



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

**FILED**

Apr 25, 2023, 12:01 pm

OFFICE OF FAIR HEARINGS

[REDACTED]  
  
PETITIONER,

AHCA Case No.: 23-FH0153

Plan ID No.: [REDACTED]

vs.

SUNSHINE STATE HEALTH PLAN, INC.,

RESPONDENT.  
  
\_\_\_\_\_ /

**FINAL ORDER**

Pursuant to notice, the undersigned Hearing Officer convened a telephonic Fair Hearing in the instant case on March 23, 2023, at 1:03 p.m. Eastern Standard Time (“EST”).

**APPEARANCES**

For the Petitioner:

[REDACTED]  
Authorized Representative

For the Respondent:

Christian Pacheco  
Senior Director of Quality Improvement  
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 Personal Care services was incorrect.

**PRELIMINARY STATEMENT**

All parties appeared for the scheduled Fair Hearing telephonically. Petitioner appeared for the Fair Hearing to provide testimony and did not call any witnesses.

Christian Pacheco, the Senior Director of Quality Improvement for Sunshine State Health Plan, Inc. (“Sunshine Health”), appeared for the Fair Hearing as representative for Respondent. The following persons appeared for the Fair Hearing as a witness for Respondent: Dr. John Carter (“Dr. Carter”), a Long-term Care (“LTC”) Medical Director for Sunshine Health; Ashara Howard, a Care Coordinator II for Sunshine Health; Giselle Rodriguez, a Care Coordinator for Sunshine Health; Katelyn Schein, a Care Coordinator II for Sunshine Health; Dr. Francis Chaar, a Medical Director for Sunshine Health; Dr. Olga Rafaelina, a Medical Director for Sunshine; and Dr. Julie Shamma, a Medical Director for Sunshine Health.

Sandra Durden, a Medical Health Care Program Analyst for the Agency for Health Care Administration (“Agency” or “AHCA”), appeared for the Fair Hearing as an observer.

Interpreter Marianna (interpreter number 01065), a Spanish Interpreter, appeared for the Fair Hearing to provide language translation services on behalf of Petitioner.

Petitioner did not introduce any exhibits at the Fair Hearing. Prior to the Fair Hearing, Respondent sent to the Office of Fair Hearings (“Office”) and Petitioner a 142-page evidence packet, which was admitted into evidence as Respondent’s Composite Exhibit 1. Respondent’s Composite Exhibit 1 includes the following documents: a Medicaid Fair Hearing Table of Contents; a Medicaid Fair Hearing Summary; a Notice of Adverse Benefit Determination (“NABD”) (dated October 31, 2022); a LTC Person Centered Care Plan (“Plan of Care”) (dated and signed on September 29, 2022); a LTC Plan of Care (dated and signed on February 2, 2023); a Florida Department of Elder Affairs 701B Comprehensive Assessment (“701-B Comprehensive Assessment”) (dated September 20, 2022); a 701-B Comprehensive Assessment (dated February 2, 2023); a Standard Appeal Acknowledgment (dated November 2, 2022); a Notice of Plan Appeal

Resolution (“NPAR”) (dated November 7, 2022); Sunshine Health’s Initial Review Summary; Sunshine Health’s Appeal Review Summary; Sunshine Health Policy and Procedure: LTC (Long Term Care) Ancillary Service Criteria (FL.LT.UM.09.00) (Effective: May 1, 2014) (“LTC Ancillary Service Criteria”); and Rule 59G-1.010, Florida Administrative Code.

**FINDINGS OF FACT**

1. Petitioner is an enrolled member of Sunshine Health. *See* Respondent’s Composite Exhibit 1, pages 1-2, 13, 32, 94-116. Sunshine Health is a managed care organization contracted by the Agency to provide services to eligible Medicaid recipients in the state of Florida. Petitioner is also an enrolled member of Medicare. *Id.* at 42.

2. As of the date of the Fair Hearing, Petitioner is [REDACTED]. *Id.* at 69. Petitioner resides in [REDACTED] *Id.* at 70. Petitioner has [REDACTED]. *Id.* at 72. Petitioner uses [REDACTED]. *Id.* at 72. Petitioner currently experiences the following health conditions: [REDACTED]

[REDACTED] *Id.* at 75-76. Petitioner is also diagnosed with [REDACTED] *Id.* at 77. Petitioner does not [REDACTED]. *Id.* at 80. Petitioner is prescribed medication to be taken daily. *Id.* at 81. Petitioner does not have a primary caregiver. *Id.* at 83-85. According to Dr. Carter at the Fair Hearing, Petitioner is also diagnosed with [REDACTED]

3. With respect to Activities of Daily Living (“ADLs”), Petitioner needs assistance (but not total help) with [REDACTED]. *Id.* at 73. Petitioner needs no assistance with [REDACTED]. *Id.* With respect to Instrumental Activities of Daily

Living (“IADLs”), Petitioner needs total assistance (cannot do at all) with [REDACTED].  
[REDACTED]. *Id.* at 74. Petitioner needs assistance  
(but not total help) with [REDACTED]. *Id.* Petitioner needs no assistance with [REDACTED].  
[REDACTED]. *Id.* Petitioner uses an [REDACTED]. *Id.*

4. On October 31, 2022, Sunshine Health issued a NABD denying Petitioner’s request for an additional 7 hours per week of Personal Care services based on medical necessity. *Id.* at 4-12. The NABD explained the basis of the reduction of services as follows, in pertinent part:

Sunshine Health has reviewed your request for an extra 7 hours per week of Personal Care Services (the person who helps bathe and dress you), which we received on 10/27/2022. After our review, this service has been: DENIED as of 10/31/2022.

We made our decision because:  
(Check all boxes that apply)

- We determined that your requested services are **not medically necessary** because the services do not meet the reason(s) checked below: (*See Rule*)
- Meet all of the criteria as defined in Rule 59G-1.010(166), F.A.C., for all nursing facility services and mixed services; OR
- 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 requested **service is not a covered benefit.**

**Other authority**

The facts that we used to make our decision are: The request for an extra 7 hours/week of Personal Care Services is denied as not medically needed. 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:**

- **14 hours/week of Personal Care Services from 09/22/2022 to 11/03/2022, then resuming**
- **7 hours/week of Personal Care Services**
- **8 hours/week of Homemaker Services**
- **7 meals/week of Home Delivered Meals**

This decision was made with Sunshine Health Policy LT.UM.09 Long Term Care Ancillary Service Criteria.

...

Sincerely,

John M. Carter, MD ["Dr. Carter"]

Medical Director

Respondent's Composite Exhibit 1, pages 4-12. (Emphasis added).

5. On November 1, 2022, Petitioner requested a plan appeal. *Id.* at 87-88. On November 7, 2022, Sunshine Health issued an NPAR *upholding* the denial of additional Personal Care services. *Id.* at 87-90. The NPAR states the following, in pertinent part:

On 11/01/2022 we received your timely plan appeal request about Sunshine Health's Notice of Adverse Benefit Determination dated 10/31/2022, Notice of Adverse Benefit Determination Number OPz30003146, denying the extra 7 hours per week of Personal Care Services provided to [Petitioner].

On 11/04/2022, after consideration of the information you provided to Sunshine Health in support of your plan appeal, **Sunshine Health hereby denies your plan appeal. As a result, [Petitioner] will not receive the extra 7 hours per week of Personal Care Services, effective 11/04/2022.**

The reason for our decision was the reconsideration request for an extra 7 hours/week of Personal Care Services is denied and the original denial is UPHELD.

**Based on the assessment** the members currently approved services are adequate to meet the members care needs. The member's present care plan includes: 14 hours/week of Personal Care Services from 09/22/2022 to 11/03/2022, then resuming 7 hours/week of Personal Care Services 8 hours/week of Homemaker Services 7 meals/week of Home Delivered Meals. 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 a Board Certified Physician in Family Medicine.

...

Thank you,  
Dr. Emile Barreau ["Dr. Barreau"]  
Corporate Medical Director

Respondent's Composite Exhibit 1, pages 87-90. (Emphasis added).

6. As of the date of the Fair Hearing, Petitioner is authorized to receive the following Florida Medicaid LTC services: 35 hours per week of Personal Care services, 5 hours per week of Homemaker services, 7 Home Delivered Meals per week, a monthly subscription of Personal Emergency Response System services, and monthly [REDACTED]. *Id.* at 35-36, 40. Petitioner receives [REDACTED]. *Id.* at 70. Petitioner's primary caregiver is Petitioner. *Id.* at 32. Petitioner also works full-time outside of the home. *Id.* at 32. Petitioner's current Florida Medicaid LTC services are rendered as follows: "Monday-Friday 7am -9am, 5pm-8pm and Saturday/Sunday -8am-1pm." *Id.* at 30.

7. On January 25, 2023, Petitioner requested a Fair Hearing regarding the denial of Personal Care services. On March 3, 2023, the undersigned Hearing Officer issued a notice, to all parties of record, consolidating both cases and scheduling the Fair Hearing to be convened by telephone on March 23, 2023, at 1:00 p.m. EST.

8. According to Petitioner's testimony presented at the Fair Hearing, Petitioner had several [REDACTED], over the past year resulting in [REDACTED]

[REDACTED]. Petitioner is requesting more assistance with ADLs and IADLs. Petitioner's [REDACTED] and Petitioner does not have any nearby natural support.

9. According to Dr. Carter's testimony presented at the Fair Hearing, Dr. Carter reviewed the Plan of Care and the 701-B Comprehensive Assessment in making his medical necessity determination. Dr. Carter opines that the current approved LTC services are sufficient to meet Petitioner's needs for assistance with ADLs and IADLs. Petitioner's natural support is also a consideration in medical necessity determination. Sunshine Health will consider any new medical records submitted under a new request for services. Because Petitioner only requires some assistance with their ADLs and IADLs, and not total assistance Sunshine Health's position is that the requested services are more than the member needs currently.

10. In making their medical necessity determinations, Dr. Barreau and Dr. Carter relied upon Sunshine Health's policy and procedure: LTC Ancillary Service Criteria. *Id.* at 4-12, 90-93. The internal criteria that Sunshine Health used to make its decision appears in the LTC Ancillary Service Criteria, which provides as follows, in pertinent part:

**C. Criteria for Type of Service:**

Criteria for each of the benefits noted in the Policy section will be used when reviewing the medical necessity of any ancillary services. In addition, the Medical Necessity Review policy FL.UM.02.01 is considered when determining medical necessity of ancillary services. The Florida Coverage Policies and Limitations Handbooks are used to determine benefits, any benefit limitations, and additional criteria.

The ancillary services of this policy are intended to augment and support the existing informal care and community services being provided to allow the member to remain safely in their home.

**1. Determinants for Services**

When considering the level of support the member requires and which of the ancillary services may support the member's cognitive, functional, environmental, and social needs, several elements are to be considered. The review for the medical necessity of the ancillary services includes consideration of the member's support needed due to ADL deficits, living situation, and supervision needs.

a) Activities of Daily Living (ADL's)/Instrumental Activities of Daily Living (IADL's)

- Independent where member is able to provide the task without support, with or without assistive devices
- Minimal functional impairment where the ADL's require one of the following:
  - Supervision
  - At least minimum assistance
  - Member ambulates with assistance of a person or a device
  - Member transfers require at least minimum assistance
- Moderate functional impairment where two of the follow apply
  - Member has ADLs requiring at least minimal assistance
  - Member ambulates with assistance of a person or device
  - Member transfers require at least minimum assistance
- Maximum and persistent functional impairment without available caregiver support where all of the following exist:
  - Member has ADLs requiring total assistance
  - Member is non-ambulatory
  - Member transfers require one (1) to two (2) person assist
  - Member's treating physician has certified that member meets Maximum functional impairment.

b) Living situation consideration

- Lives alone.
- Lives with family (with consideration of the number of days and hours that family members are not available to assist the member).
- Lives with non-family (with consideration of the number of days and hours that non- family members are not available to assist the member).

c) Supervision needs, including:

- Wandering risk: Member has already been found to leave their home unsafely and/or is unable to find their way back.
- Confused/disoriented and at risk to themselves: Member is confused and/or disoriented to the point that they are unable to perform functional activities, and if they do are at risk of harm to themselves.
- Member has a cognitive impairment that prevents them from knowing when or how to carry out personal care tasks and caregivers are not able to provide the services. The member is incapable of learning despite

efforts to train in the care tasks. The member has memory deficits, which prevent them from managing care tasks.

- Member is unable to call for help, even with a personal emergency response unit. Member's medical status will not permit the member to all for help, even with assistance of a personal emergency response unit.

d) Available Supports

- No assistance needed or Always has assistance
- Has assistance most of the time
- Rarely has assistance
- Never has assistance

e) Services in Place

- Provided by Sunshine Health
- Provided by other Provider insurance

The criteria for each ancillary service is described below:

...

**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:

- a. Assistance to the member to complete personal hygiene (bathing, grooming, mouth care, etc.)
- b. Assistance with bladder and bowel requirements that include assisting the member to and from the bathroom or with bedpan routines
- c. 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
- d. 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
- e. Performing household services (changing bed linen or arranging furniture), when such services are essential to the member's health and comfort.

Personal Care workers must be supervised by a registered nurse, licensed to practice nursing in Florida and who conducts a supervisory home visit every 60

days to observe the personal care worker. The services may be provided in the member's home or other location.

### 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

See Section C.1 for more details

Covered Personal Care services may include:

- a) Bathing - Assistance with bathing, including washing, rinsing, and drying the body or body parts.
  - Member's ability to transfer in and out of the tub or shower
  - Amount of time it takes the member to transfer in and out of the tub or shower
  - Ability of member to prepare the shower or run the bath water
  - Ability of member to use any assistive devices, such as a grab-bar or shower chair
  - Ability of member to use a sponge or wash cloth to clean himself/herself
  - How many times per week does the member bathe, consider that:
    - Incontinence episodes resulting in the need for a bath
    - Daily bathing of the elderly is not recommended due to damage that occurs to the skin from the water and the soap
    - Bathing more than once per day is a personal preference and not a necessity.
  - Full bath (bathtub, shower, or bed bath) or partial sponge bath (washing of face, underarms, and private areas).
  - A bed bath for members who are bed bound and cannot get out of the bed to be bathed in a shower or tub
- b) Dressing and Grooming – Dressing assistance includes the laying out, taking off, putting on, and fastening of clothing and footwear, and includes:
  - Member's ability to choose their own clothes, put them on, and put on socks and shoes
  - Ability to put clothes, socks and shoes on if someone lays out the clothes
  - Ability to button, zipper, tie, or buckle clothes or shoes
  - Ability to successfully use assistive devices in dressing, such as reachers, sock pullers, or shoehorns
  - Ability to dress self in the morning or evening to get ready for bed

Grooming includes assessment of member's ability to:

- Comb or brush hair
- Shave
- Complete oral hygiene, including brushing teeth, remove dentures/partial, clean dentures/partial, and replace dentures/partial
- Trim and clean fingernails and toenails

c) Eating and Feeding Considerations – Eating/Feeding is the process of a member getting oral nourishment from a receptacle (dish, plate, cup, glass, bottle, etc.) into their body after it is cooked or prepared for eating. (This does not include tube feeding as that is considered a skilled task.) Includes an assessment of the member's ability to:

- Cut foods into appropriate size pieces
- Move food or drink from the serving receptacle to their mouth

Support for eating considers the number of meals per day that the member eats.

Note: Assistance with the preparation of meals is considered as part of Meal Preparation

d) Toileting Considerations

- Taking off and putting on of clothing and/or diapers,
- Post-toilet hygiene
- Use of equipment, such as a urinal or bedpan
- Emptying of urinal or bedpan
- Cleaning of a catheter or ostomy bag
- Reminders or a toileting schedule

e) Transferring Considerations – Transferring is the member's ability to move horizontally and/or vertically between the bed, chair, wheelchair, commode, etc. It includes an assessment of the member's:

- Ability to use any mechanical devices such as a walker, cane, handrails, or wheelchair to assist with transfers
- Ability to safely transfer without the assistance of another person
- Ability to physically participate in the transfer by pivoting, holding on, or bracing themselves to assist the caregiver

f) Mobility Considerations – Mobility is the extent of the member's purposeful movement within their residence. It includes an assessment of the member's:

- Ability to purposely move about his/her residence independently with or without the use of assistive devices, this includes the ability of a member to move around in a wheelchair
- Movements being unsafe without the assistance of another person in ambulating
- Muscle weakness, unstable gait or unstable balance

Respondent's Composite Exhibit 1, page 117-141. (Emphasis added).

### **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) of the Florida Statutes ("Fla. Stat.") (2022). This order is the final administrative decision of AHCA under Fla. Stat. § 409.285(2)(a).

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

13. Because Petitioner requested new services, Fla. Admin. Code R. 59G-1.100(17)(g) assigns the burden of proof to 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.).

14. Petitioner's request for Florida Medicaid LTC services is governed by the Florida Medicaid Statewide Medicaid Managed Care Long-term Care Program Coverage Policy (March 2017) ("LTC Policy"), which is incorporated by reference in Fla. Admin. Code R. 59G-4.192. The Florida Medicaid LTC Policy provides the following, in pertinent part:

#### **1.0 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.

### **1.3.16 Natural Supports**

Unpaid supports that are provided voluntarily to the individual in lieu of home and community-based services and supports.

...

## **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 restrictive setting

#### **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.

...

#### **4.2.2 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.

15. The Florida Medicaid Definitions Policy (August 2017), incorporated by reference in Fla. Admin. Code R. 59G-1.010, provides definitions of commonly used terms that are applicable to all sections of Rule Division 59G, Florida Administrative Code (F.A.C.), unless specifically stated otherwise in a service-specific coverage policy or rule. The Florida Medicaid Definitions Policy defines “Medically Necessary” or “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 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.**

(Emphasis added).

19. Based on the NABD, and the NPAR, Respondent denied Petitioner's request for 7 hours per week of Personal Care services after a review of Petitioner's Plan of Care and 701-B Comprehensive Assessment. See supra ¶ 4-5. Respondent determined that the request was not medically necessary because it was in excess of Petitioner's needs. See supra ¶ 4-5, 8. Specifically, Respondent determined the Petitioner's currently approved Florida Medicaid LTC services and natural support are sufficient to meet Petitioner's needs. See supra ¶ 4-5, 9. The LTC Ancillary Service Criteria for Personal Care services weighs the following four (4) criteria: (a) IADLs; (b) Living Situation; (c) Supervision needs; and (d) Available supports. See supra ¶ 10. The undersigned Hearing Officer considered the elicited testimony and submitted documentation with respect to Sunshine Health's internal criteria, and the criteria for medical necessity with respect to Personal Care services.

20. The Florida Medicaid program covers Personal Care services that are determined to be medically necessary. See supra ¶ 13. Services such as Personal Care services must meet the medical necessity criteria set forth by section 2.83 of the Florida Medicaid Definitions Policy. See supra ¶ 14. A Medicaid recipient's natural supports are a consideration to determine the recipient's needs. See supra ¶ 14. To be medically necessary, the quantity of services at issue (e.g., 7 hours per week) must not be in excess of the recipient's needs. Thus, to justify a need for Personal Care services, Petitioner must prove they have an unmet need of 7 hours per week for "assistance with ADLs and IADLs." The entire 7 hours per week of Personal Care services must not be in excess of the recipient's needs or the request for additional Personal Care is not medically necessary. See supra ¶ 14.

21. With respect to the Sunshine Health LTC Ancillary Service Criteria, *supra* ¶ 9, the record indicates that the Petitioner needs assistance (but not total help) with most ADLs. *See supra* ¶ 3. Petitioner lives in the community alone with no natural support. *See supra* ¶ 2, 7. It is unclear from the Petitioner's testimony and the 701B Comprehensive Assessment whether the Petitioner requires supervision. *See supra* ¶ 2, 7. Petitioner is also authorized to receive 7 hours per week of Personal Care services, 8 hours per week of Homemaker services, and 7 Home Delivered Meals per week. *See supra* ¶ 4. Petitioner did not disagree with Respondent's 701B Comprehensive Assessment. *See supra* ¶ 7. Based on this information, Dr. Carter opined that Petitioner does not warrant an increase in Personal Care services. *See supra* ¶ 8. The record would support a finding that Petitioner may be in need of more assistance with ADLs and IADLs. The question then becomes whether the Petitioner has should that 7 hours per week are medically necessary. Here, Petitioner provided no insight as to how [redacted] calculated [redacted] need for an additional 7 hours per week. With respect to the remaining ADLs and IADLs, Petitioner provided no testimony as to [redacted] additional need for assistance in performing these tasks. Although it is understandable that Petitioner is recovering from [redacted], there is insufficient evidence to conclude that there is an unmet need of 7 hours per week of assistance helping the Petitioner walk throughout the home. It appears that Petitioner requested the correct type of Florida Medicaid LTC service for its intended purpose, but did not prove beyond a preponderance of the evidence that the quantity of services is medically necessary. The undersigned Hearing Officer cannot assume that Petitioner has an unmet need for assistance with all ADLs and IADLs, and make estimates as to how much time the additional assistance will take. This is the Petitioner's

burden to meet. Without this information, the undersigned Hearing Officer applied significant weight to the professional assessment of Respondent's medical directors.


22. Upon review of the documentary evidence and testimony elicited, the undersigned Hearing Officer finds that Petitioner *does not* meet Respondent's LTC Ancillary Service Criteria for an additional 7 hours of Personal Care services, and the Florida Medicaid program's LTC Policy for Personal Care services based on medical necessity. Petitioner failed to establish that the additional quantity of Personal Care services at issue are "individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment," and *are not* "in excess of the patient's needs." See supra ¶ 15. As a result of not meeting their burden of proof, Respondent's medical necessity determination was correct in this case.

23. Accordingly, upon consideration of the evidence into the record, the sworn testimony of all witnesses presented at the scheduled Fair Hearing, and the aforementioned applicable laws and Florida Medicaid policies, the undersigned Hearing Officer concludes that Petitioner has *not* shown that the additional 7 hours per week of Personal Care services are not in excess of Petitioner's needs. Petitioner has *not* proven by a preponderance of the evidence that Respondent's denial of Personal Care services was incorrect.

**IT IS THEREFORE ORDERED AND ADJUDGED:**

Respondent's denial of Personal Care services is hereby **AFFIRMED**. Petitioner's appeal based on Respondent's denial of Personal Care services is hereby **DENIED**.

**DONE and ORDERED** this 25th day of April, 2023, in Tallahassee, Leon County, Florida.

Joseph Mabry  
 23-FH0153  
2023.04.25  
10:43:38 -04'00'

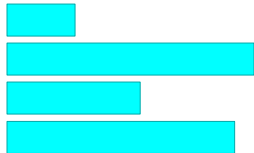
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**JOSEPH MABRY, Hearing Officer**  
**Agency for Health Care Administration**  
**Office of Fair Hearings**  
**2727 Mahan Drive, Mail Stop # 11**  
**Tallahassee, FL 32308-5407**  
**Office: (850) 412-3649**  
**Fax: (850) 487-1423**  
**Email: OfficeOfFairHearings@ahca.myflorida.com**

**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:**



**Sunshine State Health Plan, Inc.**  
**SunshineHealth\_MFH@centene.com**

**AHCA Medicaid Hearing Unit**  
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