FILED

Jun 23, 2023, 11:54 am

OFFICE OF FAIR HEARINGS

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

PETITIONER, **AHCA Case No.: 23-FH0687**

vs.

HUMANA MEDICAL PLAN, INC.,

RESPONDENT.
________________________________/

FINAL ORDER

Pursuant to notice, the Office of Fair Hearings ("OFH") convened a telephonic Medicaid Fair Hearing in the above styled case on May 16, 2023, at 2:00 p.m. Eastern Standard Time ("EST").

APPEARANCES

For the Petitioner:
Petitioner'sAuthorized Representative

For the Respondent: Joshua Mitchell
Grievance and Appeals Fair Hearing Specialist
Humana Medical Plan, Inc.

STATEMENT OF ISSUE

The issue in this matter is whether Petitioner proved by a preponderance of the evidence that Respondent's denial of an additional fourteen (14) hours per week of personal care services was incorrect.

PRELIMINARY STATEMENT

All parties and witnesses appeared telephonically. [redacted] ("Petitioner's Authorized Representative") appeared at the hearing, submitted proposed evidence, and provided testimony on the Petitioner's behalf.

Joshua Mitchell ("Mr. Mitchell"), Grievance and Appeals Fair Hearing Specialist for Humana Medical Plan, Inc. ("Humana"), appeared for the hearing and represented the Respondent. Dr. Wayne Sherman ("Dr. Sherman"), Long Term Care Medical Director for Humana, provided testimony on behalf of the Respondent.

Sandra Durden, ("Ms. Durden"), Medical Healthcare Program Analyst & Fair Hearing Liaison for the Agency for Health Care Administration ("Agency" or "AHCA"), appeared for observational purposes.

Prior to the hearing, Petitioner submitted two (2) proposed exhibits that were admitted into evidence without objection, are identified as "Petitioner's Exhibit 1" (1 page) recorded in the OFH document management system as "23-FH0687 Doctor Progress Notes.pdf", and "Petitioner's Exhibit 2" (5 pages) recorded in the OFH document management system as files "23-FH0687 Evidence.pdf".

Prior to the hearing, Respondent sent to the Office of Fair Hearings and Petitioner a two hundred and seventy (270) page evidence packet that was admitted into evidence without objection, is recorded in the OFH document management system and designated as "Evidence Packet_230FH0687_Part 1.pdf" and "Evidence Packet_230FH0687_Part 2.pdf", and is identified herein as "Respondent's Composite Exhibit 1".

FINDINGS OF FACT

1. Petitioner is an enrolled member of Humana's LTC plan. *See* Respondent's Composite Exhibit 1, page 1. Humana is a managed care organization contracted by AHCA to provide services to eligible Medicaid recipients in Florida.

2. As of the time of the hearing, Petitioner was an who lives in a private home with , who serves as the primary caregiver. *See* Respondent's Composite Exhibit 1, page 33.

3. The Petitioner has the following conditions: *See* Respondent's Composite Exhibit 1, page 35.

4. The LTSS Comprehensive Assessment, dated May 1, 2023, (LTSS Comprehensive Assessment") which is the most recent needs assessment on the record, reflects the Petitioner requires maximum assistance with all the Activities of Daily Living ("ADLs"), which include . *See* Respondent's Composite Exhibit 1, page 36. In addition, the Petitioner uses the following assistance devices: . *See* Respondent's Composite Exhibit 1, page 67.

5. Regarding his Instrumental Activities of Daily Living ("IADLs"), the LTSS Comprehensive Assessment reflects that Petitioner needs total assistance with all IADLs, which *See* Respondent's Composite Exhibit 1, page 37.

6. Petitioner is currently authorized to receive the following home and community-based services: thirty (30) hours per week of personal care services; fourteen (14) hours per week of homemaker services; three (3) hours of adult companion care services; and incontinence supplies *See* Respondent's Composite Exhibit 1, page 75.

7. On January 13, 2023, Respondent issued a "Notice of Adverse Benefit Determination ("NABD") denying an additional fourteen (14) hours per week of personal care services. *See* Respondent's Composite Exhibit 1, pages 7-14. The NABD stated the reason for Respondent's determination as follows:

> We determined that your requested services are **not medically necessary** because the services do not meet either of the reason(s) 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 used to make this determination are as follows:
>
> 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 14 hours of homemaker service each week; 30 hours of personal care service each week; and 3 hours of Adult Companion Care each week. You have requested an additional 14 hours of personal care service each week.
>
> You have [redacted]
>
> [redacted]).
>
> You live with [redacted] helps care for you. [redacted] does not work outside of the home. You use [redacted]).
>
> You have 6 hours of home health aide services daily to meet your needs. Your request for 14 hours of personal Care 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.

Respondent's Composite Exhibit 1, pages 7-14.

8. Petitioner requested an appeal of Respondent's denial. *See* Respondent's Composite Exhibit 1, page 16. On March 23, 2023, Respondent sent Petitioner a Notice of Plan Appeal Resolution ("NPAR"), denying Petitioner's plan appeal. *Id.* at 16-18. The NPAR stated as follows:

> On February 24, 2023, we received your timely plan appeal request regarding Humana Healthy Horizons Long-Term Care Plan's Notice of Adverse Benefit Determination dated January 13, 2023, authorization 167024169 denying the additional personal care hours provided to [Petitioner].
>
> On March 23, 2023, after consideration of the information you provided to Humana Long-Term Care Plan in support of your plan appeal, was reviewed by a medical director who is a MD and board certified in Family Medicine hereby denies your plan appeal.

The reason for the decision was based on information received. You are appealing the denial of the requested additional 14 hours of personal care (PC) services per week. [Petitioner] currently receives 14 hours of homemaker (HMK), 30 hours of PC, and 3 hours of adult companion care (ACC) services per week.

He lives with is alert and oriented to person but not to place or time. also hallucinates per report. currently receives 30 hours of PC for total of 47 hours of home health aide per week. does not have any significant changes in overall condition. You provide care for and are requesting additional hours. The current hours are sufficient for needs, and you can request for respite care hours if needed to avoid caregiver burn out. We are upholding the decision of the medical director and denying your appeal.

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.

See Respondent's Composite Exhibit 1, pages 16-18.

9. The Petitioner requested a Fair Hearing due to the denial of an additional fourteen (14) hours per week of personal care services. The undersigned scheduled the Fair Hearing for May 16, 2023, at 2:00 p.m., and all parties were duly notified.

10. During the Fair Hearing, the Petitioner's Authorized Representative argued that the Petitioner requires twenty-four (24) hours per day care and that needs help caring for further testified that is not currently working but is scheduled to start a part-time job. In addition, the Petitioner's Authorized Representative testified passed away eleven (11) months ago and that overwhelmed trying to care for [1]

11. Dr. Sherman is the Long-Term Care Medical Director for Humana. Dr. Sherman testified that the Petitioner already receives forty-seven (47) hours per week of home health services,

[1] The Petitioner's Authorized Representative compared the home health hours her father receives to the home health hours her mother previously received. This proceeding is specifically limited to the care of the Petitioner and any care of her mother is not relevant to this proceeding.

including thirty (30) hours of personal care services per week, fourteen (14) hours of homemaker services per week, and three (3) hours of adult companion care services per week, and that those hours are sufficient to care for the Petitioner. Dr. Sherman further testified that the requested additional fourteen (14) hours do not address any specific unmet need to perform ADLs and IADLs are not medically necessary for the care of the Petitioner.

12. A February 20, 2023, letter from Dr. David Eschelbacker, M.D., requests that the Petitioner be "assessed" for additional home healthcare hours and that the family is requesting an increase from fifty-five (55) to seventy (70) hours per week. *See* Petitioner's Exhibit 2.

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 Fla. Stat. § 409.285(2). This order is the final administrative decision of AHCA under Fla. Stat. § 409.285(2)(a).

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

15. The burden of proof in this proceeding is governed by Fla. Admin. Code R. 59G-1.100(17)(g), which provides as follows:

> The burden of proof is on the party asserting the affirmative of an issue, except as otherwise required by statute. The burden of proof is on the Agency or plan, whichever is applicable, when the issue presented is the suspension, reduction, or termination of a previously authorized service. The burden of proof is on the recipient or enrollee when the issue presented is the denial or a limited authorization of a service. The party with the burden of proof shall establish its position to the satisfaction of the Hearing Officer by a preponderance of the evidence.

16. Because Petitioner is requesting additional services, Fla. Admin. Code R. 59G-1.100(17)(g) assigns the burden of proof to the 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.).

17. The Florida Medicaid policy that applies to the requested services is the Florida Medicaid Statewide Medicaid Managed Care Long-term Care Program Coverage Policy (March 2017) (“SMMC LTC Policy”). The Agency’s SMMC LTC Policy has been incorporated, by reference, into Florida Administrative Code Rule 59G-4.192. The SMMC LTC Policy provides as follows:

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 Definitions

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

1.3.1 Activities of Daily Living (ADLs)

ADLs include:

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

. . .

1.3.5 701-B Comprehensive Assessment

An individualized, complete assessment of an individual’s medical, developmental, behavioral, social, financial, and environmental status. The assessment is conducted by a trained individual employed by the Department of Elder Affairs Comprehensive Assessment and Review for Long-Term Care Services (CARES) program or the LTC plan, to determine eligibility for the LTC program based on the need for a nursing facility level of care.

. . .

1.3.9 Instrumental Activities of Daily Living (IADLs)

When necessary for the recipient to function independently, including:

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

. . .

1.3.14 Medically Necessary or Medical Necessity

For the purposes of this policy, the service must meet either of the following criteria:

(a) Nursing facility services and mixed services must meet the medical necessity criteria defined in Rule 59G-1.010, F.A.C.

(b) All other LTC supportive services must meet all of the following:

- Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient’s needs
- Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available statewide
- Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider

And, one of the following:

- Enable the enrollee to maintain or regain functional capacity; or
- Enable the enrollee to have access to the benefits of community living, to achieve person-centered goals, and to live and work in the setting of his or her choice.

. . .

2.2 Who Can Receive

Florida Medicaid recipients requiring medically necessary LTC services who are enrolled in a LTC plan and have a nursing facility level of care determined by the CARES program. Some services may be subject to additional coverage criteria as specified in section 4.0.

. . .

4.0 Coverage Information

4.1 General Criteria

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

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

4.2 Specific Criteria

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

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

. . .

4.2.1 Home and Community-Based Supportive Services

The LTC program benefit includes coverage of the following home and community-based supportive services:

. . .

4.2.1.9 Homemaker Services

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

. . .

4.2.1.14 Personal Emergency Response Systems

For installation and service monitoring of an electronic device connected to an enrollee's phone that includes a portable "help" button, when provided to an enrollee at high risk of institutionalization to secure help in an emergency.

. . .

4.2.2 Mixed Services

Mixed services may exceed State Plan limits on those services in accordance with this policy. The Long-term Care benefit includes coverage of the following mixed services:

. . .

4.2.2.6 Personal Care

In accordance with Rule 59G-4.215, F.A.C., for enrollees under the age of 21 years. To provide assistance with ADLs and IADLs, including assistance with preparation of meals, and housekeeping chores which are incidental to the care furnished or are essential to the health and welfare of the enrollee. The scope and nature of these services do not otherwise differ from personal care services furnished to persons under the age of 21 years.

. . .

> **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.

SMMC LTC Policy, pages 1-8.

18. The Florida Medicaid Definitions Policy (August 2017) ("Definitions Policy"), which is incorporated by reference in Fla. Admin. Code R. 59G-1.010, defines "medical necessity" as follows:

> **2.83 Medically Necessary or Medical Necessity**
> The medical or allied care, goods, or services furnished or ordered must meet the following conditions:
>
> - Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe 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; and
> - 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.

Definitions Policy, page 7.

19. The Agency's Florida Medicaid Personal Care Services Coverage Policy, (November 2016) ("PC Policy") has been incorporated, by reference, into Fla. Admin. Code R. 59G-4.215. The PC Policy provides as follows:

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.

. . .

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.

. . .

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; and
- 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; and
- Requires services that can be safely provided in their home or the community.

. . .

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 recipient's place of residence
- Yard work, gardening, or home maintenance work

Florida Medicaid may reimburse for some services listed in this section through a different service benefit.

. . .

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 perineum.	15–20 minutes per partial bath
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 include, but are not limited to, assisting recipient with pre-poured medications, monitoring vital signs, and measurement of intake/output.	15–30 minutes day for all monitoring tasks performed

PC Policy, pages 3 – 8, and 10.

20. In the instant case, Respondent denied an additional fourteen (14) hours per week of personal care services. *See* supra ¶ 7 and 8. As established on the record by the evidence and testimony, Respondent denied Petitioner's request, because the Petitioner's request failed to establish that the requested services were medically necessary. *Id*.

21. Section 4.1 of the SMMC LTC Policy provides that Florida Medicaid LTC plans cover services that: (a) are determined medically necessary, as defined in the SMMC LTC Policy; (b) do not duplicate another service; and (c) meet the criteria as specified in the SMMC LTC Policy. *See* supra ¶ 17.

22. The evidence presented in this case does not reflect that the Petitioner needs an additional fourteen (14) hours per week of personal care services. Specifically, Petitioner resides in the home with [redacted]. *See* supra ¶ 2. The Petitioner requires

maximum assistance with the ADLs and IADLs and has six (6) hours of home health services Monday through Friday and seven (7) hours of home health services on Saturday and Sunday. *See* Respondent's Composite Exhibit 1, pages 62 and 63. At the time of the hearing, the Petitioner's primary caregiver did not work outside the home but testified [redacted] was scheduled to start a part-time job the following week.

23. Section 1.3.14 of the SMMC LTC Policy mandates that the requested services must "[b]e 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." *See* supra ¶ 17. Petitioner's currently authorized personal care services are "[t]o 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." *See* supra ¶ 19. Although the PC Policy provides guidance for general allowances for ADLs, *supra* ¶ 19, Petitioner provided no time estimates for each ADL to explain the amount of time Petitioner requires for his ADLs. Further, Petitioner failed to explain how the requested additional hours personal care services would be utilized to meet Petitioner's needs if approved in this matter. Petitioner's currently authorized homemaker services are "[t]he provision of general household activities (such as meal preparation) and routine household care by a trained homemaker." *See* supra ¶ 17. Given the fact that Petitioner already has personal care services to assist with [redacted] ADLs and homemaker services to assist with [redacted] IADLs, Petitioner's Authorized Representative has not established that the currently authorized services are insufficient to meet the Petitioner's needs.

24. Considering the totality of Petitioner's circumstances, including [redacted] medical condition

and diagnoses, level of need for ADLs and IADLs, and the amount of currently approved services, Petitioner failed to prove by a preponderance of the evidence that an additional fourteen (14) hours per week of personal care services are not "in excess of [Petitioner's] needs." *See* supra ¶ 17 and 19.

25. The letter from Dr. David Eschelbacher, MD, requests an assessment of the Petitioner for additional home healthcare hours. *See* supra ¶ 12. However, Section 2.83 of the Definitions Policy mandates that "[t]he 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." *See* supra ¶ 18. Therefore, the letter from Dr. Eschelbacher does prescribe anything other than an assessment which was performed, does not call for additional hours of home health services, does not identify any unmet needs relating to ADLs and IADLs, and does not, *in itself*, make the requested fourteen (14) additional hours per week of personal care services medically necessary.

26. In light of the testimony and evidence, the SMMC LTC Policy, the PC Policy, and the Definitions Policy, the undersigned Hearing Officer finds that Petitioner failed to meet burden of proving that an additional fourteen (14) hours per week of personal care services are medically necessary and not merely as a convenience for the primary caregiver. Accordingly, the undersigned Hearing Officer concludes that Petitioner failed to prove by a preponderance of the evidence that Respondent's denial of the requested additional personal care services was incorrect.

DECISION

Respondent's denial of an additional fourteen (14) hours per week of personal care service is **AFFIRMED**.

Petitioner's appeal based on Respondent's denial in this matter is **DENIED.**

DONE AND ORDERED this 23rd day of June, 2023, in Tallahassee, Leon County, Florida.

Alan J. Leifer
23-FH0687
2023.06.23
10:29:59 -04'00'

ALAN LEIFER, 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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