

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



FILED

Jul 24, 2023, 11:44 am
OFFICE OF FAIR HEARINGS

[REDACTED]

PETITIONER,

vs.

AHCA Case No.: 23-FH0905

[REDACTED]

HUMANA MEDICAL PLAN, INC.,

RESPONDENT.

_____ /

[REDACTED]

PETITIONER,

vs.

AHCA Case No.: 23-FH0912

[REDACTED]

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 consolidated case on May 18, 2023, at 10:00 a.m. Eastern Standard Time (“EST”).

APPEARANCES

For the Petitioner:

[REDACTED]

Authorized Representative

For the Respondent:

Markeshi Lee
Appeals and Fair Hearing Specialist
Humana Medical Plan, Inc.

STATEMENT OF ISSUES

The first issue in this matter is whether Petitioner proved by a preponderance of the evidence that Respondent's denial of an additional twenty-eight (28) hours per week of personal care services (Case No. 23-FH0905) was incorrect.

The second 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 homemaker per week (Case No. 23-FH0912) was incorrect.

PRELIMINARY STATEMENT

All parties and witnesses appeared telephonically. [REDACTED]), the Petitioner's [REDACTED] and designated Authorized Representative appeared and testified on behalf of the Petitioner.

Markeshi Lee, Humana Medical Plan, Inc., ("Humana"), Appeals and Fair Hearing Specialist appeared at the hearing and represented Respondent. Dr. Srujan Gaddam, Humana Medical Director ("Dr. Gaddam"), provided testimony on behalf of the Respondent.

Maria Lisa Amador, Medical Healthcare Program Analyst for the Agency for Health Care Administration ("Agency" or "AHCA"), appeared for observational purposes.

Prior to the hearing, Petitioner submitted a sixty-eight (68)-page evidence package that was admitted into evidence without objection, is pre-marked by the Petitioner and identified herein as Petitioner's Exhibits A through S, and is recorded in the OFH document management system as "23-FH0905, 23-FH0912 E-mailed Evidence Exhibit A-D.pdf"; "23-FH0905, 23-FH0912 E-mailed Evidence Exhibit E-N.pdf"; and "23-FH0905, 23-FH0912 E-mailed Evidence Exhibit O-S.pdf".

Prior to the hearing, Respondent sent to the Office of Fair Hearings and Petitioner a three hundred and thirty-five (335)-page evidence packet that was admitted into evidence without objection, is identified herein as “Respondent’s Composite Exhibit 1”, and is recorded in the OFH document management system as follows: “Evidence Packet_Part 1.pdf”; “Evidence Packet_Part 2.pdf”; “Evidence Packet_Part 3.pdf”; “Evidence Packet_Part 4.pdf”; and “Evidence Packet_Part 5.pdf”.

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 is an [REDACTED] and lives alone. See Respondent’s Composite Exhibit 1, page 101. The Petitioner’s [REDACTED] and Authorized Representative lives close by and works full-time for ten (10) hours per day, six (6) days per week. Respondent’s Composite Exhibit 1, page 138 and [REDACTED] testimony. The Authorized Representative testified [REDACTED] twice per week.

3. Petitioner has the following health conditions: [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED] See Respondent’s Composite Exhibit 1, pages 90 and 129. In addition, the Petitioner has a history of falling during the past twelve (12) months. See Respondent’s Composite Exhibit 1, page 128. Finally, the Authorized Representative stated that [REDACTED]

can be left alone for up to four (4) hours per day. See Respondent's Composite Exhibit 1, page 138.

4. The Florida Department of Elder Affairs 701B Comprehensive Assessment, dated April 12, 2023, which is the most recent 701B on the record (the "4/12/23 701B"), reflects the following regarding Petitioner's Activities of Daily Living ("ADLs"). Petitioner needs some assistance (but not total help) with [REDACTED]. See Respondent's Composite Exhibit 1, page 87. Petitioner needs supervision and prompts with [REDACTED] *Id.* In addition, the Petitioner uses assistive devices for [REDACTED] *Id.* Finally, the 701B Assessment states that the Petitioner always has assistance with performing [REDACTED] ADLs. *Id.*

5. Regarding Petitioner's Instrumental Activities of Daily Living ("IADLs"), the 4/12/23 701B reflects that Petitioner needs supervision and prompts with [REDACTED]. See Respondent's Composite Exhibit 1, page 88. Petitioner needs total assistance (cannot do at all) with all the remaining IADLs, including [REDACTED] [REDACTED]. See Respondent's Composite Exhibit 1, pages 88. In addition, the 4/12/23 Assessment reflects the Petitioner always has assistance in performing [REDACTED] IADLs. *Id.*

6. Petitioner is currently authorized to receive the following home and community-based services from the Respondent: twenty-eight (28) hours of personal care services per week and fourteen (14) hours of homemaker services per week. See Respondent's Composite Exhibit 1, page 123.

7. On January 13, 2023, the Petitioner requested an additional twenty-eight (28) hours of personal care services (Case Number 23-FH0905) and an additional fourteen (14) hours of homemaker services per week (Case Number 23-FH0912). See Respondent’s Composite Exhibit 1, pages 12-19 and 20-27. On January 19, 2023, the Respondent issued a Notice of Adverse Benefit Determination (“NABD”) in Case Numbers 23-FH0905 denying the requested twenty-eight (28) hours of additional personal care hours per week and in Case Number 23-FH0912 denying the requested fourteen (14) hours of additional hours of homemaker hours per week.

Id. The January 19, 2023, NABDs 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 criteria as defined in Rule 59G-1.010(166), F.A.C., for all nursing facility services and mixed services; OR

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:

- 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; and
- 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.

✓Other authority

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 14 hours of homemaker service each week; 28 hours of personal care service each week. You have requested an additional 14 hours of homemaker service each week; an additional 28 hours of personal care service each week.

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

[REDACTED] You do not leave your home without someone (wandering). You have not had any recent changes in your health. You have not recently been in the hospital.

You live alone. Your [REDACTED] helps care for you. Your [REDACTED] works outside of the home. You use a motorized scooter to move around (walk). You [REDACTED]
[REDACTED]
[REDACTED]

You also receive hospice care services. You have 6 hours of home health aide services daily to meet your needs.

Your request for an additional 14 hours of homemaker service each week; an additional 28 hours of personal care service 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. (Emphasis added.)

8. Petitioner timely requested an appeal of Respondent’s denial of an additional twenty-eight (28) hours of personal care services in Case Number 23-FH0905. See Respondent’s Composite Exhibit 1, pages 29-31. On February 3, 2023, the Respondent sent the Petitioner a

Notice of Plan Appeal Resolution (“NPAR”) letter in Case Number 23-FH0905 upholding the denial of twenty-eight (28) additional hours of personal care services per week and stated as follows:

The reason for the decision was based on the information received. You are appealing the denial of the requested 28 hours PC services per week.

[Petitioner] currently receives 14 hours of Homemaker (HMK) and 28 hours of PC services per week. [Petitioner] lives alone and [REDACTED] helps to take care of [REDACTED] [Petitioner] has multiple medical problems. [Petitioner] did not have any recent change and are not admitted to the hospital to show any change in [REDACTED] clinical condition. We have reviewed [Petitioner’s] documents and assessed [REDACTED] needs.

The current services that [Petitioner] receives are sufficient for [REDACTED] needs. 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.

Id.

9. Petitioner timely requested an appeal of Respondent’s denial of an additional fourteen (14) hours of homemaker services in Case Number 23-FH0912. *See* Respondent’s Composite Exhibit 1, pages 32-38. On February 2, 2023, Respondent sent Petitioner Notice of Plan Appeal Resolution letter (“NPAR”) in Case Number 23-FH0912, upholding the denial of fourteen (14) additional hours of homemaker services. *Id.* The NPAR in Case Number 23-FH0912 stated as follows:

The reason for the decision was based on the information received. You are appealing a decision made in authorization 167416634 in which a request was made for the addition of 14 hours weekly of Homemaker services and the request was denied. [Petitioner] currently has 14 hours of Homemaker service each week; 28 hours of Personal Care (PC) service each week. [Petitioner] has [REDACTED]

[REDACTED]

[REDACTED]. [Petitioner] has 6 hours of home health aide services daily to meet [REDACTED] needs. Your request for an additional 14 hours of Homemaker service each week is being denied as not medically necessary. The hours [Petitioner] is receiving should be enough to meet [REDACTED] needs and can be divided into shifts to better meet [REDACTED] needs.

This determination of the Medical Director has been made based on medical necessity 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. (Emphasis added.)

10. Petitioner requested a Fair Hearing due to the denial of an additional fourteen (14) hours per week of homemaker services and twenty-eight (28) hours per week of personal care services. On April 27, 2023, the undersigned hearing officer scheduled a Fair Hearing for May 18, 2023, at 10:00 a.m. EST.

11. During the Fair Hearing, the Authorized Representative testified that contrary to the assertions of the Respondent, [REDACTED] condition continues to decline. The Authorized Representative testified [REDACTED] is completely dependent on assistants for [REDACTED]

[REDACTED]

[REDACTED] The Authorized Representative testified the additional hours of personal care and homemaker services were requested to [REDACTED] to live comfortably in [REDACTED] own home and not in a nursing facility.

12. Dr. Gaddam testified for Humana and stated that it is the position of Humana that the already approved home health care hours, including the personal care hours and the homemaker hours are sufficient to meet the Petitioner's needs, based on the current April 24, 2023, Form 701B and that the additional requested hours are not medically necessary.

13. Dr. Mitchell Weinstein, M.D., a physician who has cared for the Petitioner since 2019, submitted a March 1, 2023, letter stating it was medically necessary that the Petitioner receive "... additional hours of home care." See Petitioner's Exhibit P. In addition, Dr. Gokan Guvoneli, M.D., another physician caring for the Petitioner, submitted a May 8, 2023, letter requesting an additional twenty-eight (28) hours of personal care services and fourteen (14) hours of homemaker services. See Petitioner's Exhibit O. In addition, Dr. Guvoneli stated that "[I]t is clear that to keep [Petitioner] comfortable with dignity, the more personal services provided to [REDACTED] in [REDACTED] home environment would provide [REDACTED] with quality of life at end of life." *Id.*

14. In addition to the services provided by the Respondent, the Petitioner has been enrolled for hospice services with Vitas Healthcare ("Vitas") continuously since September 1, 2020, and the evidence reflects the Petitioner receives forty-two (42) hours of services per week. See Petitioner's Exhibit Q and Respondent's Composite Exhibit 1, page 76. The Authorized Representative testified that Vitas visits [REDACTED] seven (7) days per week in a single shift. There is no evidence in this matter regarding the nature and frequency of services provided by Vitas, or whether the Petitioner seeks or has sought additional services from Vitas to make [REDACTED] more comfortable and allow [REDACTED] to live alone in [REDACTED] home. On January 13, 2023, Dr. Stuart Bernstein, M.D. recertified the Petitioner's eligibility for Vitas Hospice. See Respondent's Composite Exhibit 1, pages 75 – 78.

CONCLUSIONS OF LAW

15. 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).

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

17. 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.

18. 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.).

19. 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.

...

1.3.16 Natural Supports Unpaid supports that are provided voluntarily to the individual in lieu of home and community-based services and supports.

...

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.

4.2.1.15 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. (Emphasis added.)

...

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.

20. 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
- 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.

21. 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
- 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

...

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.

22. The Florida Statute governing hospice home care states in-part as follows:

(1)(b) Each hospice must also provide or arrange for such additional services as are needed to meet the palliative and support needs of the patient and family. These services may include, but are not limited to, physical therapy, occupational therapy, speech therapy, massage therapy, **home health aide services**, infusion therapy, provision of medical supplies and durable medical equipment, day care, **homemaker and chore services**, and funeral services.

(2) HOSPICE HOME CARE.—Hospice care and services provided in a private home shall be the primary form of care. The goal of hospice home care shall be to provide adequate training and support to encourage self-sufficiency and allow patients and families to maintain the patient comfortably at home for as long as possible. The services of the hospice home care program shall be of the highest quality and shall be provided by the hospice care team.

Section 400.609, Florida Statutes (1999). (**Emphasis added.**)

23. Pursuant to 42 C.F.R. § 409.45(b)(1)(i), home health aide services may include, but are not limited to:

Personal care services such as bathing, dressing, grooming, caring for hair, nail and oral hygiene that are needed to facilitate treatment or to prevent deterioration of the beneficiary's health, changing the bed linens of an incontinent beneficiary, shaving, deodorant application, skin care with lotions and/or powder, foot care, ear care, feeding, assistance with elimination (including enemas unless the skills

of a licensed nurse are required due to the beneficiary's condition, routine catheter care, and routine colostomy care), assistance with ambulation, changing position in bed, and assistance with transfers.

24. Fla. Admin. Code R. 59G-1.052(2) requires third-party resources to meet their legal obligations to pay claims before the Florida Medicaid program pays for a member's health care services. Providers must exhaust all third-party sources of payment, such as, Medicare, TRICARE, private health insurance, AARP plans, or automobile coverage prior to submitting or resubmitting a claim for reimbursement to Florida Medicaid. *Id.* at (6)(a). Florida Medicaid is the payer of last resort. *Id.* Providers may not refuse to furnish a covered Florida Medicaid service to a recipient solely because of the presence of other insurance, including Medicare, in accordance with 42 C.F.R. 447.20(b). *Id.* at (7).

Homemaker Services

25. In the instant case, Respondent denied an additional fourteen (14) additional hours of homemaker services. *See supra* ¶¶ 7 and 9. As established on the record by the evidence and testimony, Respondent denied Petitioner's request, because the Petitioner request failed to establish that the requested homemaker services were medically necessary. *Id.*

26. 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* ¶ 20. Section 4.2.1.9 of the SMMC LTC Policy defines homemaker services as 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." *See supra* ¶ 19. In

addition, Section 400.609(1)(b), Florida Statutes (1999) mandates that hospice care must also include “homemaker and chore services”.

27. The evidence presented in this case does not reflect that Petitioner needs an additional fourteen (14) hours per week of homemaker services. Regarding IADLs, which most closely align with the definition of homemaker services, Petitioner needs total assistance (cannot do at all) with the following IADLs including: [REDACTED]

[REDACTED] See supra ¶ 5. The record reflects that the Petitioner always has assistance in completing [REDACTED] IADL’s. *Id.* Petitioner currently has fourteen (14) hours of homemaker services per week for homemaker needs plus has forty-two (42) hours per week of home based assistance services that under Florida Statutes must also include homemaker services. The Authorized Representative has not presented evidence demonstrating unmet needs regarding the performance of IADLs, and in-fact the testimony and evidence presented at the hearing by the Authorized Representative reflects the assistance that is required by the Petitioner is addressed to the ADLs, such as [REDACTED] which more closely align with the definition of personal care services

28. 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 ¶ 20. Here, Petitioner is currently authorized to receive the following home and community-based services: twenty-eight (28) hours of personal care services per week, fourteen (14) hours of homemaker services per week, plus forty-two (42) hours of home based hospice services. See supra ¶ ¶ 6 and 14.

29. The record does not establish by a preponderance of the evidence that there are unmet homemaker needs, what homemaker services would no longer be performed if the requested services are not authorized, specifically how the requested additional services would be utilized, or that Petitioner's currently authorized home healthcare hours are insufficient to meet [REDACTED] homemaker needs.

30. Despite the aforementioned statutes, regulations, and policies, there is no evidence of record as to whether there was a request to Vitas to provide homemaker services or whether Vitas declined to provide the level and frequency of homemaker services. *See supra* ¶ 14. However, Vitas is responsible for the provision of homemaker services as required by federal and state law and regulation, and Medicaid shall be considered the payor of last resort when no other sources are available to pay for the rendition of services. *See supra* ¶¶ 22, 23 and 24.

31. Considering the totality of Petitioner's circumstances, including [REDACTED] medical condition and diagnoses, level of need for ADLs and IADLs, natural support, and the amount of currently approved services by Medicaid and Vitas hospice, the Petitioner has failed to prove beyond a preponderance of the evidence that an additional fourteen (14) hours per week of homemaker services in addition to the already approved fourteen (14) hours of homemaker services and forty-two (42) hours of home based hospice services are not "in excess of [Petitioner's] needs" and not duplicative of another service. *See supra* ¶¶ 19, 20, 21, 22, 23 and 24.

32. In light of the testimony and evidence in this matter, the definition of "medically necessary", the personal service Coverage Policy, and the SMMC LTC Policy, the undersigned Hearing Officer finds that the Petitioner failed to prove by a preponderance of the evidence that an additional fourteen (14) hours of homemaker services are medically necessary.

Personal Care Services

33. In the instant case, Respondent denied an additional twenty-eight (28) 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 request failed to establish that the requested services were medically necessary. *Id.* However, Respondent did not specify which medical necessity criterion was not met. Based upon Dr. Gaddam’s testimony and the NPAR, the Respondent denied the requested personal care services on the basis that they are not “medically necessary” and are “in excess of the patient’s needs.” *See supra* ¶¶ 7, 8 and 21.

34. 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* ¶ 19.

35. The evidence presented in this case does reflect that the Petitioner needs an additional twenty-eight (28) additional hours of personal care services. Regarding ADLs, Petitioner needs total assistance (cannot do at all) with [REDACTED]. *See supra* ¶ 4. In addition, the Petitioner uses assistive devices [REDACTED]. *Id.* The evidence does reflect that the Petitioner can be left alone for up to four (4) hours per day. *See supra* ¶ 3.

36. Section 1.3.14 of the SMMC LTC Policy and section 2.83 of the Definitions Policy mandates that the requested personal care 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 ¶ 19 and 20. Further Section 4.1 of the SMMC LTC Policy and the Personal Care Coverage Policy provide that services cannot duplicate services that are already provided. See supra ¶ 19 and 21. Here, Petitioner is currently authorized to receive a total of forty-two (42) hours per week of the following combined Medicaid home and community-based services, including twenty-eight (28) hours of personal care services per week and fourteen (14) hours of homemaker services per week, plus forty-two (42) hours of home hospice services per week, for a total of eighty-four (84) hours per week. See supra ¶ ¶ 6 and 14.

37. Petitioner's currently authorized Medicaid 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. The Petitioner herein requires total (maximum) assistance with all the ADLs and IADLs, with the exception of eating and using the phone, which both require some assistance or prompts and supervision. See supra ¶ 4 and 5. Other than the testimony of the Authorized Representative, the record in this matter clearly demonstrates no specific unmet needs for ADLs and IADLs.

38. Considering the totality of Petitioner's circumstances, including [REDACTED] medical condition and diagnoses, level of need for ADLs and IADLs, the amount of currently approved services, and the Petitioner's physician recommending a total of forty (40) hours of home healthcare, and the elevated risk for falls due to a newly diagnosed brain tumor, the Petitioner has proved beyond a preponderance of the evidence that an additional thirteen (13) hours per week of personal care services are not "in excess of [Petitioner's] needs." See supra ¶ 15, 21 and 22.

39. Despite the aforementioned statutes, regulations, and policies, there is no evidence of record as to whether there was a request to Vitas to provide personal care services or whether Vitas declined to provide the level and frequency of personal care services. *See supra* ¶ 14. However, Vitas is responsible for the provision of personal care services as required by federal and state law and regulation, and Medicaid shall be considered the payor of last resort when no other sources are available to pay for the rendition of services. *See supra* ¶¶ 22, 23 and 24.

40. In light of the both parties' testimony, Respondent's Composite Exhibit 1, the SMMC LTC Policy, the Authorization Requirements Policy, the PC Policy, the Definitions Policy, the provisions that Medicaid be the "payor of last resort", and the Petitioner's receipt of forty-two hours of home based hospice services, the undersigned Hearing Officer finds that Petitioner failed to meet burden of proving that the additional twenty-eight (28) hours per week of personal care services are not in excess of the Plaintiff's needs or duplicative of the services provided by hospice.

DECISION

Respondent's denial of an additional twenty-eight (28) hours of personal care services per week (Case No. 23-FH0905) is **AFFIRMED**. Petitioner's appeal based on Respondent's denial is **DENIED**.

Respondent's denial of an additional fourteen (14) hours per week of homemaker services (Case No. 23-FH0912) is **AFFIRMED**. Petitioner's appeal based on Respondent's denial is **DENIED**.

DONE AND ORDERED this 24th day of July, 2023, in Tallahassee, Leon County, Florida.

Alan J. Leifer

23-FH0905 & 23-

Alan J. Leifer

FH0912

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ALAN J. 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.

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