

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



FILED

Jun 08, 2023, 11:22 am

OFFICE OF FAIR HEARINGS

[REDACTED],

PETITIONER,

AHCA Case No.: 23-FH0168

Plan ID No.: [REDACTED]

vs.

CHILDREN'S MEDICAL SERVICES,

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned Hearing Officer convened a telephonic Fair Hearing in the instant case on April 17, 2023, at 8:30 a.m. Eastern Standard Time ("EST").

APPEARANCES

For the Petitioner:

[REDACTED]

Petitioner's Authorized Representative

For the Respondent:

Christian Pacheco

Senior Director of Quality Improvement

Children's Medical Services

STATEMENT OF ISSUE

The issue is whether Respondent proved by a preponderance of the evidence that Respondent's termination of home health services was correct.

PRELIMINARY STATEMENT

All parties appeared for the scheduled Fair Hearing telephonically. [REDACTED] (" [REDACTED]"), Petitioner's Authorized Representative and [REDACTED] appeared for the Fair Hearing on

behalf of Petitioner and provided testimony. Lizbeth Sanchez (“Ms. Sanchez”), Petitioner’s behavior analysis services provider, testified on behalf of Petitioner.

Christian Pacheco, the Senior Director of Quality Improvement for Children’s Medical Services (“CMS”), appeared for the Fair Hearing as representative for Respondent. The following persons appeared for the Fair Hearing as a witness for Respondent: Dr. John Phillips (“Dr. Phillips”), Medical Director for CMS; Amanda Wagner, Pediatric Care Manager Supervisor for CMS; and Molina Ball (“Ms. Ball”), Pediatric Care Manager for CMS. Aldria White-Futrell, Compliance Officer for CMS appeared as an observer for CMS.

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

Prior to the Fair Hearing, Petitioner sent to the Office of Fair Hearings a twenty-four (24)-page evidence packet. The evidence packet appears in the Office of Fair Hearings’ case management system as “Fair Hearing Request [Petitioner].pdf.” Absent an objection, the undersigned admitted the evidence packet into evidence as Petitioner’s Composite Exhibit 1.

Prior to the Fair Hearing, Petitioner sent to the Office of Fair Hearings a sixteen (16)-page evidence packet. The evidence packet appears in the Office of Fair Hearings’ case management system as “23-FH0168 Faxed DAR & Supporting Documents.pdf.” Absent an objection, the undersigned admitted the evidence packet into evidence as Petitioner’s Composite Exhibit 2.

Prior to the Fair Hearing, Respondent sent to the Office of Fair Hearings and Petitioner a one hundred and seventy-five (175)-page evidence packet. The evidence packet appears in the Office of Fair Hearings’ case management system as “MFH packet part 1.pdf,” and “MFH packet

part 2.pdf.” The undersigned admitted the evidence packet into evidence as Respondent’s Composite Exhibit 1.

FINDINGS OF FACT

1. Petitioner is an enrolled member of CMS. See Respondent’s Composite Exhibit 1, pages 1-2, 12-15, 36-51. CMS is a managed care organization contracted by the Agency to provide services to eligible Medicaid recipients in the state of Florida.

2. As of the date of the Fair Hearing, Petitioner is [REDACTED] ([REDACTED] [REDACTED] old. *Id.* at 12-13. Petitioner has the following medical conditions: [REDACTED]
[REDACTED]
[REDACTED]. *Id.* at 13, 16-17.

3. Petitioner’s physician, [REDACTED], wrote a prescription for the following home health services: twelve (12) hours per day on Monday through Friday. *Id.* at 14-15. The prescription indicated that Petitioner has a [REDACTED] and needs assistance with [REDACTED]
[REDACTED]. *Id.* at 15-16. Further, [REDACTED] stated that Petitioner’s [REDACTED] has [REDACTED] but did not provide describe [REDACTED]. *Id.* at 15.

4. On December 21, 2022, Petitioner requested continuation of home health services. *Id.* at

5. On December 28, 2022, CMS issued a Notice of Adverse Benefit Determination (“NABD”) terminating home health services based on medical necessity. *Id.* at 5-9. The NABD explained the basis of the determination as follows, in pertinent part:

Children's Medical Services Health Plan has reviewed a request for home health services which we received on December 21, 2022. After our review, this service has been: **DENIED** as of December 27, 2022.

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

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

- Must be needed to protect your child's life, prevent significant illness or disability to your child, or to alleviate your child's severe pain.
- Must be individualized, specific, consistent with symptoms or diagnosis of illness or injury and not be in excess of your child's needs.
- Must meet accepted medical standards and not be experimental or investigational.
- Must be able to be 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.
- Must be furnished in a manner not primarily intended for convenience of the recipient, caretaker, or provider.

(The convenience factor is not applied to the determination of the medically necessary level of private duty nursing (PDN) for children under the age of 21.)

The requested service is not a covered benefit.

Other authority:

The facts that we used to make our decision are: Sunshine Health Policy on Review for Personal Care Service Requests; FL.UM.25.00, the Sunshine Health Member Handbook, Services covered by Sunshine Health, Florida Medicaid, Private Duty Nursing Services Coverage Policy and or Florida Medicaid Home Health Visits Service Coverage Policy.

This decision was made with regards to Early and Periodic Screening, Diagnostic and Treatment Services (EPSDT).

Rationale: Request for home health aide (a trained and certified health care worker to assist a person in the home with daily activities) is denied due to lack of medical necessity (need). Previous authorization was administratively approved. This authorization was sent to the medical director (someone who has expert knowledge in the subject matter) for review. There is not enough clinical (medical) information submitted (sent in) with this request to support the medical need for a home health aide. There is no documentation (notes) your child cannot attend school. Your child is not bed bound (unable to leave your bed due to illness) or home bound (unable to leave your home due to illness). We have not been told

that this home health aide service is being requested along with skilled nursing services. There is no clinical documentation telling us your child's current physical or occupational limitation (how your condition affects your ability to function on a day to day basis). It is unclear what preventative measures has [sic] been instituted for [REDACTED] ([REDACTED] risk. Assistance of daily living (basic self care) and supervision would normally be performed on children at this age. It appears your child needs adult supervision, which does not require a home health aide or nursing assistant. There was no note stating that the parent and or guardian has physical or cognitive (ability to process knowledge) limitations and is unable to assist your child. There is no documentation as to what level of parental or guardian participation is currently present or should be expected. Babysitting services are specifically noted to not be a covered benefit. Babysitting is defined as custodial care (medical care that helps individuals with their daily basic care, such as eating and bathing), daycare, afterschool care, supervision or similar childcare unrelated to the services that are documented to be medically necessary (needed) for your child. Reconsideration (change of decision) of this request can be done with complete updated information is submitted for review addressing these issues.

Respondent's Composite Exhibit 1, page 5-9.

5. On January 4, 2023, Petitioner requested a plan appeal. *Id.* at 23-25. On January 11, 2023, CMS issued a Notice of Plan Appeal Resolution ("NPAR") upholding its determination. *Id.* at 29-

32. The NPAR states the following, in pertinent part:

On 01/04/2023 we received your timely plan appeal request regarding Children's Medical Services Health Plan Notice of Adverse Benefit Determination dated 12/28/2022, NABD Number [REDACTED] the Home health services provided to [Petitioner].

The request has been reviewed. The review was completed by a licensed doctor. The doctor was not a part of the first review or the findings from that review.

The Medical Director involved is Board Certified MD with a specialty in Pediatrics[.]

On 01/10/2023, after consideration of the information you provided to Children's Medical Services Health Plan in support of your plan appeal, Children's Medical Services Health Plan hereby Denies your plan appeal. As a result, [Petitioner] will not receive Home health services, effective 01/10/2023.

The facts that we used to make our decision are: The previous denial to authorize a home health aide for your child is upheld due to lack of medical necessity. The clinical information submitted with this request does not support the medical need for a home health aide. Your child appears to need adult supervision / babysitting services. Adult supervision does not require a home health aide. We did not receive a parent/guardian work/school form. The reasons for this decision are based on a set of standards. This included Criteria: SUNSHINE POLICY AND PROCEDURE Review for Personal Care Services Requests FL.UM.25; Personal Care Services Coverage Policy, Agency for Health Care Administration, November 2016. This decision was made with regards to EPSDT.

Respondent's Composite Exhibit 1, pages 29-32.

6. On January 25, 2023, [REDACTED] requested a Fair Hearing on behalf of Petitioner regarding the termination of home health services. On March 27, 2023, the undersigned Hearing Officer issued a notice to all parties of record, scheduling the Fair Hearing to be convened by telephone on April 17, 2023, at 8:30 a.m. EST.

7. Dr. Phillips testified that Petitioner received two previous approvals for home health services without a CMS Medical Director's review for medical necessity. The first approval was from [REDACTED], through [REDACTED], during the time that CMS integrated with Sunshine State Health Plan, Inc. ("Sunshine") and the services were administratively approved for continuity of care purposes. The second approval was from [REDACTED], through [REDACTED], which corresponded to an automatic approval waiver period due to a hurricane. The first time that a CMS Medical Director reviewed Petitioner's home health aide services request for medical necessity was for the period at issue, which is January 16, 2023, through July 14, 2023.

8. Dr. Phillips testified that the determination in this case was based on the documents provided by [REDACTED] to CMS for review. *Id.* at 12-22. The request was for twelve (12) hours per day for five days per week, Monday through Friday. Dr. Phillips established that the

physician visit documentation form does not provide detailed information on Petitioner's functional and cognitive impairment. *Id.* at 16. The documentation included an office visit note from the primary care doctor concerning a sick visit for a [REDACTED] on [REDACTED], but did not support the medical necessity of the services at issue. *Id.* at 18-22. Dr. Phillips further established that [REDACTED] medical limitations form did not provide enough information to show [REDACTED] is not physically capable of caring for Petitioner. *Id.* at 22. As Dr. Phillips testified, [REDACTED] also does not have a job that takes [REDACTED] away from the home leaving Petitioner unattended.

9. Dr. Phillips established that Petitioner does not currently attend school. Further, Petitioner receives behavior analysis therapy at the therapist's office from 9:00 a.m. through 4:00 p.m. on Monday, Tuesday, Thursday, and Friday, and from 9:00 a.m. through 2:00 p.m. on Wednesdays. Dr. Phillips asserted that documentation of Petitioner's cognitive and functional problems did not support the medical necessity of the services.

10. [REDACTED] testified that Petitioner was taken out of school due to being [REDACTED] and having to be placed on a waiting list for behavior analysis services. After waiting for almost 2 months, Petitioner began ABA services, but it took almost [REDACTED] for Petitioner to make progress on [REDACTED]. Petitioner is currently on a waiting list to attend school with a behavior analysis provider present during school hours. Regarding [REDACTED] own physical limitations, [REDACTED] testified that [REDACTED] is unable to work due to [REDACTED]. [REDACTED] asserted that [REDACTED] needs a great deal of help to complete activities such as running errands and going to the store due to Petitioner's maladaptive behavior.

11. Ms. Sanchez testified that she provides behavior analysis services for the Petitioner. She indicated that Petitioner's [REDACTED] and [REDACTED] have recently increased in intensity. Ms. Sanchez recommends that the Petitioner return to a school but only with a behavior analysis provider present during school hours.

12. In making its medical necessity determination, CMS relied upon the Sunshine Health Policy on Review for Personal Care Services. *Id.* at 5-11, 29-35. The policy states as follows, in pertinent part:

DEFINITIONS:

Personal Care Services are services that assist a member with ADLs or IADLs. These services can be provided to members up to the age of 21. Personal care service assistance can be in the form of hands-on assistance (actually performing the task for the member) or cuing along, with supervision, to ensure the member performs the personal care task properly. The personal care services must be prescribed by a treating physician, provided by a home health aide or independent personal care provider, and supervised by a registered nurse if provided through a home health agency, or supervised by the parent or legal guardian if provided by a non-home health agency, or supervised by the member, if the services are provided by a non-home health agency and the member is a legal adult between the ages of 18 up to 21 with no legal guardian.

POLICY:

Sunshine Health's Review of Personal Care Services Requests clinical policy supports the utilization management review process for the MMA, Children's Medical Service (CMS) and Child Welfare benefits described in the Florida Provider's Handbook entitled, Personal Care Services Coverage Policy.

PROCEDURE:

Personal Care Services Criteria:

Personal care services are covered for members who are under the age of 21. In order to be considered for approval, the member's treating physician must order the service. The member must meet all of the following criteria:

- Member must have one of the functional impairments noted in the "Level of Functional Impairment" section below.
- Member has a documented medical condition or disability that substantially limits the member's ability to perform their Activities of Daily Living (ADL) and Instrumental Activities of Daily Living (IADL) or has a

documented cognitive impairment such as Autism which prevents him/her from knowing when or how to carry out the personal care task.

- Member has a documented functional limitation and evidence is documented
- Member requires more individual and continuous care than can be provided through a home health aide visit
- Member does not have a parent or legal guardian able to provide ADL or IADL care
- Member would normally perform the age-appropriate personal care task without the medical condition or disability, and his/her parent or legal guardian is not able to provide ADL or IADL care

Limitations and Exclusions

- Members, who may benefit from personal care services, include those eligible members who are under the age of 21, only.
- Banking or flex hours of approved personal care service hours is not allowed. Only the number of hours that are approved as medically necessary can be approved. The total number of hours per week, hours per day, and days per week approved must be followed. Any variations would need to be requested and approved in advance by Sunshine Health.
- Personal care services are not covered in the following locations:
 - Hospitals
 - Nursing facilities
 - Intermediate care facilities for individuals with intellectual disabilities
 - Physician offices
 - Clinics
 - Prescribed pediatric extended care centers
- Personal care services can be covered outside the member's residence if the services are unavailable through other public or private resources, including schools (with documentation of such) and the services are medically necessary while the member is outside his/her home.
- Personal care services can be provided to a member whose parent or legal guardian is not able to provide ADL or IADL care. Supporting documentation must be provided to substantiate a parent or legal guardian's inability to participate in the care of the member.
- Personal care services can be authorized to supplement care provided by parents and legal guardians. Parents and legal guardians must participate in providing care to the fullest extent possible. Where needed, the home health service provider must offer training to enable parents and legal guardians to provide care they can safely render without jeopardizing the health or safety of the recipient. The home health services provider must

document the methods used to train a parent or legal guardian in the medical record.

- Personal care services do not include:
- Social services
- Transportation services (except when necessary to protect the health and safety of the recipient and no other transportation service is available or when provided as an IADL for recipients under the age of 21 years)
- Escort services
- Care, grooming, or feeding of pets and animals
- Yard work, gardening, or home maintenance work
- Day care or after school care
- Assistance with homework
- Companion sitting or leisure activities
- Housekeeping (except light housekeeping), homemaker, and chore services, including any shopping except grocery shopping when provided as an IADL for recipients under the age of 21 years
- Respite care
- Services which can be effectively and efficiently obtained outside the recipient's place of residence without any medical contraindications
- Baby-sitting

Level of Functional Impairment:

The information below must be provided by the treating provider to determine the level of functional impairment:

- Minimal functional impairment as evidenced by one (1) of the following indicators:
 - ADLs requiring at least minimum assistance
 - Ambulates with assist of person/device
 - Transfers requiring at least minimum assistance
- Moderate functional impairment as evidenced by two (2) the following indicators:
 - ADLs requiring at least minimum assistance
 - Ambulates with assist of person/device
 - Transfers requiring at least minimum assistance
- Maximum functional impairment as evidenced by all of the following indicators:
 - ADLs requiring total assistance
 - Non-ambulatory
 - Transfers requiring one (1) to two (2) persons assist
- Maximum and persistent functional impairment without available parent or legal guardian support as evidenced by all of the following indicators:
 - ADLs requiring total assistance
 - Non-ambulatory

- Transfers requiring one (1) to two (2) persons assist
- Treating physician certified that all the above impairments are present

Review Process

To assist in determining the medical necessity of personal care services, the clinical criteria established in this policy will be applied. A request for medical necessity review is consistent with Sunshine Health medical policies:

- FL.UM.02.01 - Medical Necessity Review and Continuity of Care
- FL.UM.02.00 – Use of Clinical Criteria
- Any decision to deny, reduce, suspend or terminate services must be made by a Sunshine Health Medical Director as outlined in the policy Use of Clinical Criteria FL.UM.02.00 Determinations and provider notifications will be made according to the expediency of the case as described in the Timeliness of UM Decisions and Notification FL.UM.05.00

Information Required for Review

The treating provider must submit to Sunshine Health’s utilization management department the following information when initially requesting personal care services:

Plan of Care

- Plan of Care (POC) and/or MD order.

Medical condition, disability, cognitive, or functional limitation

- Documentation of the member’s current medical condition, disability, cognitive limitation or functional limitation and how this is substantially limiting the member’s ability to perform specific Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs)
 - ADLs include: eating (oral feedings and fluid intake), bathing, dressing, toileting, transferring, and maintaining continence (examples include taking care of a catheter or colostomy bag or changing a disposable incontinence product while the member is unable to control his/her bowel or bladder).
 - IADLs include: personal hygiene, light housekeeping, laundry, meal preparation, transportation, grocery shopping, using the telephone to take care of essential tasks (examples include paying bills and setting up medical appointments), medication management, and money management.
- Service Need
 - Documented need for services that cannot be provided by a home health aide, including information on the reason that the member requires more individual and continuous care than can be provided through a home health aide visit.

Support for ADLs and IADLs

- Description of parent or legal guardian ability to support member’s ADLs and IADLs, including:
 - Information on the level of ADL and IADL support that the parent or legal guardian is able to safely provide.
 - If training needs are needed to enable the parent or legal guardian to safely provide ADL or IADL support, description of the level of training needed.

Living situation consideration for members age 18 up to 21

- Provide information on the member’s housing situation:
 - 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).

Age-appropriate personal care tasks

- Provide information related to the age appropriateness of the member being able to perform the specific ADL or IADL task, such as grocery shopping, preparing meals, money management medication administration, laundry, or light housekeeping.

The length of the initial authorization can be for up to 180 days.

Respondent’s Composite Exhibit 1 at pages 52-62.

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 section 409.285(2), Florida Statutes (2022). This order is the final administrative decision of AHCA under section 409.285(2)(a).

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

15. Because Respondent terminated an existing service, Fla. Admin. Code R. 59G-1.100(17)(g) assigns the burden of proof to Respondent. The standard of proof in an administrative hearing is a preponderance of the evidence. The preponderance of the evidence standard requires proof by “the greater weight of the evidence” (Black’s Law Dictionary at 1201, 7th Ed.).

16. Petitioner’s request for home health services is governed by the Florida Medicaid Home Health Visit Services Coverage Policy (November 2016) (“Home Health Policy”), which is incorporated by reference in Fla. Admin. Code R. 59G-4.130. See Respondent’s Composite Exhibit 1 at pages 160-171. The Home Health Policy provides the following, in pertinent part:

1.0 INTRODUCTION

1.1 Description

Florida Medicaid home health visits provide medically necessary skilled nursing and home health aide services to recipients whose medical condition, illness, or injury requires the care to be delivered in their home or in the community.

1.1.1 Florida Medicaid Policies

This policy is intended for use by home health providers that render services to eligible Florida Medicaid recipients. It must be used in conjunction with Florida Medicaid’s General Policies (as defined in section 1.3) and any applicable service-specific and claim reimbursement policies with which providers must comply.

Note: All Florida Medicaid policies are promulgated in Rule Division 59G, Florida Administrative Code (F.A.C.). Coverage policies are available on the Agency for Health Care Administration’s (AHCA) Web site at <http://ahca.myflorida.com/Medicaid/review/index.shtml>.

1.1.2 Statewide Medicaid Managed Care Plans

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

...

1.3 Definitions

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

1.3.1 Activities of Daily Living (ADLs)

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

1.3.2 Babysitting

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

1.3.7 Home Health Services

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

1.3.8 Instrumental Activities of Daily Living (IADLs)

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

1.3.9 Intermittent Home Health Visits

Medically necessary skilled nursing and home health aide services that are provided at intervals for the length of time necessary to complete the service.

1.3.10 Medically Necessary/Medical Necessity

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

...

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 four intermittent home health visits, per day, for recipients under the age of 21 years and pregnant recipients age 21 years and older
- Up to three intermittent home health visits, per day, for non-pregnant recipients age 21 years and older

Recipients who meet the following criteria may receive any combination of skilled nursing or home health aide visit services up to the coverage limits specified in this policy:

- Is under the care of a physician and have a physician's order for home health services
- Require services that can be safely provided in their home or in the community

See the Florida Medicaid personal care and private duty nursing services coverage policies if the recipient is under the age of 21 years and requires more care than can be furnished through a home health visit.

4.2.1 Short-term Nursing in an Intermediate Care Facility (ICF)

Florida Medicaid reimburses for short-term skilled nursing visits provided by an RN or LPN in an ICF when the services are medically necessary to avoid transferring the recipient to a nursing facility.

4.2.2 Home Health Aide Visits for Recipients Under the Age of 21 Years

Florida Medicaid reimburses for home health aide visits for recipients under the age of 21 years who have a medical condition or disability that substantially limits their ability to perform ADLs or IADLs.

4.2.2.1 Parental Responsibility

Florida Medicaid reimburses for home health aide visits rendered to a recipient whose parent or legal guardian is not able to provide ADL or IADL care, and to supplement care provided by parents and legal guardians. Parents and legal guardians must participate in providing care to the fullest extent possible. Providers must offer training to enable parents and legal guardians to provide care they can safely render without jeopardizing the health or safety of the recipient when needed.

4.3 Early and Periodic Screening, Diagnosis, and Treatment

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

...

5.0 EXCLUSION

5.1 General Non-Covered Criteria

Services related to this policy are not reimbursed when any of the following apply:

- The service does not meet the medical necessity criteria listed in 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
- Intermittent home health visits rendered less than an hour apart
- 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

Respondent's Composite Exhibit 1, pages 160-171.

17. States must provide Early and Periodic Screening, Diagnostic, and Treatment ("EPSDT") services to Medicaid-eligible children under age 21 when requested under the Medicaid state plan. See 42 U.S.C. § 1396a(a)(43); 42 U.S.C. § 1396d(a)(4). According to 42 U.S.C. § 1396d(r)(5),

EPSDT services mean, in relevant part, the following items and services:

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

18. Petitioner is under the age of 21 years, and therefore EPSDT applies to [REDACTED] request for services. However, a state may place medical necessity limitations on EPSDT services. See 42

C.F.R. §§ 440.230(a), (b), (d). Section 409.905(2), Florida Statutes, limits EPSDT services with a medical necessity standard:

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

19. The Florida Medicaid Definitions Policy (“Definitions Policy”) (August 2017), incorporated by reference in Fla. Admin. Code R. 59G-1.010, states as follows, in pertinent part:

2.2 Activities of Daily Living (ADLs)

ADLs include:

- Bathing
- Dressing
- Eating (oral feedings and fluid intake)
- Maintaining continence (examples include taking care of a catheter or colostomy bag or changing a disposable incontinence product when the recipient is unable to control bowel or bladder functions)
- Toileting
- Transferring

2.18 Caregiver

Person(s) attending to the needs of another person, who is physically or mentally impaired, injured, incapacitated, or a child unable to care for him or herself.

2.64 Instrumental Activities of Daily Living (IADLs)

IADLs include:

- 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)

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.

19. In this case, Respondent terminated Petitioner's home health services (12 hours per day, 5 days per week) on the basis that the services are not "individualized, specific, consistent with symptoms or diagnosis of illness or injury" and are "in excess of [Petitioner's] needs." See *supra* ¶ 4. Dr. Phillips provided credible and persuasive testimony, *supra* ¶ 7-9, that continuation of services could not be approved due to the lack of documentation supporting Petitioner's medical condition, the lack of documentation on [REDACTED], and the lack of a caregiver work schedule.

20. The Home Health Policy is clear that Florida Medicaid reimburses for home health aide visits rendered to a recipient whose parent or legal guardian is not able to provide ADL or IADL care, and to supplement care provided by parents and legal guardians. See *supra* ¶ 16. Further, parents and legal guardians must participate in providing care to the fullest extent possible. See

supra ¶ 16. Medicaid does not reimburse for babysitting. See supra ¶ 16. Babysitting is defined as custodial care, daycare, afterschool care, supervision, or similar childcare unrelated to the services that are documented to be medically necessary for the recipient. See supra ¶ 16.

21. In the instant case, the record does not show that the requested home health aide services are warranted. As Petitioner is under the age of twenty-one (21), Florida Medicaid would cover the requested if they were medically necessary. A component of medical necessity is that the services must not be “in excess of the patient’s needs.” Here, as Dr. Phillips credibly testified, Petitioner’s medical provider provided little documentation regarding Petitioner’s cognitive and functional limitations. ██████ did not rebut Dr. Phillips’ testimony with evidence of how long it takes to provide Petitioner with care or a schedule of Petitioner’s activities of daily living and instrumental activities of daily living. Moreover, because ██████ does not work outside the home, the record is unclear as to why ██████ would be unable to provide the home health care. ██████ testified that ██████ needed assistance with errands and going to the store. However, the undersigned did not find this testimony to be credible in light of Petitioner receiving behavior analysis therapy at the therapist’s office from 9:00 a.m. – 4:00 p.m. on Monday, Tuesday, Thursday, and Friday, and from 9:00 a.m. – 2:00 p.m. on Wednesdays. It was unclear why ██████ is unable to run errands during that time.


22. Upon consideration of the testimony, evidence, and applicable policies, the undersigned finds that Respondent proved by a preponderance of the evidence that the home health aide services at issue are in excess of Petitioner’s needs. As such, Respondent has shown that the requested services are not medically necessary. Looking at all the evidence relevant to the particular needs of this Petitioner, the Respondent demonstrated that the continuation of the

home health services is not necessary to correct or ameliorate a defect or a physical and mental illness or condition. Accordingly, Respondent proved by a preponderance of the evidence that Respondent's termination of home health services was correct.

IT IS THEREFORE ORDERED AND ADJUDGED:

Respondent's termination of home health services is hereby **AFFIRMED**. Petitioner's appeal based on Respondent's termination of home health services is hereby **DENIED**.

DONE and ORDERED this 8th day of June 2023, in Tallahassee, Leon County, Florida.

 Laura Gallagher
23-FH0168
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LAURA GALLAGHER, Hearing Officer
Agency for Health Care Administration
Office of Fair Hearings
2727 Mahan Drive, Mail Stop # 11
Tallahassee, FL 32308-5407

NOTICE OF A RIGHT TO JUDICIAL REVIEW

A PARTY WHO IS ADVERSELY AFFECTED BY THIS FINAL ORDER IS ENTITLED TO JUDICIAL REVIEW, WHICH SHALL BE INSTITUTED BY FILING THE ORIGINAL NOTICE OF APPEAL WITH THE AGENCY CLERK OF AHCA, AND A COPY, ALONG WITH THE FILING FEE PRESCRIBED BY LAW, WITH THE DISTRICT COURT OF APPEAL IN THE APPELLATE DISTRICT WHERE THE AGENCY MAINTAINS ITS HEADQUARTERS OR WHERE A PARTY RESIDES. REVIEW PROCEEDINGS SHALL BE CONDUCTED IN ACCORDANCE WITH THE FLORIDA APPELLATE RULES. THE NOTICE OF APPEAL MUST BE FILED WITHIN 30 DAYS OF THE RENDITION OF THE ORDER TO BE REVIEWED.

COPIES FURNISHED TO:

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