



FILED

Jun 28, 2023, 10:09 am

OFFICE OF FAIR HEARINGS

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

█

PETITIONER,

AHCA Case No.: 23-FH0605

█

vs.

HUMANA MEDICAL PLAN, INC.,

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic Fair Hearing on the instant case on April 25, 2023, at 1:10 p.m. Eastern Standard Time ("EST").

APPEARANCES

For the Petitioner:

█

Petitioner

For the Respondent:

Michael Moens
Grievance and Appeals 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 additional personal care services was incorrect.

PRELIMINARY STATEMENT

All parties appeared telephonically. Petitioner appeared on [REDACTED] own behalf. [REDACTED]

[REDACTED] er and caregiver, appeared for the Fair Hearing as a witness for Petitioner.

Michael Moens ("Mr. Moens"), Grievance and Appeals Fair Hearing Specialist for Humana Medical Plan, Inc. ("Humana") appeared for the Fair Hearing as representative for Respondent. Dr. Srujan Gaddam ("Dr. Gaddam"), Medical Director for Humana, appeared for the Fair Hearing as a witness for Respondent.

Marielisa Amador, Medical/Health Care Program Analyst for the Agency for Health Care Administration ("Agency" or "AHCA"), appeared as an observer.

Petitioner did not introduce any exhibits at the hearing. Prior to the hearing, Respondent sent to the Office of Fair Hearings and Petitioner a two hundred and ninety-five (295)-page evidence packet. The two hundred and ninety-five (295)-page packet appears in the Office of Fair Hearings' document management system as file titles "Evidence Packet 23-FH0605_Part1.pdf"¹; "Evidence Packet 23-FH0605_Part2.pdf"²; and "Evidence Packet 23-FH0605_Part3.pdf"³. Absent an objection from the Petitioner, the undersigned admitted the two hundred and ninety-five (295)-page packet into evidence as Respondent's Composite Exhibit 1 ("RCE-1").

FINDINGS OF FACT

1. Petitioner is an enrolled member of Humana. See RCE-1 at page 1. Humana is a managed care organization contracted by the Agency to provide services to eligible Medicaid recipients in Florida.

¹ Pages 1 – 108 of RCE-1.

² Pages 109 – 203 of RCE-1.

³ Pages 204 – 295 of RCE-1.

2. Petitioner is [REDACTED]. *Id.* Petitioner lives with [REDACTED]. *Id.* at 65. Petitioner is [REDACTED] *Id.* at 68. Petitioner is diagnosed with [REDACTED]

[REDACTED] *d.* at 25, 70. Petitioner has undergone [REDACTED] [REDACTED] *Id.* at 71.

3. As provided in the Florida Department of Elder Affairs: 701B Comprehensive Assessment (“701B”), Petitioner’s needs for activities of daily living (“ADLs”) are as follows: [REDACTED] [REDACTED], Petitioner needs assistance (but not total help); [REDACTED] Petitioner needs supervision or prompting. *Id.* at 68. In regard to [REDACTED] instrumental activities of daily living (“IADLs”), Petitioner needs total assistance (cannot do at all) for [REDACTED] *Id.* at 69. Petitioner needs assistance (but not total help) for [REDACTED] [REDACTED]. *Id.*

4. [REDACTED]. *Id.* at 78. [REDACTED] and primary care giver. *Id.* [REDACTED] does not work outside of the home. *Id.*

5. Petitioner is currently approved to receive twenty-one (21) hours of personal care services and seven (7) hours of homemaker services, weekly. *Id.* at 25.

6. Petitioner requested an additional twelve (12) hours of personal care services, weekly. Respondent issued a Notice of Adverse Benefit Determination (“NABD”), dated February 1, 2023, denying the services. *Id.* at 3 – 7. 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 7 hours of homemaker service each week; 21 hours of personal care service each week. You have requested an additional 12 hours of personal care service each week.

You have [REDACTED]. You do not have trouble making your needs known. You have [REDACTED]

You live with [REDACTED] helps care for you. [REDACTED] is your DSW (direct service worker). You use a wheelchair to move around (walk). You need some help

[REDACTED]

You have 28 hours of home health aide services daily to meet your needs. Your request for an additional 12 hours of personal each week is being denied as not medically necessary.

The hours you are receiving should be enough to meet your needs and can be divided into shifts to better meet your needs.

...

Id. at 3 – 4.

7. Petitioner requested a plan appeal and received a Notice of Plan Appeal Resolution (“NPAR”) dated March 13, 2023, upholding the denial of an additional 12 hours of personal care services, weekly. *Id.* at 17 – 19. The NPAR explained as follows:

...

The reason for the decision was based on the information received. You have requested that the additional 12 hours of direct service worker (DSW) personal care service each week that was denied in your initial request be reconsidered (appeal).

You have several (multiple) medical problems. You do not have trouble making your needs known. You sometimes have trouble thinking clearly or remembering things. You live with [REDACTED] helps to care for you and is your direct service worker (DSW). You use a wheelchair to move around (chair/bedbound). You need some help [REDACTED]

The denial of 12 additional hours of direct service worker (PDO) personal care service each week is being upheld. The hours you are currently receiving should be enough to meet your medical needs and can be divided into shifts to better meet your needs.

This determination of the Medical Director has been made based on medical necessity (as defined by Florida law) and reflects the application of the plan’s approved review criteria and guidelines, defined in Chapter 59G-1.010 (2.83) Florida Administrative Code.

...

Id. at 17 – 18.

8. On March 22, 2023, Petitioner requested a Fair Hearing to challenge the denial of additional personal care services. On March 27, 2023, the undersigned issued an Order Scheduling Fair Hearing by Telephone and Prehearing Instructions, setting the hearing for April 25, 2023, at 1:00 p.m. EST.

9. At Fair Hearing, Petitioner testified to the following:

- a. Petitioner experiences much pain and spasms in [REDACTED] legs. Petitioner requested the additional hours because [REDACTED], provides [REDACTED] assistance. This assistance includes [REDACTED]
[REDACTED]. Bathing takes about one hour and 15 minutes. [REDACTED] takes Petitioner to all medical appointments.
- b. Petitioner would prefer two extra hours per day to cover Monday through Sunday.

10. At Fair Hearing, [REDACTED] testified to the following:

- a. [REDACTED] has been taking care of Petitioner since Petitioner broke [REDACTED] femur bone, which made [REDACTED] wheelchair bound.
- b. [REDACTED] daily care schedule for Petitioner is as follows: [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED] contends that four (4) personal care service hours daily are insufficient.
- c. When Petitioner is not feeling well due to [REDACTED] takes Petitioner to a walk-in clinic. [REDACTED]
[REDACTED]
annually.

11. At Fair Hearing, Dr. Gaddam established the following:

- a. Petitioner lives with [REDACTED] sister full time, who does not work outside of the home.

- b. Based on the 701B assessment, Humana considered Petitioner’s needs for assistance with [REDACTED] See RCE-1 at page 68. Petitioner currently has four (4) hours of home health services (three hours of personal care services and one hour of homemaker services, per day) which should be sufficient hours to meet her needs.

CONCLUSIONS OF LAW

12. 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).

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

14. Because Petitioner is requesting additional 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.)

15. 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 personal 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 Specific Criteria

Florida Medicaid LTC plans cover services that meet all of the following:

- Consistent with the type, amount, duration, frequency, and scope of services specified in an enrollee's authorized plan of care
- Provided in accordance with a goal in the enrollee's plan of care
- Intended to enable the enrollee to reside in the most appropriate and least.

...

4.2.2.6 Personal Care

In accordance with Rule 59G-4.215, F.A.C., for enrollees under the age of 21 years. To provide assistance with ADLs and IADLs, including assistance with preparation of meals, and housekeeping chores which are incidental to the care furnished or are essential to the health and welfare of the enrollee. The scope and nature of

these services do not otherwise differ from personal care services furnished to persons under the age of 21 years.

...

6.0 Documentation

...

6.2 Specific Criteria

In order to receive LTC services, services must be documented on an individualized plan of care based upon a comprehensive needs assessment. The comprehensive assessment includes the completion of the 701-B Comprehensive Assessment and the LTC Supplemental Assessment.

16. 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 her or her choice.

17. 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.

18. The Florida Medicaid Personal Care Services Coverage Policy (November 2016) (“Personal Care Policy”), incorporated by reference in Fla. Admin. Code R. 59G-4.215, governs personal care services available under Florida Medicaid. The PC Policy provides the following with respect to personal care services:

4.2 Specific Criteria

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

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

...

5.2 Specific Non-Covered Criteria

Florida Medicaid does not reimburse for the following:

- A skill level other than what is prescribed in the physician order and approved plan of care (POC)

- Assistance with homework
- Babysitting
- Care, grooming, or feeding of pets and animals
- Certification of the POC by a physician
- Companion sitting or leisure activities
- Escort services
- Housekeeping (except light housekeeping to make the environment safe), homemaker, and chore services
- Nursing assessments related to the POC
- Professional development training or supervision of home health staff or other home health personnel
- Respite care to facilitate the parent or legal guardian attending to personal matters
- Services funded under section 110 of the Rehabilitation Act of 1973 or under the provisions of the Individuals with Disabilities Educational Act
- Services furnished by relatives as defined in section 429.02(18), F.S., household members, or any person with custodial or legal responsibility for the recipient. (Except when a recipient is enrolled in the Consumer-Directed Care Plus program)
- Services provided in any of the following locations:
 - Hospitals
 - Intermediate care facility for individuals with intellectual disabilities
 - Nursing facilities
 - Prescribed pediatric extended care centers
 - Residential facilities or assisted living facilities when the services duplicate those provided by the facility
- Services rendered prior to the development and approval of the POC
- Travel time to or from the recipient’s place of residence
- Yard work, gardening, or home maintenance work

7.0 Authorization

7.1 General Criteria

The authorization information described below is applicable to the fee-for-service delivery system. For more information on general authorization requirements, please refer to Florida Medicaid’s General Policies on authorization requirements.

...

Personal Care Task	General Time Allowances
Bathing	
Full-body Bath: Tub, shower or sponge/bed bath.	Up to 30 minutes. May rotate with partial bath based on recipient’s needs
Partial Bath: A sponge bath includes, at a minimum, bathing of the face, hands, and	15–20 minutes per partial bath

perineum.	
Dressing	
Laying out clothing, handing and retrieving clothing, putting clothes on and taking them off, including handling fasteners, zippers, and buttons.	15 minutes
Application of prosthetic devices or application of therapeutic stockings.	May add 15 minutes for applying hose and/or Prosthesis
Grooming and Skin Care	
Brushing teeth, denture care, shaving, washing and drying face and hands. Applying lotion to non-broken skin.	15–30 minutes
Shampoo and comb hair, basic hair care, basic nail care.	15 minutes
Positioning	
Moving recipient to and from a lying position, turning side to side, and positioning recipient in bed.	10 minutes/every 2 hours when medically indicated
Transfers	
Moving recipient into and out of a bed, chair, or wheelchair. May include the use of assistive devices.	15 minutes/every 2 hours when medically indicated
Toileting and Maintaining Continence	
Includes transfer on or off the toilet, bedside commode, urinal, or bedpan. Includes cleaning the perineum and cleaning after an incontinent episode. Includes taking care of a catheter or colostomy bag or changing a disposable incontinence product.	15–45 minutes
Eating	
Taking in food by any method. Extra time may be allowed for preparing a special diet.	30 minutes per meal
Delegated Medical Monitoring and Activities	
Non-skilled medical tasks that are delegated to the aide by the RN, in accordance with Florida laws and practice acts. The tasks	15–30 minutes day for all monitoring tasks performed

include, but are not limited to, assisting recipient with pre-poured medications, monitoring vital signs, and measurement of intake/output.	
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PC Policy at pages 5 – 7, and 10.

19. Petitioner requested twelve (12) additional hours of personal care services, weekly. *See* ¶ 6. In the NABD, dated February 1, 2023, Respondent denied Petitioner’s request. *See* ¶ 6. Respondent cited to the medical necessity as the basis for their decision. However, Respondent did not specify which prong of medical necessity it used to makes its decision. *See* ¶ 6 – 7. Petitioner has the burden of proof to show by a preponderance of evidence that the Respondent’s determination was incorrect. *See* ¶ 14.

20. The LTC Policy states that Florida Medicaid LTC plans cover services that meet all of the following: (1) are determined medically necessary; (2) do not duplicate another service; and (3) meet the criteria specified in the policy. *See* ¶ 15.

21. Petitioner is currently approved to receive twenty-one (21) hours of personal care services and seven (7) hours of homemaker services, weekly. *See* ¶ 5. According to the LTC Policy, personal care services are used to provide medically necessary assistance with ADLs and IADLs, including assistance with preparation of meals, and housekeeping chores which are essential to the health and welfare of the enrollee. *See* ¶ 15.

22. Here, Petitioner did not establish that the additional twelve (12) hours of personal care services, weekly, were not in excess of Petitioner’s needs. The testimony and documents in the record show Petitioner requires assistance due to [REDACTED] medical conditions. *See* ¶ 2. Petitioner’s needs are demonstrated in the 701B dated January 25, 2023, which indicated for ADLs, Petitioner

requires assistance (but not total help) with [REDACTED]
[REDACTED]. See ¶ 3. Moreover, in regard to her IADLs, Petitioner needs total assistance (cannot do at all) for [REDACTED]
[REDACTED]. See ¶ 3. Petitioner needs assistance (but not total help) for [REDACTED]
[REDACTED]. See ¶ 3. [REDACTED] testified that [REDACTED] care schedule with Petitioner is from 7 a.m. to 8 p.m., daily. See ¶ 10. Petitioner testified that [REDACTED] requested the additional hours because [REDACTED], provides [REDACTED] ADLs and IADLs, in addition to taking [REDACTED] doctor visits. See ¶ 9. According to Dr. Gaddam's testimony, Humana took into consideration Petitioner's needs for assistance and determined that Petitioner's four (4) hours of home health services (three hours of personal care services and one hour of homemaker services), per day, should be sufficient hours to meet [REDACTED] needs. See ¶ 11. Petitioner did not introduce evidence to demonstrate any unmet needs in [REDACTED] ADLs or IADLs with the currently approved service hours. The record reflects that [REDACTED] does not work outside the home. See ¶ 4. The record does not contain any evidence to show how [REDACTED] is no longer able to provide adequate care for Petitioner.

23. Further, section 1.3.4 of the LTC Policy maintains that medically necessary services should not be "primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider." See ¶ 16. At Fair Hearing, Petitioner and [REDACTED] both testified that additional service hours were requested because [REDACTED] provides assistance to Petitioner and needs those hours to cover the daily schedule of care. See ¶ 9 – 10. Petitioner did not introduce evidence to demonstrate that the request was not for [REDACTED] own and [REDACTED]. As such, the undersigned finds that Petitioner has not met [REDACTED] burden.

24. Upon consideration of the testimony provided, evidence submitted, and applicable policies, the undersigned finds that Petitioner did not prove by a preponderance of the evidence that 12 additional personal care hours per week are not in excess of the Petitioner's needs and are not primarily intended for the convenience to the recipient, the recipient's caretaker, or the provider. Therefore, the record does not demonstrate that the requested additional personal care services are medically necessary. Accordingly, the undersigned finds that Petitioner has not proved by a preponderance of the evidence that Respondent's denial of the additional hours of personal care services was incorrect.

IT IS THEREFORE ORDERED AND ADJUDGED THAT:

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

DONE AND ORDERED this 28th day of June, 2023 in Tallahassee, Leon County, Florida.



Kimberly Roche
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KIMBERLY ROCHE, 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:

[REDACTED]
[REDACTED]
[REDACTED]

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