



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

FILED

Apr 05, 2023, 10:10 am
OFFICE OF FAIR HEARINGS

[Redacted]

PETITIONER,

AHCA Case No.: 23-FH0120

Plan ID No.: [Redacted]

vs.

HUMANA MEDICAL PLAN, INC.,

RESPONDENT.

_____ /

[Redacted],

PETITIONER,

AHCA Case No.: 23-FH0134

Plan ID No.: [Redacted]

vs.

HUMANA MEDICAL 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 February 27, 2023, and March 13, 2023, at 10:00 a.m. Eastern Standard Time (“EST”).

APPEARANCES

For the Petitioner:

[Redacted]

Petitioner’s Authorized Representative

For the Respondent:

Michael Moens
Fair Hearing Specialist
Humana Medical Plan, Inc.

STATEMENT OF ISSUE

The first issue is whether Petitioner proved by a preponderance of the evidence that Respondent's denial of Petitioner's request for personal care services was incorrect.

The second issue is whether Petitioner proved by a preponderance of the evidence that Respondent's denial of Petitioner's request for homemaker services was incorrect.

PRELIMINARY STATEMENT

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

Michael Moens, Fair Hearing Specialist for Humana Medical Plan, Inc. ("Humana"), appeared at the hearing and represented Respondent. Dr. Wayne Sherman ("Dr. Sherman"), Long Term Care Medical Director for Humana, provided testimony on behalf of the Respondent.

Sandra Durden, Medical/Health Care Program Analyst and Fair Hearing Liaison for the Agency for Health Care Administration ("Agency" or "AHCA"), appeared for observational purposes.

Prior to the February 27, 2023, Fair hearing, the Respondent timely sent to the Office of Fair Hearings and Petitioner a 277-page evidence packet. The Petitioner objected to the Respondent's evidence package, arguing the documents do not reflect the current status of [REDACTED]. The Respondent's 277-page package was admitted into evidence over the Petitioner's objection, and is identified as "Respondent's Composite Exhibit 1, recorded in the OFH document management system as "Evidence Packet 23-FH0120 & 23-FH0134 2_Part 1.pdf"; "Evidence

Packet 23-FH0120 & 23-FH0134 2_Part 2. pdf”; and “Evidence Packet 23-FH0120 & 23-FH0134 2_Part 3.pdf”.

After convening proceedings on February 27, 2023, the Petitioner stated [REDACTED] wanted to submit documents into evidence and believed [REDACTED] could do that after the conclusion of the Fair hearing. In the interest of fairness and without objection, the Petitioner was provided the opportunity to submit evidence, a continuance was granted without objection, and pursuant to a March 2, 2023, rescheduling Order, the Fair hearing in this matter resumed on March 13, 2023. The Petitioner timely submitted a 14-page fax containing several letters and medical records from Hospice that were admitted into evidence without objection, and is recorded in the OFH document management system as “23-FH0120 Faxed Evidence.pdf.”

FINDINGS OF FACT

1. Petitioner is an enrolled member of Humana’s LTC health plan. See Respondent’s Composite Exhibit 1, page 1. Humana is a managed care organization contracted by AHCA to provide services to eligible Medicaid recipients in Florida.
2. At the time of the hearing, Petitioner is a [REDACTED] who lives in a [REDACTED] [REDACTED]. See Respondent’s Composite Exhibit 1, page 46.
3. Petitioner has the following health conditions: [REDACTED] [REDACTED] [REDACTED]. See Respondent’s Composite Exhibit 1, pages 35. In addition to receiving Medicaid benefits, the Petitioner is also receiving hospice care from Viera-Wuesthoff Health System Brevard Hospice and Palliative Care. See Petitioner’s Composite Exhibit 1, page 3.

4. The Florida Department of Elder Affairs 701B Comprehensive Assessment (“701B”), dated August 16, 2022 (the “8/16/22 701B”), which is the most recent 701B on the record, reflects the following regarding Petitioner’s Activities of Daily Living (“ADLs”). Petitioner needs some assistance (but not total help) with [REDACTED]. See Respondent’s Composite Exhibit 1, page 50. Petitioner uses [REDACTED] for [REDACTED]. *Id.* The Petitioner’s primary caregiver and the Designated Authorized Representative in this matter states [REDACTED] health continues to decline and since the review documented in the 8/16/23 701B, and [REDACTED] requires a greater degree of assistance for the ADLs.

5. Regarding Petitioner’s Instrumental Activities of Daily Living (“IADLs”), the 8/16/22 701B reflects that Petitioner needs some assistance (but not total help) with [REDACTED]. Respondent’s Composite Exhibit 1, page 51. Petitioner uses [REDACTED]. *Id.* Petitioner needs total assistance (cannot do at all) with [REDACTED]. *Id.* The Petitioner’s primary caregiver and [REDACTED] states that [REDACTED] needs total assistance with all the IADLS. *Id.*

6. Petitioner is currently authorized to receive 25 hours per week of personal care home services, and 10 hours per week of homemaker services. See Respondent’s Composite Exhibit 1, page 33 - 37.

7. On September 1, 2022, Respondent issued a NABD in Case Number 23-FH0120 denying an additional 5 hours per week of personal care services. See Respondent’s Composite Exhibit 1, pages 3 – 10. Also on September 1, 2022, the Respondent issued a NABD in Case Number 23-

FH0134 denying an additional 1 hour per week of homemaker services. See Respondent's Composite Exhibit 11-18. Both NABDs stated the reason for Respondent's determinations 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 support to have access to the benefits of community living, to achieve person-centered goals, and live and work in the setting of their choice.

...

You currently have 10 hours of homemaker service each week; 25 hours of personal care service each week. You have requested an additional 1 hour of homemaker service each week; an additional 5 hours of personal care service each week. You have [REDACTED]. You do not have [REDACTED]. You sometimes have [REDACTED]. You do not [REDACTED]. You have not had [REDACTED]. You have not recently [REDACTED]. You live with [REDACTED]. Your [REDACTED]. Your [REDACTED]. They are [REDACTED]. You use a [REDACTED]. You need [REDACTED]. You need some help [REDACTED]. You need help with [REDACTED];

[REDACTED]. You sometimes [REDACTED]
[REDACTED] Your request for an additional 1 hours of homemaker service each week and an additional 5 hours of personal care service each week is being denied as not medically necessary. The hours you are receiving should be enough to meet your needs and can be divided into shifts to better meet your needs.

Respondent's Composite Exhibit 1, pages 3-10 and 11-18.

8. Petitioner requested an appeal of Respondent's denials and on January 17, 2023, Respondent sent Petitioner an NPAR in Case Numbers 23-FH0120 and 23-FH0134 denying Petitioner's plan appeal. See Respondent's Composite Exhibit 1, pages 26-28 and 29-31. The NPARs both stated as follows:

The reason for the decision was based on the information received. You are appealing the denial of [Petitioner's] request for an additional 1 hour of homemaker service each week and an additional 5 hours of personal care service each week. [REDACTED] currently receives 10 hours of homemaker service each week and 25 hours of personal care service each week. We have reviewed the documents and reassessed [REDACTED] needs. [REDACTED] was approved for some additional hours in June 2022. [REDACTED] did not have a change in [REDACTED] medical condition, recent hospitalization, ER visit, or rehab stay since [REDACTED] last request. The current 35 hours of home services should be sufficient to meet [REDACTED] needs and can be re-distributed to provide hours on Saturdays. We are therefore upholding the decision of the medical director and denying your appeal.

Id.

9. Respondent relied upon the definition of "medical necessity" and the application of Humana's review criteria and guidelines defined in Chapter 59G-1.010 (2.83) Florida Administrative Code. *Id.* at 26 and 29.

10. Petitioner requested a Fair Hearing due to the denial of an additional 5 hours per week of personal care services and the 1 additional hour per week of homemaker services. Pursuant to a March 2, 2023, Order Rescheduling Hearing, all parties were duly notified and the Fair hearing in this matter was held on March 13, 2023, at 10:00 a.m. EST.

11. During the Fair Hearing, [REDACTED] testified and the Respondent confirmed that Petitioner has personal care and homemaker assistance for 5 hours on Sunday, 6 hours per day on Monday through Friday, and 0 hours on Saturday. See also Respondent's Composite Exhibit 1, page 87. [REDACTED] testified the individual who provides assistance on Sundays through Fridays requires a day off each week, leaving no coverage on Sunday, which is why the Petitioner requested the additional 5 hours of personal care and additional 1 hour of homemaker serves per week. [REDACTED] further testified that [REDACTED] was unwilling to reduce the hours on Monday through Friday and redistribute those hours to Saturday so Petitioner would have assistance for every day of the week. Lastly, [REDACTED] testified [REDACTED] does not work outside the home.

12. In addition to the personal care and homemaker services provided by Medicaid, the Petitioner also receives home health assistance from Viera-Wuesthoff Health System Brevard Hospice and Palliative Care on Mondays and Tuesdays, plus hospice has provided medical equipment, including a [REDACTED]. See Petitioner's Composite Exhibit 1, page 6. The Petitioner testified she was told by hospice that any additional personal care and homemaker hours were the responsibility of Humana.

CONCLUSIONS OF LAW

13. 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).

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

15. 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.

16. 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.).

17. 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.

18. 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.

19. 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.

20. In the instant case, Respondent denied an additional 5 hours per week of personal care services and an additional 1 hour per week of homemaker services. *See supra* ¶ 6.

21. 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* ¶ 7.

22. 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* ¶ 19.

23. The evidence presented in this case does not reflect that Petitioner needs an additional 5 hours per week of personal care services and 1 hour per week of homemaker services. Specifically, Petitioner resides with [REDACTED] caregiver. *See supra* ¶ 2. Regarding ADLs, Petitioner needs some assistance (but not total help) with [REDACTED], while requiring supervision 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.

24. Petitioner's caregiver does not work outside the home. *See supra* ¶ 11. Although [REDACTED] noted that [REDACTED] has no personal care or homemaker services on Saturday, [REDACTED] refuses to deduct from aides hours during the week and spread them out so [REDACTED] has assistance on Saturday. *Id.*

25. 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 ¶ 17. Here, Petitioner is currently authorized to receive 25 hours per week of personal care services and 5 hours per week of homemaker services. See supra ¶ 6.

26. 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 ¶ 19. Although the PC Policy provides guidance for general allowances for ADLs, *supra* ¶ 19, Petitioner provided no time estimates for each ADL to explain the amount of time Petitioner requires for [REDACTED] ADLs or accounts for the 2 times per week that hospice provides assistance. Further, Petitioner neglected to 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 ¶ 17. Given the fact that Petitioner already has personal care services to assist with her ADLs and homemaker services to assist with her IADLs, Petitioner has not established that her currently authorized services are insufficient to meet her needs.

27. 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 5 hours per week of personal care services and 1 additional hour of homemaker services are not “in excess

of [Petitioner's] needs." See supra ¶ 18 and 19.


28. 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 her burden of proving that an additional 5 hours per week of personal care services and 1 additional hour of homemaker 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 5 hours per week of personal care service and 1 additional hour of homemaker services is **AFFIRMED**.

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

DONE AND ORDERED this 5th day of April, 2023, in Tallahassee, Leon County, Florida.

 Alan J. Leifer
23-FH0120 & 23-FH0134
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ALAN J. LEIFER, 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:

[REDACTED]
[REDACTED]
[REDACTED]

**Humana Medical Plan, Inc.
GAMedicaidRightFax@humana.com**

**AHCA Medicaid Hearing Unit
MedicaidHearingUnit@ahca.myflorida.com**