida.
2. Petitioner is an 89-year-old female who resides in a private residence. *See* Respondent’s Composite Exhibit 1, page 22. Petitioner has the following medical conditions: high blood pressure; constant incontinence of bowel and bladder; high cholesterol; urinary tract infection (past); and Alzheimer’s. *Id.* at 28 and 29. Petitioner “requires supervision 24/7 due to her Alzheimer’s.” *Id.* at 31. The 701B reflects that Petitioner does not receive any of the following specialty care: IV fluids, IV medications, wound care, tube feedings, suctioning, bladder/bowel treatment, dialysis, or oxygen. *Id.* at 29.
3. The 701B reflects the following regarding Petitioner’s activities of daily living (“ADLs”). Petitioner uses assistive devices for bathing and walking/mobility. *See* Respondent’s Composite Exhibit 1, page 26. Petitioner needs assistance (but not total help) with bathing, dressing eating, using the bathroom, transferring, and walking/mobility. *Id.*

4. The 701B reflects the following regarding Petitioner's instrumental activities of daily living ("IADLs"). Petitioner needs assistance (but not total help) with using the telephone. See Respondent's Composite Exhibit 1, page 27. Petitioner needs total assistance (cannot do at all) with heavy chores, light housekeeping, managing money, preparing meals, shopping, managing medication, and using the transportation. *Id.* Petitioner's daughter "prepares meals for member" and "administers medication." See Respondent's Composite Exhibit 1, pages 33 and 36.

Additionally, the 701B states as follows:

Member is receiving the following services under the LTC program. -PC- 24 hours a week/ 96 units (3 hours daily Monday- Friday/ 2 hours Saturday/ 2 hours Sunday)(PDO- [REDACTED] [DSW]

-PDO-Consumer Direct/ Fiscal Agent- Daily// PDO- [REDACTED] / PDO Representative- Daily

-DMS: (COMPLETE SERVICE CARE)

T4527-U1-Pull Ups [sic] Extra Absorbency-Large 2 cases (144 units) A4554-U2- Disposable Underpads 30x30 Large Size 1 box- 100 units (1 case every other month)- Effective 6/5/2020 by UM// A4335-U1-Incontinence Wipes - Soft Pack- 2 packs (96 units)// A4927-Gloves, Non Sterile (Vinyl) Powder Free- 1 box size Large (100 units)

Respondent's Composite Exhibit 1, page 27.

5. On February 2, 2021, Respondent issued an NABD denying the 32 additional hours per week of personal care services, explaining that the requested services are not medically necessary. See Respondent's Composite Exhibit 1, page 5.

6. Petitioner requested a plan appeal. On February 16, 2021, Respondent sent Petitioner an NPAR, denying Petitioner's plan appeal. See Respondent's Composite Exhibit 1, page 59. The NPAR stated as follows:

On February 08, 2021 we received your timely plan appeal request regarding UnitedHealthcare Community Plan's Notice of Adverse Benefit Determination dated February 2, 2021, [REDACTED], denying the Personal Care (32 more

hours/week) provided to [Petitioner].

On February 16, 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, a Medical Doctor, Board Certified in Family Medicine, reviewed the appeal. This doctor did not make the original decision. The decision was based on Florida Medicaid rules: Florida Administrative Code 59G-1.010(166).

You asked for more personal care. You would like 32 more hours a week. We cannot approve this because it is not medically needed. Based on my professional judgment, having 32 more hours per week of personal care is more than you need. You have family help. You can also help yourself some. This is why we cannot approve what you asked for. Please talk about this with your doctor.

The plan pays for required services and supplies provided for the purpose of preventing, diagnosing or treating a sickness, injury, disease or symptoms. The plan authorizes UnitedHealthcare to determine whether a service or supply is eligible for coverage under the plan.

Respondent's Composite Exhibit 1, pages 60 - 61.

7. Petitioner is currently authorized to receive 24 hours per week of personal care services and personal care supplies (pull-ups, incontinence wipes, gloves, and underpads). See Respondent's Composite Exhibit 1, page 27.

8. On March 9, 2021, Petitioner requested a Fair Hearing due to the denial of the additional 32 hours per week of personal care services. The undersigned scheduled the Fair Hearing for April 20, 2021, at [REDACTED], and all parties were duly notified.

9. [REDACTED] is Petitioner's daughter. Petitioner resides in the home with [REDACTED] and [REDACTED]'s husband. [REDACTED] does not work outside the home, and she is Petitioner's primary

caretaker. [REDACTED] believes that Petitioner is completely disabled, cannot do anything for herself, and needs someone with her all the time.

10. Dr. Karver is a LTC Medical Director for United. Dr. Karver explained that Respondent's position is that Petitioner's currently approved 24 hours per week of personal care services adequately meet Petitioner's needs.

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. 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.

14. Because Petitioner is requesting additional services, Fla. Admin. Code R. 59G-1.100(17)(g) assigns the burden of proof to the Petitioner. The standard of proof in an administrative hearing is a preponderance of the evidence. The preponderance of the evidence standard requires proof by "the greater weight of the evidence" (Black's Law Dictionary at 1201, 7th Ed.).

15. The Florida Medicaid policy that applies to the requested services is the SMMC LTC Policy.

The Agency's SMMC LTC Policy has been incorporated, by reference, into Florida Administrative Code Rule 59G-4.192. The SMMC 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.

...

2.2 Who Can Receive

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

...

4.0 Coverage Information

4.1 General Criteria

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

- Are determined medically necessary, as defined in this rule
- Do not duplicate another service

- Meet the criteria as specified in this policy

4.2 Specific Criteria

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

- Consistent with the type, amount, duration, frequency, and scope of services specified in an enrollee’s authorized plan of care
- Provided in accordance with a goal in the enrollee’s plan of care
- Intended to enable the enrollee to reside in the most appropriate and least.

...

4.2.2 Mixed Services

Mixed services may exceed State Plan limits on those services in accordance with his 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.

...

6.0 Documentation

...

6.2 Specific Criteria

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

SMMC LTC Policy, pages 1-8.

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

2.83 Medically Necessary or Medical Necessity

The medical or allied care, goods, or services furnished or ordered must meet the following conditions:

- Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain

- Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs
- Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational
- Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available statewide
- Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider

The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services does not, in itself, make such care, goods or services medically necessary or a medical necessity or a covered service.

17. The Agency's PC Policy has been incorporated, by reference, into Fla. Admin. Code R. 59G-

4.215. The PC Policy provides as follows:

1.1 Description

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

...

1.1.2 Statewide Medicaid Managed Care Plans

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

...

4.0 Coverage Information

4.1 General Criteria

Florida Medicaid reimburses for services that meet all of the following:

- Are determined medically necessary
- Do not duplicate another service
- Meet the criteria as specified in this policy

4.2 Specific Criteria

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

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

...

5.1 General Non-Covered Criteria

Services related to this policy are not reimbursed when any of the following apply:

- The service does not meet the medical necessity criteria listed in section 1.0.
- The recipient does not meet the eligibility requirements listed in section 2.0.
- The service unnecessarily duplicates another provider's service.

5.2 Specific Non-Covered Criteria

Florida Medicaid does not reimburse for the following:

- A skill level other than what is prescribed in the physician order and approved plan of care (POC)
- Assistance with homework
- Babysitting
- Care, grooming, or feeding of pets and animals
- Certification of the POC by a physician
- Companion sitting or leisure activities
- Escort services
- Housekeeping (except light housekeeping to make the environment safe), homemaker, and chore services
- Nursing assessments related to the POC
- Professional development training or supervision of home health staff or other home health personnel
- Respite care to facilitate the parent or legal guardian attending to personal matters
- Services funded under section 110 of the Rehabilitation Act of 1973 or under the provisions of the Individuals with Disabilities Educational Act
- Services furnished by relatives as defined in section 429.02(18), F.S., household members, or any person with custodial or legal responsibility for the recipient. (Except when a recipient is enrolled in the Consumer-Directed Care Plus program)
- Services provided in any of the following locations:
 - Hospitals

- Intermediate care facility for individuals with intellectual disabilities – Nursing facilities
- Prescribed pediatric extended care centers
- Residential facilities or assisted living facilities when the services duplicate those provided by the facility
- Services rendered prior to the development and approval of the POC
- Travel time to or from the recipient’s place of residence
- Yard work, gardening, or home maintenance work

Florida Medicaid may reimburse for some services listed in this section through a different service benefit.

...

7.0 Authorization

7.1 General Criteria

The authorization information described below is applicable to the fee-for-service delivery system. For more information on general authorization requirements, please refer to Florida Medicaid’s General Policies on authorization requirements.

...

Personal Care Task	General Time Allowances
Bathing	
Full-body Bath: Tub, shower or sponge/bed bath.	Up to 30 minutes. May rotate with partial bath based on recipient’s needs
Partial Bath: A sponge bath includes, at a minimum, bathing of the face, hands, and perineum.	15–20 minutes per partial bath
Dressing	
Laying out clothing, handing and retrieving clothing, putting clothes on and taking them off, including handling fasteners, zippers, and buttons.	15 minutes
Application of prosthetic devices or application of therapeutic stockings.	May add 15 minutes for applying hose and/or Prosthesis
Grooming and Skin Care	

Brushing teeth, denture care, shaving, washing and drying face and hands. Applying lotion to non-broken skin.	15–30 minutes
Shampoo and comb hair, basic hair care, basic nail care.	15 minutes
Positioning	
Moving recipient to and from a lying position, turning side to side, and positioning recipient in bed.	10 minutes/every 2 hours when medically indicated
Transfers	
Moving recipient into and out of a bed, chair, or wheelchair. May include the use of assistive devices.	15 minutes/every 2 hours when medically indicated
Toileting and Maintaining Continence	
Includes transfer on or off the toilet, bedside commode, urinal, or bedpan. Includes cleaning the perineum and cleaning after an incontinent episode. Includes taking care of a catheter or colostomy bag or changing a disposable incontinence product.	15–45 minutes
Eating	
Taking in food by any method. Extra time may be allowed for preparing a special diet.	30 minutes per meal
Delegated Medical Monitoring and Activities	
Non-skilled medical tasks that are delegated to the aide by the RN, in accordance with Florida laws and practice acts. The tasks include, but are not limited to, assisting recipient with pre-poured medications, monitoring vital signs, and measurement of intake/output.	15–30 minutes day for all monitoring tasks performed

PC Policy, pages 3 – 8, and 10.

18. In the instant case, Respondent denied an additional 32 hours per week of personal care services. See supra ¶ 5 and 6. As established on the record by the evidence and testimony, Respondent denied Petitioner’s request, because the documentation submitted in support of

Petitioner's request failed to establish that the requested services were medically necessary. *See supra* ¶ 5 and 6.

19. Section 4.1 of the SMMC LTC Policy provides that Florida Medicaid LTC plans cover services that: (a) are determined medically necessary, as defined in the SMMC LTC Policy; (b) do not duplicate another service; and (c) meet the criteria as specified in the SMMC LTC Policy. *See supra* ¶ 15.

20. Section 4.2.2.6 of the SMMC LTC Policy reflects that personal care services are [t]o provide assistance with ADLs and IADLs, including assistance with preparation of meals, and housekeeping chores which are incidental to the care furnished or are essential to the health and welfare of the enrollee." *See supra* ¶ 15. Further, the PC Policy provides that personal care services are to "provide medically necessary assistance, in the home or in the community, with [ADL] and age appropriate [IADL] to enable recipients to accomplish tasks they would normally be able to do for themselves if they did not have a medical condition or disability." *See supra* ¶ 17.

21. The evidence presented in this case does not reflect that Petitioner needs an additional 32 hours per week of personal care services. Specifically, regarding ADLs, the 701B reflects that Petitioner uses assistive devices for bathing and walking/mobility; and needs assistance (but not total help) with bathing, dressing eating, using the bathroom, transferring, and walking/mobility. *See supra* ¶ 3. Regarding IADLs, Petitioner needs: assistance (but not total help) with using the telephone; and needs total assistance (cannot do at all) with heavy chores, light housekeeping, managing money, preparing meals, shopping, managing medication, and using the transportation. *See supra* ¶ 4. Petitioner has multiple medical conditions, including

Alzheimer's and constant incontinence of bowel and bladder. *See supra* ¶ 2. Petitioner "requires supervision 24/7 due to her Alzheimer's." *See supra* ¶ 2.

22. However, Petitioner resides in the home with [REDACTED] and [REDACTED]'s husband. *See supra* ¶ 9. [REDACTED] does not work outside the home, and she is Petitioner's primary caretaker. *See supra* ¶ 9. The record reflects that Petitioner does not receive any of the following specialty care: IV fluids, IV medications, wound care, tube feedings, suctioning, bladder/bowel treatment, dialysis, or oxygen. *See supra* ¶ 2. Although the PC Policy provides guidance for general allowances for ADLs, *supra* ¶ 17, [REDACTED] provided no time estimates for each ADL to explain the amount of time Petitioner requires for her ADLs. Although [REDACTED] believes that Petitioner completely disabled, cannot do anything for herself, and needs someone with her all the time, *supra* ¶ 9, [REDACTED] neglected to explain how the requested additional hours personal care services, will be utilized to meet Petitioner's needs if approved in this matter. Considering the totality of Petitioner's circumstances – including Petitioner's ADL needs, and the fact that Petitioner resides in the home with [REDACTED] and [REDACTED]'s husband, and does not require specialty care – Petitioner's evidence fails to justify the approval of an additional 32 hours per week of personal care services. Based upon the evidence presented by both parties, Petitioner failed to establish that additional hours of personal care services are warranted in this case.

23. The Definitions Policy requires that the requested services must "[b]e individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs." *See supra* ¶ 16. Petitioner is currently authorized to receive 24 hours per week of personal care services and personal care supplies


(pull-ups, incontinence wipes, gloves, and underpads). *See supra* ¶ 7. Although Petitioner “requires supervision 24/7 due to her Alzheimer's,” needs assistance with ADLs, and was described as completely disabled by ██████████, *supra* ¶ 2, 3, 4 and 9, ██████████ offered no testimony or evidence that explained why Petitioner’s currently authorized personal care services are not sufficient to meet these needs. Although Petitioner has constant bowel and bladder incontinence, she is authorized to receive personal care supplies (pull-ups, incontinence wipes, gloves, and underpads) for her incontinence needs. *See supra* ¶ 7. Dr. Karver explained that Respondent’s position is that Petitioner’s currently approved 24 hours per week of personal care services adequately meet Petitioner’s needs. *See supra* ¶ 10. Given that Dr. Karver is a Medical Director at United, her testimony is credible. Considering Petitioner’s living situation, medical condition, and level of assistance required for ADLs, *supra* ¶ 2 and 3, Petitioner did not demonstrate that an additional 32 hours per week of personal care services is medically necessary. Further, given that Petitioner failed to establish that the additional hours of personal care services are warranted in this matter, *supra* ¶ 22, the requested additional services are “in excess of [Petitioner’s] needs.” *See supra* ¶ 16.

24. In light of the both parties’ testimony, the evidence, the SMMC LTC Policy, the PC Policy, and the Definitions Policy, the undersigned Hearing Officer finds that Petitioner failed to meet her burden of proving that an additional 32 hours per week of personal care services are medically necessary. Accordingly, the undersigned Hearing Officer concludes that Petitioner failed to prove by a preponderance of the evidence that Respondent’s denial of the requested additional personal care services was incorrect.

DECISION

Respondent's denial of the 32 additional hours per week of personal care services is **AFFIRMED**. Petitioner's appeal based on Respondent's denial in this matter is **DENIED**.

DONE AND ORDERED this 17th day of May, 2021, in Tallahassee, Leon County, Florida.

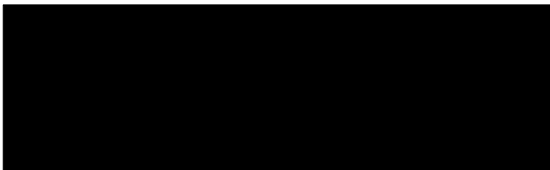

Tracie Hardin
21-FH [REDACTED]
2021.05.17 07:40:54
-04'00'

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

NOTICE OF A RIGHT TO JUDICIAL REVIEW

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

COPIES FURNISHED TO:



UnitedHealthcare of Florida, Inc.
UHC_Hearings@uhc.com

AHCA Medicaid Hearing Unit
MedicaidHearingUnit@ahca.myflorida.com