

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



FILED

Jan 04, 2023, 10:58 am

OFFICE OF FAIR HEARINGS

[REDACTED],

PETITIONER,

AHCA Case No.: 22-FH1543

Plan ID No.: [REDACTED]

vs.

SIMPLY HEALTHCARE PLANS, INC.,

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic Fair Hearing on the instant case on November 22, 2022, at 9:02 a.m. Eastern Standard Time (“EST”).

APPEARANCES

For the Petitioner:

[REDACTED]

Petitioner’s Authorized Representative

For the Respondent:

Sharon Nealy
Fair Hearing Coordinator
Simply Healthcare Plans, Inc.

STATEMENT OF ISSUE

The issue is whether Respondent proved by a preponderance of the evidence that Respondent’s decision to reduce Petitioner’s personal care services was correct.

PRELIMINARY STATEMENT

All parties appeared telephonically. Petitioner’s Authorized Representative and [REDACTED],

[REDACTED] (“[REDACTED]”), appeared on behalf of the Petitioner.

Sharon Nealy, Fair Hearing Coordinator for Simply Healthcare Plans, Inc. (“Simply”) appeared on behalf of Respondent. The following attended as witnesses for Respondent: Dr. Jason Schulman (“Dr. Shulman”), Medical Director for Simply; and Tanya Keller, National State Fair Hearing Nurse for Simply.

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

Petitioner did not introduce any exhibits at the hearing. Prior to the hearing, Respondent sent to the Office of Fair Hearings and Petitioner a sixty-seven (67)-page evidence packet. The sixty-seven (67)-page evidence packet appears in the Office of Fair Hearings document management system as file title “FL Simply [Petitioner Name].pdf”. Absent an objection from the Petitioner, the undersigned admitted the sixty-seven (67)-page evidence packet into evidence as Respondent’s Composite Exhibit 1 (“RCE 1”).

FINDINGS OF FACT

1. Petitioner is an enrolled member of Simply. See page 4 of RCE 1. Simply is a managed care organization contracted by the Agency to provide services to eligible Medicaid recipients in Florida.

2. Petitioner is [REDACTED] ([REDACTED])-years old. *Id.* at 8. Petitioner is diagnosed with [REDACTED] [REDACTED]. *Id.* at 13. Petitioner “[REDACTED] [REDACTED]”. *Id.* Petitioner requests assistance with activities of daily living (“ADLs”). *Id.* at 11.

3. The home health aide provides assistance with the following:
HHA to assist patient with personal care and ADL’s as ordered: [REDACTED]

[REDACTED]

...

Page 13 of RCE 1.

4. [REDACTED] works from 8:00 a.m. – 5:00 p.m., Monday – Friday, 5:30 p.m. - 8:00 p.m., Monday – Friday, and 8:00 a.m. – 3:00 p.m., Saturday. *Id.* at 34-35.

5. In a Notice of Adverse Benefit Determination (“NABD”), dated June 23, 2022, Respondent terminated Petitioner’s personal care services. The NABD explained the basis of the denial as follows:

We determined that your requested services are not medically necessary because the services do not meet the reason(s) checked below: (See Rule 59G-1.010)

...

- Must be individualized, specific, consistent with symptoms or diagnosis of illness or injury and not be in excess of the patient’s needs.

...

The facts that we used to make our decision are: We cannot cover your child’s home care (S9122). [REDACTED] needs help with some things, like [REDACTED]. [REDACTED] is at school during the day. When [REDACTED] gets home, [REDACTED] has help (ABA Therapist from 3:15 to 8:15). [REDACTED] does not need another home aid for all this time. We do not know why another person is needed to help. This decision is based on the Medicaid Home Personal Care Services Coverage Policy 4.0-4.2 and Appendix 9.1.

...

Page 17 – 18 of RCE 1.

6. Petitioner requested a plan appeal and received a Notice of Plan Appeal Resolution (“NPAR”), dated August 10, 2022, that reinstated fifteen (15) hours per week of personal care services. *Id.* 50 – 52. The NPAR explained as follows:

On 08/10/2022, after consideration of the information you provided to Simply in support of your plan appeal, Simply hereby partially approves your plan appeal. Based on review of the details we have and the Florida Medicaid Home Personal Care Services Coverage Policy 4.0- 4.2 with consideration to Appendix 9.1: Review

Criteria for Personal Care Services, the prior denial of coverage for the continued hourly home care serviced is partially rescinded and partially approved. Therefore, [Petitioner] is approved for: S9122: hourly Home Health Care Aide– 3 hours a day, Monday - Friday. And denied: S9122: hourly Home Healthcare Aide– 3 hours a day, Monday - Friday. This therapy is meant to help your child process the world. This is not specific help with [REDACTED] self-care or with household help. The therapy is occurring during the time after school when the home health aide was coming. We were not told that the therapist cannot help with your child’s self-care while [REDACTED] is in the program. We were not told how the hourly home aide is needed during your child’s therapy time. The details we have do not show why the two services need to overlap before you get home. Your child does need some hourly home care. We do not see why all the old hours are needed. We would need more details on how the therapy works with your child. We would need to know why both the aide and the therapist are needed in the home at the same time. We will cover 3 hours a day of this hourly home care. This time should meet your child’s self-care needs until you are home. More details would be needed to support more care than this. Your case was looked at by a Family and Geriatric Medicine Medical Director for Simply.

...

Pages 50 – 51 of RCE 1.

7. On August 15, 2022, Petitioner requested a Fair Hearing to challenge the reduction of personal care services from thirty (30) hours weekly to fifteen (15) hours, weekly. On October 11, 2022, the undersigned issued an Order Scheduling Fair Hearing by Telephone and Prehearing Instructions, setting the hearing for November 22, 2022, at 9:00 a.m. EST.

8. Dr. Shulman testified to the following:

- a. The plan’s decision was based on the Florida Medicaid Personal Care Services Coverage Policy (“Policy”). Dr. Shulman referenced section 5.2 of the Policy which provides that “babysitting” is a non-covered service.
- b. The plan did not receive any clinical information that Petitioner needed assistance with walking, transferring, or was tube fed.

9. [REDACTED] is Petitioner’s [REDACTED] [REDACTED] testified to the following:

- a. Petitioner needs help with [REDACTED]
[REDACTED]
- b. Petitioner engages in [REDACTED] while [REDACTED] is being assisted with [REDACTED] ADLs.
- c. The home health aide makes dinner for Petitioner.

CONCLUSIONS OF LAW

10. 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) of the Florida Statutes (2019). This order is the final administrative decision of AHCA under Fla. Stat. § 409.285(2)(a).

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

12. Because Respondent is reducing a previously authorized service, Fla. Admin. Code R. 59G-1.100(17)(g) assigns the burden of proof to Respondent. 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.)

13. The Agency’s Florida Medicaid Personal Care Services Coverage Policy, November 2016 (“Policy”) has been incorporated, by reference, into Fla. Admin. Code R. 59G-4.215, governs Personal Care services available under Florida Medicaid. The Policy provides the following with respect to personal care services services:

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.

...

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

...

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 IADL 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.

...

4.2.2 Services Provided by Independent Personal Care Providers

Personal care services provided by independent personal care providers must be:

- Supervised by the parent or legal guardian if provided by a non-home health agency when the recipient is under the age of 18 years.
- Supervised by the recipient, or their authorized representative, if the services are provided by a non-home health agency when the recipient is between the age of 18 and 21 years with no legal guardian.

...

4.3 Early and Period 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 1095(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.

14. The Policy further addresses excluded services as follows:

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 recipients place of residence
- Yard work, gardening, or home maintenance work.

15. States must provide Early and Periodic Screening, Diagnostic, and Treatment (“EPSDT”) services to Medicaid-eligible children under age 21 when requested under the Medicaid state plan. *See* 42 U.S.C. § 1396a(a)(43); 42 U.S.C. § 1396d(a)(4). According to 42 U.S.C. § 1396d(r)(5), EPSDT services mean, in relevant part, the following items and services:

Such other necessary health care, diagnostic services, treatment, and other measures described in subsection (a) of this section to correct or ameliorate defects and physical and mental illness and conditions discovered by the screen services, whether or not such services are covered under the state plan.

16. Petitioner is under age [REDACTED] and therefore EPSDT applies to [REDACTED] request for services. However, a state may place medical necessity limitations on EPSDT services. *See* 42 C.F.R. §§ 440.230(a), (b), (d). Fla. Stat. § 409.905(2) limits EPSDT services with a medical necessity standard:

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.

17. The Florida Medicaid Definitions Policy (August 2017) (“Definitions Policy”), incorporated by reference in Fla. Admin. Code R. 59G-1.010, provides the applicable definitions for Florida Statewide Medicaid Managed Care policy. The Definitions Policy provides the following definitions applicable to the instant case:

2.2 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

2.64 Instrumental Activities of Daily Living (IADLs)

When necessary for the recipient to function independently, including:

- Grocery shopping
- Laundry
- Light housework
- Meal preparation
- Money Management
- Personal hygiene
- Transportation
- Using the telephone to take care of essential tasks (examples include paying bills and setting up medical appointments)

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 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.

18. In the NABD, dated June 23, 2022, Respondent terminated Petitioner’s personal care services. *See* ¶ 5. Respondent explained that the previously authorized personal care services were not “individualized, specific, consistent with symptoms or diagnosis of illness or injury and not be in excess of the patient’s needs. *Id.* However, in the NPAR, dated August 10, 2022, Respondent reinstated fifteen (15) hours of personal care services. *See* ¶ 6. In the NPAR Respondent explained that three hours per weekday “should meet [Petitioner’s] self-care needs”. *Id.*

19. As Respondent bears the burden of proof, Respondent must show that the previously authorized services are no longer medically necessary for Petitioner. As provided in the Policy, personal care services are to “provide medically necessary assistance . . . with activities of daily living (ADL) and age appropriate instrumental activities of daily living (IADL).” *See* ¶ 13. As shown by the record, Petitioner is diagnosed with [REDACTED] and [REDACTED]. *See* ¶ 2. Regarding [REDACTED] ADLs, Petitioner needs assistance with [REDACTED]. [REDACTED] *See* ¶ 3. Appendix 9.1 of the Policy provides the time allotted for personal care tasks. The time allotted for tasks applicable for Petitioner are as follows: a [REDACTED] is allotted up to 30 minutes; [REDACTED] is allotted up to 15 minutes; and [REDACTED] is allotted between 30 and 45 minutes. Additionally, the care aide makes dinner for Petitioner. *See* ¶ 9. Here, [REDACTED] testified that Petitioner engages in [REDACTED] while be assisted with ADLs, *id*, thus the time necessary to complete ADLs may take longer than provided for in the Policy. However, based on the Policy, Petitioner’s ADLs should take approximately 1.5 hours each day, which would leave another 1.5 hours to make dinner for Petitioner, or assist with any other IADLs. As such, based on the record, it would appear that three (3) hours per day is sufficient to assist


with Petitioner’s ADLs and IADLs. Given that Respondent established that the reduction of personal care services is warranted in this matter, the requested XX hours per week of personal care services is “in excess of [Petitioner’s] needs.” See supra ¶ 17.

20. Upon consideration of the testimony provided, evidence submitted, and applicable polices, the undersigned concludes that Respondent proved by a preponderance of the evidence that the reduction of personal care services was medically necessary. Looking at all the evidence relevant to the particular needs of Petitioner, Respondent demonstrated that thirty (30) hours of personal care services were not necessary to correct or ameliorate a defect or a physical and mental illness or condition. Accordingly, Respondent proved by a preponderance of the evidence that the reduction of personal care services was correct.

IT IS HEREBY ORDERED AND ADJUDGED THAT:

Respondent’s denial is **AFFIRMED**. Petitioner’s appeal based on Respondent’s denial is **DENIED**.

DONE and ORDERED this 4th day of January 2023, in Tallahassee, Leon County, Florida.


Joseph Mabry
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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.

Copies Furnished To:



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