

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



FILED

Apr 13, 2023, 11:39 am
OFFICE OF FAIR HEARINGS

[REDACTED]

PETITIONER,

AHCA Case No.: 23-FH0097

Plan ID No.: [REDACTED]

vs.

SUNSHINE STATE HEALTH PLAN, INC.,

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the Office of Fair Hearings (“OFH”) convened a telephonic Medicaid Fair Hearing in the above styled case on March 17, 2023, at 10:00 a.m. Eastern Standard Time (“EST”).

APPEARANCES

For the Petitioner: [REDACTED].
Petitioner

For the Respondent: Kimberly Bouchette
Clinical Appeals Coordinator
Sunshine State Health Plan, Inc.

STATEMENT OF ISSUE

The issue is whether Petitioner proved by a preponderance of the evidence that Respondent’s denial of an additional 20 hours per week of personal care services was incorrect.

PRELIMINARY STATEMENT

All parties and witnesses appeared telephonically. Petitioner and [REDACTED] appeared at the hearing and provided testimony on the Petitioner’s behalf.

Kimberly Bouchette, Clinical Appeals Coordinator for Sunshine State Health Plan, Inc. (“Sunshine”), appeared for the hearing and represented Respondent. Dr. John Carter (“Dr. Carter”), Long Term Care Medical Director for Sunshine, provided testimony on behalf of the Respondent. The following individuals also appeared on behalf of Respondent but did not provide testimony: Katlin Shine, Sunshine Care Coordinator, and Samantha Sutton, Sunshine Supervisor of Case Management.

Sandra Durden, Medical Healthcare Program Analyst for the Agency for Health Care Administration (“Agency” or “AHCA”), appeared for observational purposes.

Prior to the hearing, Petitioner sent a 14-page evidence packet to the Office of Fair Hearings that was admitted into evidence without objection, and is recorded in the OFH document management system as “23-FH0097 Faxed Evidence.pdf”.

Prior to the hearing, Respondent sent to the Office of Fair Hearings and Petitioner a 137-page evidence packet. The evidence packet has been recorded in the OFH document management system and designated as file “MFH Packet [REDACTED].pdf.” Without objection, the Respondent’s 137-page evidence packet was admitted into evidence as is identified as “Respondent’s Composite Exhibit 1”.

FINDINGS OF FACT

1. Petitioner is an enrolled member of Sunshine’s LTC plan. See Respondent’s Composite Exhibit 1, pages 2 and 92. Sunshine is a managed care organization contracted by AHCA to provide services to eligible Medicaid recipients in Florida.
2. As of the time of the hearing, Petitioner was a [REDACTED] who lives in a [REDACTED]
[REDACTED] See Respondent’s Composite Exhibit 1, page 13.

3. Petitioner has the following health conditions: [REDACTED]
[REDACTED]
[REDACTED]. See Respondent's Composite Exhibit 1, pages 65, and 69 through 71. The Petitioner has a diagnosis of [REDACTED]
[REDACTED]
[REDACTED]. Respondent's Composite Exhibit 1, page 65.

4. The Florida Department of Elder Affairs 701B Comprehensive Assessment ("701B"), dated January 9, 2023, (the "1/9/23 701B"), which is the most recent 701B on the record, reflects the following regarding Petitioner's Activities of Daily Living ("ADLs"). Petitioner needs no assistance with [REDACTED]. See Respondent's Composite Exhibit 1, page 67. Petitioner uses [REDACTED]. *Id.* Petitioner needs assistance (but not total help) with [REDACTED]. *Id.*

5. Regarding Petitioner's Instrumental Activities of Daily Living ("IADLs"), the 1/9/23 701B reflects that Petitioner needs some assistance (but not total help) with [REDACTED]
[REDACTED]
[REDACTED]. See Respondent's Composite Exhibit 1, page 68.

6. The Petitioner submitted a letter from Dr. Mustapha Benjouali ("Dr. Pardo"), dated February 15, 2023, requesting that the Petitioner receive 40 hours of home health services each week. Petitioner's Composite Exhibit 1, page 3.

7. Petitioner is currently authorized to receive the 30 hours per week of personal care services and 10 hours per week of homemaker services, for a total of 40 hours of home-based services. See Respondent's Composite Exhibit 1, page 5.

8. On October 26, 2022, Respondent issued a NABD denying an additional 20 hours per week of personal care services. See Respondent's Composite Exhibit 1, pages 4 – 12. The NABD stated the reason for Respondent's determination as follows:

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 following criteria for all extended state plan services used for the purposes of maintenance therapy and all other home and community-based services:

1. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs;
2. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available statewide; and
3. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider;

And one of the following:

1. Enable the enrollee to maintain or regain functional capacity; or
2. Enable an enrollee receiving long-term services and supports to have access to the benefits of community living, to achieve person-centered goals, and live and work in the setting of their choice.

...

The facts that we used to make our decision are: The request for an extra 20 hours per week of Personal Care Services is denied for lack of medical necessity. Based on the assessment, the member's currently approved services are adequate to meet the member's care needs. The member's present care plan includes 30 hours per week of Personal Care Services and 10 hours per week of Homemaker Services. This decision was made with Sunshine Health Policy LT.UM.09 Long Term Care Ancillary Service Criteria.

Respondent's Composite Exhibit 1, pages 4 – 5.

9. On December 14, 2023, the Petitioner requested an appeal of Respondent’s denials. See Respondent’s Composite Exhibit 1, pages 87-91. On December 22, 2022, Respondent sent Petitioner an NPAR, denying Petitioner’s plan appeal. *Id.* The NPAR stated as follows:

The reason for our decision was the request for an extra 20 hours per week of Personal Care Services is denied for lack of medical necessity. Based on the assessment, the member's currently approved services are adequate to meet the member's care needs. The member's present care plan includes 30 hours per week of Personal Care Services and 10 hours per week of Homemaker Services. This decision was made with Sunshine Health Policy LT.UM.09 Long Term Care Ancillary Service Criteria. This decision was made by a Medical Director who is Board Certified Physician in Internal Medicine.

Id.

10. Respondent relied upon the Humana Health Policy and Procedure LT.UM.09 to make its determination in this case, which states in pertinent part, as follows:

6. Homemaker Services

Homemaker provides assistance with essential shopping, light housework, laundry, and meal preparation. These services are provided to member’s who exhibit a functional deficit that impairs their ability to complete these tasks and lack an available support system. Services are provided to support member’s health, safety, and ensure basic standards are met. Services are provided by a trained homemaker when the individual regularly responsible for these services is temporarily absent or unable to manage these activities.

Approval Criteria

Homemaker Service reviews include four (4) criteria:

- a) Instrumental Activities of Daily Living (IADL) limitations
- b) Living situation
- c) Supervision needs
- d) Available supports

...

7. Personal Care Services

A service that provides assistance with eating, bathing, dressing and personal hygiene, and other activities of daily living. The service includes assistance with preparation of meals, but does not include the cost of meals. The service may also include housekeeping tasks such as bed making, dusting and vacuuming, which are incidental to the care furnished or are essential to the health and welfare of the member, rather than the member’s family. Personal care services include the

following:

- Assistance to the member to complete personal hygiene (bathing, grooming, mouth care, etc.)
- Assistance with bladder and bowel requirements that include assisting the member to and from the bathroom or with bedpan routines
- Assisting the member in following through with physician orders
The Personal Care provider cannot not administer any medications, but may bring medications to the member and remind the member to take the medicine at specific times
- Assisting with food, nutrition, and diet activities, including preparing meals, when required and other incidental services, (i.e. housekeeping chores) essential to the health and welfare of the member
- Performing household services (changing bed linen or arranging furniture), when such services are essential to the member's health and comfort.

...

Approval Criteria

Personal Care Services reviews include four (4) criteria:

- a) Activity of Daily Living (ADL) limitations
- b) Living situation
- c) Supervision needs
- d) Available Supports

...

8. Personal Emergency Response Systems (PERS)

The installation and service of an electronic device that enables members at high risk of institutionalization to secure help in an emergency. The PERS is connected to the member's phone and programmed to signal a response center once a "help" button is activated. The member may also wear a portable "help" button to allow for mobility. PERS services are limited to those members who live alone or who are alone for significant parts of the day, and have no regular caregiver for extended periods of time, and who would otherwise require extensive supervision. Members must be aware of the purpose of the button and aware to press it in the event of an emergency.

Respondent's Composite Exhibit 1, pages 112-136.

11. Petitioner requested a Fair Hearing due to the denial of an additional 20 hours per week of personal care services. The undersigned scheduled the Fair Hearing for March 17, 2023, at 10:00 a.m., and all parties were duly notified.

12. The Petitioner has [redacted] with whom [redacted], spoke on [redacted] behalf for much of the hearing. [redacted] is the Petitioner's principal caregiver who doesn't

work outside the home and expressed feelings of being overwhelmed. The Petitioner principally suffers from a [REDACTED] while [REDACTED] was on-duty as a police officer, and [REDACTED] testified that the Petitioner is experiencing an [REDACTED]. [REDACTED] also testified the Petitioner recently began [REDACTED], is having [REDACTED] and that although [REDACTED] is doing her best, caring for the Petitioner takes more than what [REDACTED] capable of.

13. Dr. Carter is the Long-Term Care Medical Director for Sunshine. He has experience in internal medicine, geriatric medicine, and hospice and palliative medicine. Respondent denied the requested services in this case because the currently approved services are adequate to meet the Petitioner's needs. Dr. Carter further testified that nothing he has reviewed or the testimony at the hearing demonstrated the approved services are inadequate to meet the Petitioner's needs.

CONCLUSIONS OF LAW

14. 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).

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

16. 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.

17. 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.).

18. The Florida Medicaid policy that applies to the requested services is the Florida Medicaid Statewide Medicaid Managed Care Long-term Care Program Coverage Policy (“March 2017”) (“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.

...

4.2.1 Home and Community-Based Supportive Services

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

...

4.2.1.9 Homemaker Services

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

...

4.2.1.14 Personal Emergency Response Systems

For installation and service monitoring of an electronic device connected to an enrollee’s phone that includes a portable “help” button, when provided to an enrollee at high risk of institutionalization to secure help in an emergency.

...

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.

...

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.

19. 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.

20. The Agency’s Florida Medicaid Personal Care Services Coverage Policy, November 2016 (“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.

21. In the instant case, Respondent denied an additional 20 hours per week of personal care services. See supra ¶ 8 and 9.

22. As established on the record by the evidence and testimony, Respondent denied Petitioner’s request after concluding the currently approved services are adequate to meet the Petitioner’s needs.

23. 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* ¶ 20.

24. The evidence presented in this case does not reflect that Petitioner needs an additional 20 hours per week of personal care services. Specifically, Petitioner lives with [REDACTED]. *See supra* ¶ 2. Regarding ADLs, Petitioner needs no assistance with [REDACTED]; [REDACTED]; and needs assistance (but not total help) with [REDACTED]. *See supra* ¶ 4. Regarding IADLs, Petitioner: needs some assistance (but not total help) with [REDACTED] and needs total assistance (cannot do at all) with [REDACTED]. *See supra* ¶ 5. Petitioner has multiple medical conditions, including [REDACTED]. *See supra* ¶ 3.

25. However, Petitioner has a diagnosis of [REDACTED] but is [REDACTED]. *See supra* ¶ 3. The Petitioner’s primary caregiver does not work outside the home. *See supra* ¶ 12.

26. Section 1.3.14 of the SMMC LTC Policy mandates 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* ¶ 18. Here, Petitioner is currently authorized to receive 30 hours per week of personal care services and 10 hours per week of homemaker services. *See supra* ¶ 8.

27. Petitioner’s currently authorized 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 ¶ 20. Although the PC Policy provides guidance for general allowances for ADLs, *supra* ¶ 20, Petitioner provided no time estimates for each ADL to explain the amount of time Petitioner requires for [redacted] ADLs. Further, Petitioner did not explain how the requested additional hours personal care services, will be utilized to meet Petitioner’s needs if approved in this matter. Petitioner’s currently authorized homemaker services are “[t]he provision of general household activities (such as meal preparation) and routine household care (including laundry and pest control) by a trained homemaker.” See supra ¶ 18. Given the fact that Petitioner already has personal care services to assist with [redacted] ADLs and homemaker services to assist with [redacted] IADLs, Petitioner has not established that [redacted] currently authorized services are insufficient to meet [redacted] needs.

28. Considering the totality of Petitioner’s circumstances, including [redacted] medical condition and diagnoses, level of need for ADLs and IADLs, and the amount of currently approved services, Petitioner failed to prove by a preponderance of the evidence that an additional 20 hours per week of personal care services are not “in excess of [Petitioner’s] needs.” See supra ¶ 18 and 19.

29. The letter from Dr. Benjouali, that the Petitioner receive 40 hours of home health services each week. See supra ¶ 3. However, section 2.83 of the Definitions Policy mandates that “[t]he 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.” See supra ¶ 19. Therefore, the letter from Dr. Benjouali does not, *in itself*, make the requested additional services medically necessary. However, at this time, the Petitioner already receives 40 hours of home based services. See supra ¶ 7.


30. In light of the testimony and evidence, the SMMC LTC Policy, the PC Policy, and the Definitions Policy, the undersigned Hearing Officer finds that Petitioner failed to meet [redacted] burden of proving that an additional 20 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 an additional 20 hours per week of personal care service is **AFFIRMED**.

Petitioner’s appeal based on Respondent’s denial in this matter is **DENIED**.

DONE AND ORDERED this 13th day of April, 2023, in Tallahassee, Leon County, Florida.

Alan J. Leifer
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Alan J. Leifer, Hearing Officer
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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:

[REDACTED]
[REDACTED]
[REDACTED]

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