



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

**FILED**

May 19, 2023, 8:21 am

OFFICE OF FAIR HEARINGS

[REDACTED]

PETITIONER,

AHCA Case No.: 23-FH0382

vs.

AGENCY FOR HEALTH CARE  
ADMINISTRATION,

RESPONDENT.

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**FINAL ORDER**

Pursuant to notice, the undersigned convened a telephonic Fair Hearing on the instant case on April 6, 2023, at 9:01 a.m. Eastern Standard Time ("EST").

**APPEARANCES**

For the Petitioner:

[REDACTED]

Petitioner's Authorized Representative

For the Respondent:

Lee Ann Williams  
Medical/Health Care Program Analyst  
Agency for Health Care Administration

**STATEMENT OF ISSUE**

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

The second issue is whether Petitioner proved by a preponderance of the evidence that Respondent's decision to deny Petitioner's request for additional personal care services was incorrect.

**PRELIMINARY STATEMENT**

All parties appeared telephonically. Petitioner’s Authorized Representative and father, [REDACTED] on behalf of the Petitioner.

Lee Ann Williams, Medical/Health Care Program Analyst for the Agency for Health Care Administration (“Agency or “AHCA”), appeared on behalf of Respondent. Dr. Chris Kunis (“Dr. Kunis”), Medical Director for eQHealth Solutions (“eQHealth”), attended as a witness for Respondent.

Petitioner did not introduce any exhibits at the hearing. Prior to the hearing, Respondent sent to the Office of Fair Hearings and Petitioner a sixty-five (65)-page evidence packet and an eighty (80)-page evidence packet. The sixty-five (65)-page evidence packet appears in the Office of Fair Hearings’ document management system as the file title “56890356 FH 04.06.2023.pdf” and the eighty (80)-page evidence packet appears as “23-FH0382 AHCA CDC Plus Evidence packet.pdf”. Absent an objection from the Petitioner, the undersigned admitted the sixty-five (65)-page packet into evidence as Respondent’s Composite Exhibit 1 (“RCE 1”) and the eighty (80)-page evidence packet was admitted as Respondent’s Composite Exhibit 2 (“RCE 2”).

**FINDINGS OF FACT**

1. Petitioner receives Medicaid services on a fee-for-service basis from the Agency. eQHealth is a Quality Improvement Organization contracted by the agency to review prior authorization requests for services. See page 2 of RCE 2.

2. Petitioner is [REDACTED] See page 16 of RCE 1. Petitioner is [REDACTED] [REDACTED] *Id.* at 52. Petitioner [REDACTED] [REDACTED] *Id.* at 55.

3. [REDACTED] works from 8:00 a.m. until 6:00 p.m., Monday through Friday, and alternating Saturdays from 9:00 a.m. until 5:00 p.m. *Id.* at 56. Petitioner's [REDACTED] works from 8:00 a.m. until 6:00 p.m., Monday through Friday, and alternating Saturdays from 9:00 a.m. until 5:00 p.m. *Id.* at 57.

4. Petitioner was previously approved to receive four (4) hours of personal care services, daily, Monday through Saturday. *Id.* at 16. Petitioner requested an additional hour each day, Monday through Saturday. *Id.* at 22. In a Notice of Outcome ("NOO"), dated February 8, 2023, Respondent terminated Petitioner's personal care services. *Id.* at 22 – 23. Respondent explained the basis of the termination as follows:

[T]he requested services are not medically necessary under the following standard(s):

Individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness under treatment, and not in excess of the patient's needs.

The NOO further provided:

Request is for PCS services for [REDACTED]. Patient [REDACTED]; no recent ER visits or hospitalizations; [REDACTED] words Mon > Sat. PCS services would be provided by [REDACTED] under CDC+ program. As per Medicaid Handbook [REDACTED] must provide as much care as they can and as [REDACTED] is available to provide all required care so must do so without being a paid service provider. Deny this request.

...

Pages 22 – 23 of RCE 1.

5. Petitioner requested reconsideration of the Respondent's decision. In a Notice of Reconsideration ("NRD"), dated February 25, 2023, Respondent upheld its decision. *Id.* at 31 – 32.

6. On February 22, 2023, Petitioner requested a Fair Hearing to challenge the termination and denial of services. On March 13, 2023, the undersigned issued an Order Scheduling Fair

Hearing by Telephone and Prehearing Instructions, setting the hearing for April 6, 2023, at 9:00 a.m. EST.

7. Dr. Kunis is a Medical Director for eQHealth. Dr. Kunis testified to the following:
  - a. Petitioner's [REDACTED] is to provide care, and per the guidelines, [REDACTED] are to provide as much care as possible.
  - b. Supervision is not covered under personal care services.
8. [REDACTED] testified to the following:
  - a. Petitioner's [REDACTED]
  - b. [REDACTED] has been selected to provide care for Petitioner.

#### **CONCLUSIONS OF LAW**

9. The Agency's Office of Fair Hearings has jurisdiction over the subject matter of this proceeding and the parties pursuant to section 409.285(2) of the Florida Statutes (2019). This order is the final administrative decision of AHCA under Fla. Stat. § 409.285(2)(a).
10. This hearing was held as a *de novo* proceeding pursuant to Fla. Admin. Code R. 59G-1.100(17)(b).
11. Because Petitioner is requesting a new service, 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.)
12. The Florida Medicaid Personal Care Services Coverage Policy ("Policy") incorporated by reference in Fla. Admin. Code R. 59G-4.215, governs Personal Care services available under

Florida Medicaid. The Policy provides the following with respect to personal care services and companion care services:

**1.1 Description**

Florida Medicaid personal care services provide medically necessary assistance, in the home or in the community, with activities of daily living (ADL) and age appropriate instrumental activities of daily living (IADL) to enable recipients to accomplish tasks they would normally be able to do for themselves if they did not have a medical condition or disability.

...

**4.1 General Criteria**

Florida Medicaid reimburses for services that meet all of the following:

- Are determined medically necessary
- Do not duplicate another service
- Meet the criteria as specified in this policy

...

**4.2. Specific Criteria**

Florida Medicaid reimburses for up to 24 hours of personal care services per day, per recipient, in order to provide assistance with ADLs and age appropriate IADLs when the recipient meets the following criteria:

- Has a medical condition or disability that substantially limits their ability to perform ADLs or IADLs and do not have a parent or legal guardian able to provide the required care
- Is under the care of a physician and has a physician’s order for personal care services
- Requires more extensive and continual care than can be provided through a home health visit
- Requires services that can be safely provided in their home or the community

...

**4.2.1 Parental Responsibility**

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

...

**4.2.2 Services Provided by Independent Personal Care Providers**

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

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

...

#### **4.3 Early and Period Screening, Diagnosis, and Treatment**

As required by federal law, Florida Medicaid provides services to eligible recipients under the age of 21 years, if such services are medically necessary to correct or ameliorate a defect, a condition, or a physical or mental illness. Included are diagnostic services, treatment, equipment, supplies, and other measures described in section 1095(a) of the SSA, codified in Title 42 of the United States Code 1396d(a). As such, services for recipients under the age of 21 years exceeding the coverage described within this policy or the associated fee schedule may be approved, if medically necessary.

13. The Policy further addresses excluded services as follows:

##### **5.1 General Non-Covered Criteria**

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

- The service does not meet the medical necessity criteria listed in section 1.0.
- The recipient does not meet the eligibility requirements listed in section 2.0.
- The service unnecessarily duplicates another provider's service.

##### **5.2 Specific Non-Covered Criteria**

Florida Medicaid does not reimburse for the following:

- A skill level other than what is prescribed in the physician order and approved plan of care (POC)
- Assistance with homework
- Babysitting
- Care, grooming, or feeding of pets and animals
- Certification of the POC by a physician
- Companion sitting or leisure activities
- Escort services
- Housekeeping (except light housekeeping to make the environment safe), homemaker, and chore services
- Nursing assessments related to the POC
- Professional development training or supervision of home health staff or other home health personnel
- Respite care to facilitate the parent or legal guardian attending to personal matters

- Services funded under section 110 of the Rehabilitation Act of 1973 or under the provisions of the Individuals with Disabilities Educational Act
- Services furnished by relatives as defined in section 429.02(18), F.S., household members, or any person with custodial or legal responsibility for the recipient. (Except when a recipient is enrolled in the Consumer-Directed Care Plus program)
- Services provided in any of the following locations:
  - Hospitals
  - Intermediate care facility for individuals with intellectual disabilities
  - Nursing facilities
  - Prescribed pediatric extended care centers
  - Residential facilities or assisted living facilities when the services duplicate those provided by the facility
- Services rendered prior to the development and approval of the POC
- Travel time to or from the recipients place of residence
- Yard work, gardening, or home maintenance work.

14. 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.

15. Petitioner is [REDACTED]

However, a state may place medical necessity limitations on EPSDT services. *See* 42 C.F.R. §§ 440.230(a), (b), (d). Fla. Stat. § 409.905(2) limits EPSDT services with a medical necessity standard:

The [Agency] shall pay for early and periodic screening and diagnosis of a recipient under age 21 to ascertain physical and mental problems and conditions and all services determined by the agency to be medically necessary for the treatment, correction, or amelioration of these problems and conditions, including personal

care, private duty nursing, durable medical equipment, physical therapy, occupational therapy, speech therapy, respiratory therapy, and immunizations.

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

### **2.2 Activities of Daily Living (ADLs)**

ADLs include:

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

### **2.64 Instrumental Activities of Daily Living (IADLs)**

When necessary for the recipient to function independently, including:

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

### **2.83 Medically Necessary or Medical Necessity**

The medical or allied care, goods, or services furnished or ordered must meet the following conditions:

- Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate pain
- Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs

- Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational
- Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available statewide
- Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider

The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services does not, in itself, make such care, goods or services medically necessary or a medical necessity or a covered service.

17. The Florida Medicaid Authorization Requirements Policy ("Authorization Policy"), incorporated by reference in Fla. Admin. Code R. 59G-1.053, provides as follows:

**3.2.1 Continued Authorization Requests**

The QIO shall not deny or reduce the amount, frequency, or duration of a service that is already being provided, unless:

- The reduction is to correct for factual error or omissions in prior certifications.
- There is a documented improvement in the recipient's medical condition.
- There is a documented change in the recipient's circumstances.
- The reviewing physician determines the recipient will not gain any additional benefit by continuing services at the current level.

A. Termination of Personal Care Services

18. Petitioner requested an increase in personal care services, from the previously approved twenty-four (24) hours, weekly, to thirty (30) hours weekly. See ¶ 4. Respondent denied Petitioner's request and terminated Petitioner's personal care services entirely. *Id.* Respondent explained that it was not medically necessary for Petitioner to receive personal care services, specifically that personal care services did not meet the requirement that services be "individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness under treatment, and not in excess of the patient's needs." *Id.* Respondent further explained that

Petitioner's "mother is available to provide all care so must do so without being a paid service provider." *Id.*

19. As provided by the ESPDT requirements, the recipient must meet the medical necessity criteria as outlined in Fla. Admin. Code R. 59G-1.010. As provided in section 2.83 of the Definitions Policy, a component of medical necessity is that services must be "[i]ndividualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs." As provided in the PCS Policy, personal care services are intended to "provide medically necessary assistance . . . with activities of daily living (ADL) and age appropriate instrumental activities of daily living (IADL)." As shown by the record, Petitioner [REDACTED] See ¶ 2. As such, the record reflects that Petitioner needs assistance with ADLs, and thus personal care services are individualized and specific to Petitioner's needs. Moreover, the record shows that Petitioner's [REDACTED] work during the day, see ¶ 3, and that Petitioner's [REDACTED] will not provide care. See ¶ 8. As such, Respondent did not demonstrate that the previously approved personal care services are in excess of Petitioner's needs.

20. Upon consideration of the testimony provided, evidence submitted, and applicable policies, the undersigned concludes that Respondent did not prove by a preponderance of the evidence that the termination of personal care services was necessary. Looking at all the evidence relevant to the particular needs of Petitioner, Respondent did not demonstrate that the previously authorized services, are not necessary to correct or ameliorate a defect or a physical and mental illness or condition. Accordingly, Respondent did not prove by a preponderance of the evidence that Respondent's termination of personal care services was correct.

B. Denial of Personal Care Services

21. As discussed, *supra* ¶ 18, Petitioner requested an additional six (6) hours of personal care services. Respondent denied Petitioner's request and explained that the request was not "[i]ndividualized, specific, and consistent with symptoms or confirmed diagnosis of the illness under treatment" and "was in excess of the patient's needs."

22. As Petitioner bears the burden of proof, Petitioner must show that it is medically necessary to receive an additional twenty (20) hours of personal care services, weekly. As discussed, *supra* ¶ 19, personal care services are intended to assist with ADLs and IADLs, and Petitioner needs assistance with his ADLs. However, there is little evidence to show that the previously approved services are inadequate to meet Petitioner's needs. Petitioner did not show that which ADLs were not being met with the services already in place. As such, Petitioner did not show that [REDACTED] request for additional personal care services was in excess of [REDACTED] needs.


23. Upon consideration of the testimony provided, evidence submitted, and applicable policies, the undersigned concludes that Petitioner did not prove by a preponderance of the evidence that additional personal care services was medically necessary. Looking at all the evidence relevant to the particular needs of Petitioner, Petitioner did not demonstrate that additional personal care services are necessary to correct or ameliorate a defect or a physical and mental illness or condition. Accordingly, Petitioner did not prove by a preponderance of the evidence that Respondent's denial of personal care services was incorrect.

**IT IS HEREBY ORDERED AND ADJUDGED THAT:**

Respondent's termination of personal care services is **REVERSED**. Petitioner's appeal based on Respondent's termination is **GRANTED**.

Respondent's denial of personal care services is **AFFIRMED**. Petitioner's appeal based on Respondent's denial is **DENIED**.

**DONE AND ORDERED** this 19th day of May, 2023, in Tallahassee, Leon County, Florida.

 Joseph Mabry  
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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**

**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:**



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