

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



FILED

Jan 30, 2023, 9:22 am
OFFICE OF FAIR HEARINGS

[REDACTED],

PETITIONER,

AHCA Case No.: 22-FH1465

vs.

AGENCY FOR HEALTH CARE
ADMINISTRATION,

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned Hearing Officer convened a telephonic Medicaid Fair Hearing in the above-styled case on October 28, 2022, at 3:30 p.m. Eastern Standard Time ("EST") and November 2, 2022, at 11:00 a.m. EST.

APPEARANCES

For the Petitioner: [REDACTED] (October 28, 2022, hearing)
Petitioner's Authorized Representative

For the Petitioner: [REDACTED] (November 3, 2022, hearing)
Petitioner's Authorized Representative

For the Respondent: Chrissie Simmons
Medical Health Care Program Analyst
Agency for Health Care Administration

STATEMENT OF ISSUE

At the Fair Hearing, the parties agreed on the record that the issue is whether Petitioner proved by a preponderance of the evidence that Respondent's denial of Petitioner's request for additional personal care services was correct.

PRELIMINARY STATEMENT

All parties and witnesses appeared telephonically. [REDACTED] (“[REDACTED]”), Petitioner’s [REDACTED], appeared as Petitioner’s representative at the October 28, 2022, hearing, and she provided testimony on behalf of Petitioner. [REDACTED] (“[REDACTED]”) with Special Needs Guidance Group, appeared as Petitioner’s representative at the November 2, 2022, hearing, and she provided testimony on behalf of Petitioner. [REDACTED] (“[REDACTED]”), Petitioner’s [REDACTED], appeared as a witness for Petitioner.

Chrissie Simmons, Medical Health Care Program Analyst for the Agency for Health Care Administration (“Agency” or “AHCA”), appeared as a representative for Respondent. Dr. Rakesh Mittal (“Dr. Mittal”), Physician Consultant for eQHealth Solutions, Inc., appeared as a witness for Respondent.

Petitioner introduced a nineteen (19)-page evidence packet at the Fair Hearing. The packet is maintained in the Office of Fair Hearings’ Case management system as “FH Request [Petitioner].pdf.” Without objection, the undersigned admitted the evidence packet into evidence as Petitioner’s Composite Exhibit 1.

Respondent introduced a seventy-five (75)-page evidence package at the Fair Hearing. The packet is maintained in the Office of Fair Hearings’ Case management system as “54914046 FH 10.28.2022.pdf.” Absent an objection from Petitioner, the undersigned admitted the evidence packet into evidence as Respondent’s Composite Exhibit 1. Respondent introduced an eighty (80)-page evidence package at the Fair Hearing. The packet is maintained in the Office of Fair Hearings’ Case management system as “1465_PCS with CDC Plus_AHCA Evidence.pdf.” Absent

an objection from Petitioner, the undersigned admitted the evidence packet into evidence as Respondent's Composite Exhibit 2.

FINDINGS OF FACT

1. AHCA is a single state agency responsible for administering the Medicaid program and for ensuring compliance with state and federal Medicaid Rules. See Respondent's Composite Exhibit 1 at page 2.

2. Petitioner receives Medicaid services on a fee-for-service basis from the Agency. *Id.* at 21. eQHealth is a Quality Improvement Organization ("QIO") contracted by AHCA to review prior authorization requests for services. See Respondent's Composite Exhibit 2 at page 2. The Agency through contractual agreement authorized eQHealth to make medical necessity determinations regarding requests for fee-for-service Medicaid services requiring prior authorizations. *Id.* eQHealth is explicitly authorized to make medical necessity determinations for personal care services and to act as a witness for the Agency in all Fair Hearing proceedings resulting from decisions and actions made by eQHealth in accordance with the contractual agreement. *Id.*

3. Petitioner's Plan of Care indicates that [REDACTED] is a [REDACTED] ([REDACTED]-year-old [REDACTED] diagnosed with [REDACTED] [REDACTED]. See Respondent's Composite Exhibit 1 at page 16-17, 48, 52. Petitioner has [REDACTED]. *Id.* at 16-17, 48. Petitioner is [REDACTED] ([REDACTED]). *Id.*

4. Petitioner resides with [REDACTED] parents. *Id.* at 42. [REDACTED] work schedule is fifteen (15) hours per week as follows: Monday and Wednesday – varies; Tuesday, Thursday, and Friday - 8:45 a.m.to 3:45 p.m. (varies). [REDACTED] established that [REDACTED] cannot lift over fifty (50) pounds

due to back problems. *Id.* at 54. [REDACTED] work schedule is 8:00 a.m. to 6:00 p.m. Monday through Friday, and 9:00 a.m. to 2:00 p.m. on Saturday. He is required to travel on business, and his schedule for Sunday “varies.” *Id.* at 53.

5. Regarding Activities of Daily Living (“ADLs”), Petitioner is [REDACTED] and [REDACTED]. *Id.* at 17. Petitioner [REDACTED]. *Id.* at 17, 43. As stated on Petitioner’s Physician Visit Documentation Form, certified by Dr. Robert Chong on [REDACTED], Petitioner requires total assistance with [REDACTED]. *Id.* at 51. Petitioner is [REDACTED]. *Id.* at 17, 45, 49. Petitioner does not use a [REDACTED]. *Id.* at 43. [REDACTED] has [REDACTED]. *Id.* at 44.

6. On July 25, 2022, Respondent issued a Notice of Outcome (“NOO”) concerning personal care services. *Id.* at 24. Respondent determined that the requested additional personal care services were not medically necessary. *Id.* The notice stated as follows:

The request for services is denied in whole or in part because they are not medically necessary as defined in 59G-1.010, Florida Administrative Code. Specifically the requested services are not medically necessary under the following standard(s):

Individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness under treatment, and not in excess of the patient’s needs.

The rationale for our decision is as follows:
PR Principal Reason – Denial:

Submitted information does not support the medical necessity for requested services.

The request is excessive based on the severity of delay and the school and work schedules. PCS is not intended for monitoring and supervision and parents have to provide to the best of their ability. Variable schedules cannot be taken into account.[emphasis added]

Id. at 24-26.

7. As Dr. Mittal testified, Petitioner is approved for four (4) hours on Tuesday and Thursday (for a total of eight (8) hours per week) of personal care services. *Id.* at 17. Petitioner requested two (2) additional hours on Monday through Friday, five (5) additional hours on Saturday, and three (3) additional hours Monday through Friday on non-school days. *Id.* Thus, in total, Petitioner requested an additional fifteen (15) hours per week of personal care services, plus three (3) additional hours on Monday through Friday during non-school days.

8. On August 2, 2022, ██████████ requested a Fair Hearing due to the denial of the additional personal care services at issue. On September 29, 2022, the undersigned scheduled the Fair Hearing for October 28, 2022, at 3:30 p.m. At the Fair hearing, the parties were unable to finish in the allotted time, and a continuance was granted. On October 31, 2022, the undersigned rescheduled the Fair Hearing to convene on November 2, 2022, at 11:00 a.m., and all parties were duly notified.

9. ██████████ testified that ██████████ would be able to work additional hours if the requested services are approved. ██████████ established that ██████████ is unable to lift more than fifty (50) due to back problems, that ██████████ back pain is worsening, and that ██████████ medical condition should be taken into account due to the number of falls Petitioner's experiences when they are alone together. ██████████ asserted that Petitioner does not ██████████ ██████████. ██████████ asserted that Petitioner is a ██████████ ██████████. ██████████ testified that ██████████ work hours vary based on when ██████████ has care available and ██████████ employer's needs.

10. Dr. Mittal is Board Certified in pediatrics, Board Certified in pediatric emergency medicine and teaches pediatric medicine. Testified that parents of Florida Medicaid recipients are required by the Florida Medicaid program to provide as much care as possible and the Florida Medicaid program only supplements the care provided by the parents. He asserted that, in this case, [REDACTED] is able to care for Petitioner with assistance from [REDACTED] when home. Dr. Mittal testified that variable work schedules, such as [REDACTED] submitted in this case, cannot be taken into consideration unless the reported number of hours are actually worked. Dr. Mittal opined that the approved level of personal care services are adequate to meet Petitioner's needs. Dr. Mittal testified that based on the parents' work schedules, the parents' ability to provide care to date, and the Petitioner's level of independence with ADLs, Petitioner's request for additional personal care services is in excess of 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 section 409.285(2), Florida Statutes (2019). This order is the final administrative decision of AHCA under section 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 Personal Care Services Coverage Policy (November 2016) (“PC Policy”), incorporated by reference in Fla. Admin. Code R. 59G-4.215, governs Petitioners’ request for fifteen (15) additional hours of personal care services per week. The PC Policy states as follows:

1.1 Description

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

...

1.1.2 Statewide Medicaid Managed Care Plans

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

...

1.3 Definitions

The following definitions are applicable to this policy. For additional definitions that are applicable to all sections of Rule Division 59G, F.A.C., please refer to the Florida Medicaid definitions policy.

1.3.1 Activities of Daily Living (ADL)

As defined in Rule 59G-1.010, F.A.C.

1.3.2 Babysitting

Custodial care, daycare, afterschool care, supervision, or similar childcare unrelated to the services that are documented to be medically necessary for the recipient.

...

1.3.6 Home Health Services

Medically necessary services that can be safely provided to the recipient in their home or in the community that include home health visits (skilled nursing and home health aide services), private duty nursing, and personal care services.

...

2.0 Eligible recipient

2.1 General Criteria

An eligible recipient must be enrolled in the Florida Medicaid program on the date of service and meet the criteria provided in this policy. Provider(s) must verify each recipient's eligibility each time a service is rendered.

2.2 Who can receive

Florida Medicaid recipients under the age of 21 years requiring medically necessary personal care services. Some services may be subject to additional coverage as specified in section 4.0.

18. The PC Policy provides the following general and specific criteria for coverage of personal care services:

4.0 Coverage Information

4.1 General Criteria

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

- Are determined to be 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

...

4.2.1 Parental Responsibility

Florida Medicaid reimburses for personal care services rendered to a recipient whose parent or legal guardian is not able to provide ADL or IALS care, and to supplement care provided by parents and legal guardians. Parents and legal

guardians must participate in providing care to the fullest extent possible. Providers must offer training to enable parents and legal guardians to provide care they can safely render without jeopardizing the health or safety of the recipient when needed.

PC Policy at pages 3 - 6.

19. The PC Policy provides the following general and specific exclusions to the coverage of personal care services:

5.0 Exclusion

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

5.2 Specific Non-Covered Criteria

Florida Medicaid does not reimburse for the following

...

- Babysitting

16. The Florida Medicaid Authorization Requirements Policy ("Authorization Requirements Policy") (June 2016), incorporated by reference in Fla. Admin. Code R. 59G-1.053, provides general requirements for providers to obtain authorization to render Florida Medicaid services.

The Authorization Requirements Policy states:

1.2 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 Authorization

The process of obtaining approval for reimbursement of a service based on medical necessity.

...

1.3.6 Provider

The term used to describe any entity, facility, person, or group that has been approved for enrollment or registered with Florida Medicaid.

1.3.7 Quality Improvement Organization

Entity designated to perform utilization review, quality assurance, and quality improvement activities for Florida Medicaid-covered services rendered by fee-for-service providers (also known as the QIO).

...

2.0 Authorization Requirements

...

2.4.2 Requests for Additional Information

The QIO may request additional information, as necessary, to determine medical necessity.

...

3.0 Determination Process

3.1 Review Criteria

The QIO may use a national standardized set of criteria, or other set of criteria, approved by AHCA, as a guide for authorizations performed at the first review level. If services cannot be approved at the first level review, the QIO's physician peer reviewer will determine medical necessity using his or her clinical judgment, acceptable standards of care, state and federal laws, and AHCA's medical necessity definition.

3.2 Review Process

The QIO will review each authorization request and will approve, deny, or request additional information. The QIO may deny a portion of the requested units of service if it cannot substantiate medical necessity based upon the information submitted.

3.2.1 Continued Authorization Requests

The QIO shall not deny or reduce the amount, frequency, or duration of a service that is already being provided, unless:

- The reduction is to correct for factual errors or omissions in prior certifications.
- There is a documented improvement in the recipient's medical condition.
- There is a documented change in the recipient's circumstances.
- The reviewing physician determines the recipient will not gain any additional benefit by continuing services at the current level.

Id. at

24. The PC Policy provides the following with respect to Florida Medicaid recipients under the age of 21 years, requesting coverage for PCS services:

4.3 Early and Periodic Screening, Diagnosis, and Treatment

As required by federal law, Florida Medicaid provides services to eligible recipients under the age of 21 years, if such services are medically necessary to correct or ameliorate a defect, a condition, or a physical or mental illness. Included are diagnostic services, treatment, equipment, supplies, and other measures described in section 1905(a) of the SSA, codified in Title 42 of the United States Code 1396d(a). As such, services for recipients under the age of 21 years exceeding the coverage described within this policy or the associated fee schedule may be approved, if medically necessary. For more information, please refer to Florida Medicaid's General Policies on authorization requirements.

Id. at

25. Given that Petitioner is [REDACTED] ([REDACTED] years old, the PC Policy permits coverage for the personal care services at issue. However, a state may place medical necessity limitations on Early and Periodic Screening, Diagnosis, and Treatment ("EPSDT") services. See 42 C.F.R. §§ 440.230(a), (b), (d). Pursuant to section 409.905(2), Florida Statutes:

The [Agency] shall pay for early and periodic screening and diagnosis of a recipient under age 21 to ascertain physical and mental problems and conditions and all services determined by the agency to be medically necessary for the treatment, correction, or amelioration of these problems and conditions, including personal care, private duty nursing, durable medical equipment, physical therapy, occupational therapy, speech therapy, respiratory therapy, and immunizations.

26. Once it is determined that EPSDT applies to a request for a service, the Florida Medicaid program determines the amount or necessity for that service based on the State of Florida's definition of medical necessity. The 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.

Id. at

20. The evidence admitted and testimony presented established that Respondent denied the personal care services at issue because Respondent's QIO determined that the hours were not medically necessary according to section 2.83 of the Definitions Policy. Specifically, the request was not determined to be "individualized, specific, and consistent with the symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs." See supra ¶ 6.

21. The record demonstrates that the additional personal care services are not warranted under the circumstances of this case. Dr. Mittal provided credible and persuasive testimony that Petitioner's needs for assistance with ADLs and IADLs can be met by Petitioner's parents. See supra ¶ 10. Dr. Mittal's testimony, which cited section 4.2.1 of the PC Policy, is that Florida Medicaid requires parents to provide as much care as possible. See supra ¶ 18. According to ██████ testimony, Petitioner needs the services so that ██████ can be available to work more hours and to preserve ██████ back. See supra ¶ 9. However, the issue is whether Petitioner proved by a preponderance to the evidence that Respondent's denial of the requested services was incorrect. In this case, ██████ provided a work "schedule" with variable hours. See supra ¶ 4. As Dr.

Mittal testified, variable work schedules, such as [REDACTED] submitted in this case, cannot be taken into consideration – only the number of hours that are actually worked. See supra ¶ 10. [REDACTED] further asserted that her back problems have worsened, Petitioner experiences falls, and that [REDACTED] needs more assistance when [REDACTED] is not available due to [REDACTED] work schedule. See supra ¶ 9. The records reflects that [REDACTED] works ten (10) hours per day on the weekdays, five (5) hours on Saturday, and travels overnight on business. See supra ¶ 4. The record is unclear why, if [REDACTED] is unable to care for Petitioner due to her back problems, only two (2) additional hours per weekday were requested in light of [REDACTED] work schedule. Dr. Mittal provided credible and persuasive testimony that the approved number of personal care services are adequate based on the documentation provided. See supra ¶ 6, 10. The undersigned finds that Petitioner did not provide sufficient testimony and evidence that it is medically necessary for Petitioner to receive the requested additional hours per week of personal care services to assist with ADLs and IADLS as defined by section 2.2 and 2.64 of the PC Policy.

22. Looking at all of the evidence relevant to the particular needs of Petitioner, the record does not demonstrate that the requested personal care services at issue in this case are necessary to correct or ameliorate defects and physical and mental illness and conditions discovered by the screen services. In light of both parties' testimony, Petitioner's Composite Exhibit 1, Respondent's Composite Exhibit 1 and 2, the PC Policy, the Definitions Policy, the Authorization Requirements Policy, and Petitioner's needs and natural supports, the undersigned finds that Petitioner did not meet the burden of proving by a preponderance of the evidence that the personal care services are medically necessary. Accordingly, the undersigned Hearing Officer

finds that Petitioner did not prove by a preponderance of the evidence that Respondent's denial of additional personal care services was incorrect.

DECISION

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

DONE AND ORDERED this 30th day of January 2023, in Tallahassee, Leon County, Florida.



Laura Gallagher
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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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AHCA Medicaid Hearing Unit

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