



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

**FILED**

May 26, 2023, 9:09 am

OFFICE OF FAIR HEARINGS

[REDACTED]

PETITIONER,

AHCA Case No.:23-FH0406

[REDACTED]

vs.

HUMANA MEDICAL PLAN, INC.,

RESPONDENT.

\_\_\_\_\_ /

**FINAL ORDER**

Pursuant to notice, the undersigned convened a telephonic Fair Hearing on the instant case on April 12, 2023, at 1:00 p.m. Eastern Standard Time (“EST”).

**APPEARANCES**

For the Petitioner:

[REDACTED]

Petitioner’s Authorized Representative

For the Respondent:

Markeshi Lee  
Medicaid Fair Hearing Specialist  
Humana Medical Plan, Inc.

**STATEMENT OF ISSUE**

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

**PRELIMINARY STATEMENT**

All parties appeared telephonically. Petitioner’s Authorized Representative and [REDACTED]

[REDACTED] appeared on behalf of the Petitioner. Petitioner’s [REDACTED]

[REDACTED] appeared as a witness for Petitioner.

Markeshi Lee, Medicaid Fair Hearing Specialist for Humana Medical Plan, Inc. (“Humana”) appeared on behalf of Respondent. Dr. Avra Bowers (“Dr. Bowers”), Medical Director for Humana, attended as a witness for Respondent.

The following attended as observers: Marielisa Amador, Medical/Health Care Program Analyst for the Agency for Health Care Administration (“Agency” or “AHCA”); and Kameisha Presley, Hearing Officer for the Agency.

Petitioner did not introduce any exhibits at the hearing. Prior to the hearing, Respondent sent to the Office of Fair Hearings and Petitioner a three hundred and forty-six (346)-page evidence packet. The evidence packet appears in the Office of Fair Hearings’ document management system as file titles “Evidence Packet\_Part 1.pdf”, “Evidence Packet\_Part2.pdf”, and “Evidence Packet\_Part 3.pdf”. Absent an objection from the Petitioner undersigned admitted the page packet into evidence as Respondent’s Composite Exhibit 1 (“RCE 1”).

#### **FINDINGS OF FACT**

1. Petitioner is an enrolled member of Humana. *See* page 1 of RCE 1. Humana is a managed care organization contracted by the Agency to provide services to eligible Medicaid recipients in Florida.
2. Petitioner was [REDACTED]. *Id.* Petitioner lives with [REDACTED]. *Id.* at 28. [REDACTED] provides care for Petitioner for eighty-four (84) hours each week. *Id.* at 44. Caring for Petitioner has placed “a lot of strain” on [REDACTED] which includes difficulties with maintaining relationships with family and friends, employment, finances, and finding time to do things that [REDACTED] enjoys. *Id.*

3. Petitioner suffered [REDACTED]. *Id.* at 28 and 29. Petitioner

[REDACTED] *Id.* at 28. Petitioner [REDACTED]

[REDACTED] *Id.* at 28 and 31. Petitioner suffers from [REDACTED] *Id.* at 29.

4. Petitioner's needs total assistance (cannot do at all) for [REDACTED]

[REDACTED] *Id.* at 31 and 32.

5. Petitioner is currently approved for eleven (11) hours of homemaker services, weekly, and eighty-four (84) hours of attendant care services, weekly. *Id.* at 23.

6. Petitioner requested eighty-four (84) hours of attendant care services. Petitioner's request was denied in the Notice of Adverse Benefit Determination ("NABD"), dated November 17, 2022. The NABD explained the basis of the denial as follows:

We determined that your requested services are not medically necessary because the services do not meet either of the reasons checked below: (*See Rule*)

...

- Meet all of the following criteria for all extended state plan services used for the purposes of maintenance therapy and all other home and community-based services:
  1. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs;
  2. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available statewide; and
  3. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider;

and one of the following:

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

The facts that we used to make our decision are:

This determination of the Medical Director has been made based on medical necessity (as defined by Florida law – specifically see checked box above) and reflects the application of the Plan’s approved review criteria and guidelines.

You currently have 11 hours of homemaker service each week; 21 hours of personal care service each week; and 84 hours of attendant care each week. You have requested an additional 84 hours of attendant care each week.

You have [REDACTED]  
[REDACTED]  
[REDACTED]  
[REDACTED]  
[REDACTED]

You were recently in the hospital [REDACTED] You have returned home. You live [REDACTED]  
[REDACTED]  
[REDACTED]  
[REDACTED]  
[REDACTED]

Your request for an additional 84 hours of attendant care each week is being denied as not medically necessary. The hours you are receiving should be enough to meet your medical needs and can be divided into shifts to better meet your medical needs. We recommend that you consider requesting respite care if needed.

...

Pages 9 – 10 of RCE 1.

7. Petitioner requested a plan appeal and received a Notice of Plan Appeal Resolution (“NPAR”), dated January 13, 2023, upholding the denial. *Id.*

8. On February 27, 2023, Petitioner requested a Fair Hearing to challenge the denial of attendant care services. On March 23, 2023, the undersigned issued an Order Scheduling Fair Hearing by Telephone and Prehearing Instructions, setting the hearing for April 12, 2023, at 1:00 p.m. EST.

9. [REDACTED] is Petitioner’s [REDACTED] testified to the following:

- a. Petitioner is completely incapacitated – [REDACTED] is unable to assist in caring for [REDACTED] needs or making [REDACTED] needs known.
  - b. Petitioner currently has twelve (12) hours, daily, of attendant care, but those hours could not be split because they could not find anyone to provide care for those shifts. Currently, the attendant care aides work from 8:00 p.m. until 8:00 a.m.
  - c. The attendant care aides [REDACTED]  
[REDACTED] the Petitioner.
  - d. [REDACTED] performs care for Petitioner at all other times.
  - e. [REDACTED] was unable to maintain [REDACTED] business because of caring for Petitioner.
  - f. Petitioner's [REDACTED] works off shore, two weeks on and two weeks off.
10. Dr. Bowers is a Medical Director for Humana. Dr. Bowers testified to the following:
- a. Dr. Bowers believes that the services in place are sufficient to care for Petitioner, based on the fact that Petitioner lives with his caregiver, and the attendant care services can be split into shifts.
  - b. Petitioner is allotted 300 hours of respite cares services for the year.
  - c. Petitioner formerly received twenty-one (21) hours of personal care services, weekly, but those services were terminated.

#### **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 Fla. Stat. § 409.285(2)(2019). 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 Fla. Admin. Code R. 59G-1.100(17)(b).

13. 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.)

14. The Florida Medicaid Statewide Managed Care Long-term Care Program Coverage Policy (March 2017) (“LTC Policy”), incorporated by reference in Fla. Admin. Code R. 59G-4.192, governs Long-Term Care services available under Florida Medicaid. The LTC Policy provides the following with respect to attendant care services:

**1.1 Description and Program Goal**

Under the Statewide Medicaid Managed Care Long-Term Care (LTC) program, managed care plans (LTC plans) are required to provide an array of home and community-based services that enable enrollees to live in the community and to avoid institutionalization.

...

**1.3.1 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

...

**1.3.9 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)

...

#### **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

...

#### **4.2.1.9 Homemaker Services**

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

...

#### **4.2.1.15 Respite Care**

The provision of services on a short-term basis due to the absence of, or need to relieve, the enrollee's natural supports on a planned or an emergency basis.

...

#### **4.2.2.2 Attendant Nursing Care**

In accordance with Rule 59G-4.261, F.A.C., for enrollees under the age of 21 years. To provide nursing care of both a supportive and health related nature, specific to the needs of a medically stable, physically handicapped enrollee age 21 and older who requires more individual and continuous care than an intermittent nursing visit. The scope and nature of these services do not otherwise differ from private duty nursing services furnished to persons under the age of 21 years.

...

15. The LTC Policy also addresses medical necessity:

#### **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.

16. The Florida Medicaid Definitions Policy, incorporated by reference in Fla. Admin. Code R. 59G-1.010, defines "Medically Necessary" or "Medical Necessity" as follows:

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. Petitioner requested eighty-four (84) hours of attendant care services. See ¶ 6. In the NABD, dated November 17, 2022, Respondent denied Petitioner's request. *Id.* Respondent explained that Petitioner's request was not medically necessary, but did not specify which prong

of medical necessity was used to make its decision. *Id.* Respondent explained that the “hours you are receiving should be enough to meet your medical needs and can be divided into shifts to better meet your needs.” *Id.*

18. As provided in the LTC Policy, attended care services are nursing services for persons who require “more individual and continuous care than an intermittent nursing visit”. See ¶ 14. As shown by the record, Petitioner has extensive medical needs. See ¶ 3. For example, Petitioner requires [REDACTED]. See ¶¶ 3, 9. Petitioner needs total assistance with all ADLs and IADLs. See ¶ 4. Petitioner is currently receiving eighty-four (84) hours of attendant care services and eleven (11) hours of homemaker services, weekly. See ¶ 5. Petitioner formerly received personal care services, however, these were terminated previously. See ¶ 10.


19. As Petitioner bears the burden of proof, Petitioner must show that the request for eighty-four (84) hours, weekly, of attendant care services is medically necessary. Petitioner already receives twelve (12) hours of attendant care services, daily, and this request would allow for total coverage, twenty-four (24) hours per day, seven (7) days per week. Here, the record indicates that Petitioner may need care for twenty-four (24) hours each day, however, Petitioner’s [REDACTED] also provides care for [REDACTED] the additional hours would be duplicative of services being provided. Moreover, Petitioner has three hundred (300) hours of respite care available for that can be used by [REDACTED] for when she needs to be away. See ¶ 10. As such, Petitioner did not demonstrate that an additional eighty-four (84) hours of attendant care services are not in excess of his needs.

20. Therefore, upon consideration of the testimony provided, evidence submitted, and applicable polices, the undersigned finds that Petitioner did not prove by a preponderance of the evidence that the denial of attendant care services was incorrect.

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

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

**DONE** and **ORDERED** this 26th day of May, 2023, in Tallahassee, Leon County, Florida.

Joseph Mabry  
 23-FH0406  
2023.05.26  
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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:**



**Humana**  
**GAMedicaidRightFax@humana.com**

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