



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

FILED

Jul 24, 2023, 12:09 pm
OFFICE OF FAIR HEARINGS

[REDACTED]

PETITIONER,

AHCA Case No.: 23-FH0965

[REDACTED]

vs.

HUMANA MEDICAL PLAN, INC.,

RESPONDENT.

_____ /

[REDACTED]

PETITIONER,

AHCA Case No.: 23-FH0969

[REDACTED]

vs.

HUMANA MEDICAL PLAN, INC.,

RESPONDENT.

_____ /

[REDACTED]

PETITIONER,

AHCA Case No.: 23-FH0970

[REDACTED]

vs.

HUMANA MEDICAL PLAN, INC.,

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the Office of Fair Hearings convened a telephonic Medicaid Fair Hearing in the above styled case on May 25, 2023, at 1:00 p.m. and June 1, 2023, at 9:00 a.m. Eastern Standard Time (“EST”).

APPEARANCES

For the Petitioner: [REDACTED]
Petitioner’s Authorized Representative

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

STATEMENT OF ISSUE

The first issue is whether Petitioner proved by a preponderance of the evidence that Respondent’s denial of ten (10) hours per week of homemaker services was incorrect.

The second issue is whether Petitioner proved by a preponderance of the evidence that Respondent’s denial of thirty-five (35) hours per week of personal care services was incorrect.

The third issue is whether Respondent proved by a preponderance of the evidence that Respondent’s reduction of an eighty (80) hours per week of attendant care services to sixty (60) hours per week was correct.

PRELIMINARY STATEMENT

All parties and witnesses appeared telephonically. [REDACTED] Petitioner’s Authorized Representative, [REDACTED], and Direct Service Worker under the Participant Direction Option (“PDO”) program, appeared at the hearing and provided testimony on Petitioner’s behalf. Petitioner also appeared at the hearing.

Joshua Mitchell, Grievance & Appeals Fair Hearing Specialist for Humana Medical Plan, Inc. ("Humana") represented Respondent. Dr. Manohar Chenchugalla ("Dr. Chenchugalla"), Medical Director for Humana, provided testimony on behalf of the Respondent.

Linda Latson, Fair Hearing Liaison for the Agency for Health Care Administration ("Agency" or "AHCA"), appeared for observational purposes.

Prior to the hearing, Petitioner sent to the Office of Fair Hearings and Respondent three (3) documents, totaling four (4) pages as and for an evidence packet. The evidence packet appears in the Office of Fair Hearings' Case Management system as "Member Documents Received (1).pdf", "Member Documents Received (2).pdf", and "Member Documents Received (3).pdf". Absent an objection from Respondent, the undersigned admitted Petitioner's evidence packet into evidence as Petitioner's Composite Exhibit 1 ("PCE 1").

Prior to the hearing, Respondent sent to the Office of Fair Hearings and Petitioner a three hundred and thirty-five (335)-page evidence packet. The evidence packet appears in the Office of Fair Hearings' Case Management system as "Evidence Packet 23-FH0965, 23-FH0969, 23-FH0970_Part1.pdf," "Evidence Packet 23-FH0965, 23-FH0969, 23-FH0970_Part2.pdf," "Evidence Packet 23-FH0965, 23-FH0969, 23-FH0970_Part3.pdf," "Evidence Packet 23-FH0965, 23-FH0969, 23-FH0970_Part4.pdf," and "Evidence Packet 23-FH0965, 23-FH0969, 23-FH0970_Part5.pdf". Absent an objection from Petitioner, the undersigned admitted Respondent's evidence packet into evidence as Respondent's Composite Exhibit 1 ("RCE 1").

At the fair hearing, Mr. Mitchell requested time to submit additional evidence, an eleven (11) page Plan of Care summary. Mr. Mitchell was given until Friday, June 2, 2023, at 5:00 p.m. to submit that document. Petitioner was given until Friday, June 9, 2023, at 5:00 p.m. to respond

to the additional evidence. The eleven (11) page Plan of Care summary totals twelve (12) pages with the coversheet and was received on June 1, 2023. The evidence packet appears in the Office of Fair Hearings' Case Management system as "Additional Evidence 23-FH0965 23-FH0969 23-FH0970.pdf". Absent a response from Petitioner, the undersigned admitted Respondent's twelve (12) page evidence packet into evidence as Respondent's Composite Exhibit 2 ("RCE 2").

FINDINGS OF FACT

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

2. As of the time of the hearing, Petitioner was [REDACTED] in a private residence. *Id.* at 40, 43, 46, and 83.

3. Petitioner has the following health conditions: [REDACTED] *Id.* at 9, 17, 25, 34, and 51. Petitioner does not have trouble thinking clearly or remembering things, does not leave [REDACTED] home without someone (wandering), has not had any recent changes in [REDACTED] health, and has not been recently in the hospital. *Id.* at 34, 36, and 38. Petitioner is alert and oriented times 3. *Id.* at 85. Petitioner [REDACTED]. *Id.* at 92.

4. [REDACTED] provided the responses to the questions on Petitioner's Florida Department of Elder Affairs: 701B Comprehensive Assessment, dated April 26, 2023 ("701B Assessment"). *Id.* at 84.

5. According to the 701B Assessment, regarding Petitioner's Activities of Daily Living ("ADLs"), Petitioner needs total assistance (cannot do at all) [REDACTED]

[REDACTED] *Id.* at 87. Petitioner rarely has assistance with ADLs. *Id.*

6. According to the 701B Assessment, regarding Petitioner’s Instrumental Activities of Daily Living (“IADLs”), Petitioner needs total assistance (cannot do at all) with [REDACTED]

[REDACTED] *Id.* at 88.

Petitioner needs assistance (but not total help) with [REDACTED]. *Id.* Petitioner needs

[REDACTED] *Id.* Petitioner never has assistance with heavy chores; rarely has assistance with light housekeeping, preparing meals and shopping; has

[REDACTED]

[REDACTED] needs no assistance with using the telephone. *Id.*

7. On March 1, 2023, Respondent issued three (3) different Notice of Adverse Benefit Determinations (“NABDs”) denying ten (10) hours weekly of homemaker PDO, denying thirty-five (35) hours weekly of personal care PDO, and reducing attendant care from eighty hours (80) to thirty-five (35) hours weekly. *Id.* at 8 – 9, 16 – 17, and 24 – 25. The NABDs stated identical reasons for Respondent’s determinations as follows, in pertinent part:

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 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 are requesting to reduce the attendant care from 80 hours to 35 hours per week and are requesting to give 10 hours of homemaker (HMK) PDO and 35 hours of personal care (PC) PDO hours per week. You currently receive 80 hours of attendant care. You made this request as you are not receiving the full attendant care hours due to lack of staff from provider. You reside at home with your parents. You are alert and oriented to person, place, and time. Yo[u] have multiple medical problems including a condition called spinal muscular dystrophy (disease affecting muscles). Your mother works outside the home Monday through Friday. We have reviewed your needs. Your attendant care is reduced to 60 hours per week, and you are approved with 20 hours of PC PDO. We recommend that the case manager reach out to the provider relations to search for home health providers to be able provide the 60 hours of attendant care hours approved. We are denying your request for 10 hours of JMK PDO.

Id. at 9, 17, and 25.

8. Petitioner requested plan appeals for both of Respondent's denials and for Respondent's reduction. On March 9, 2023, Respondent issued three (3) Notice of Plan Appeal Resolutions ("NPARs"), upholding the denial of ten (10) hours weekly of homemaker PDO services, denial of thirty-five (35) hours weekly of personal care PDO services, and reduction of attendant care services from eighty hours (80) to thirty-five (35) hours weekly. *Id.* at 40 – 41, 43 – 44, and 46 – 47. The NPARs stated similar reasons for Respondent's denials and reduction as follows, in pertinent part:

For 23-FH0965 (reference Plan ID No. A23068756440) –

On March 3, 2023, we received your timely plan appeal request regarding Humana Healthy Horizons Comprehensive Plan’s Notice of Adverse Benefit Determination dated March 1, 2023, 169219441, denying the 10 homemaker Participant Directed Option (PDO) hours weekly provided to [Petitioner].

On March 21, 2023, after consideration of the information you provided to Humana Healthy Horizons Comprehensive Plan in support of your plan appeal, was reviewed by, a medical director who is a MD and board certified in Internal Medicine hereby partially approves your plan appeal.

The reason for the decision was based on the information received. You have requested that the 10 hours of direct service worker (DSW) homemaker service each week that was denied in your initial request be reconsidered (appeal).

[Petitioner] has [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]

[Petitioner] is being approved for 7 hours of direct service worker (DSW) homemaker service each week. [REDACTED] lives with others who share in household responsibilities. These hours should be enough to meet [REDACTED] medical 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 (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.

For 23-FH0969 (reference Plan ID No. A23063490232) –

On March 3, 2023, we received your timely plan appeal request regarding Humana Healthy Horizons Comprehensive Plan’s Notice of Adverse Benefit Determination dated March 1, 2023, 169219360, partially denying the 35 personal care Participant Directed Option (PDO) hours weekly provided to [Petitioner].

On March 21, 2023, after consideration of the information you provided to Humana Healthy Horizons Comprehensive Plan in support of your plan appeal, was reviewed by, a medical director who is a MD and board certified in Internal Medicine hereby denies your plan appeal.

The reason for the decision was based on the information received. You have requested that the 15 hours of direct service worker (DSW) personal care service each week that was denied in your initial request be reconsidered (appeal).

[Petitioner] has [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]

The denial of the 15 hours of direct service worker (DSW) personal care service each week is being upheld. The hours [REDACTED] is currently receiving should be enough to meet [REDACTED] medical 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 (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.

For 23-FH0970 (reference Plan ID No. A23068225670) –

On March 3, 2023, we received your timely plan appeal request regarding Humana Healthy Horizons Comprehensive Plan's Notice of Adverse Benefit Determination dated March 1, 2023, 157793423, reducing the attendant care hours weekly provided to [Petitioner].

On March 21, 2023, after consideration of the information you provided to Humana Healthy Horizons Comprehensive Plan in support of your plan appeal, was reviewed by, a medical director who is a MD and board certified in Internal Medicine hereby denies your plan appeal.

The reason for the decision was based on the information received. You have requested that the 20 hours of attendant care service each week that were reduced (decreased) in your initial request be reconsidered (appeal).

[Petitioner] has [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]

The reduction (decrease) of the 20 hours of attendant care service each week is being upheld. You had requested that these hours be reduced. These hours were replaced with

20 hours of direct service worker (PDO) personal care services each week per your request. These hours should be enough to meet [REDACTED] medical 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 (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.

9. Petitioner requested a Fair Hearing due to the denial of homemaker PDO services, denial of personal care PDO services, and reduction of attendant care services. On May 4, 2023, the undersigned scheduled the Fair Hearing for May 25, 2021, at 1:00 p.m., and all parties were duly notified. During the hearing, Petitioner requested a continuance in order to submit documents to be considered as evidence. Absent an objection from Respondent, the undersigned granted Petitioner's request for a continuance. Pursuant to a second notice, the Office of Fair Hearings convened a telephonic Medicaid Fair Hearing in the above styled case on June 1, 2023, at 9:00 a.m. EST.

10. According to [REDACTED] testimony presented at the Fair Hearing, Petitioner is requesting additional Florida Medicaid LTC services due to getting weaker. [REDACTED] expressed frustration at the lack of continuity of care for Petitioner's services. [REDACTED] explained that when they moved to Cape Coral in April of 2022, Petitioner could no longer receive care through Simply Healthcare because it was not available in the new county. In May of 2022 Petitioner switched to Humana. [REDACTED] testified that there was a change in attendant care hours from 100 hours to 80 hours. Petitioner was expecting the same number of hours under Humana that they had with Simply based on the Continuity of Care Provisions policy. See PCE 1 at 2 – 3. Petitioner is not receiving any assistance or therapy other than the PDO. [REDACTED] is no longer employed, and [REDACTED] is employed part time outside of the home for thirty-five (35) hours per week. Both

██████████ were approved for PDO services of twenty-seven (27) hours per week in total. Petitioner does not have family support other than ██████ parents. Petitioner's diagnosis has not changed and ██████ symptoms have not improved.

11. According to Petitioner's testimony presented at the Fair Hearing, Petitioner does not want to end up in a nursing home or facility. Petitioner does not want to be away from the only family ██████ has ever known.

12. Dr. Chenchugalla is a Medical Director for Humana. According to Dr. Chenchugalla's testimony presented at the Fair Hearing, Humana's position is that the service hours that Petitioner receives are sufficient for his needs. Petitioner requested to have ██████ attendant care hours reduced from eighty (80) hours to sixty (60) hours per week in March of 2022, because the provider was having an issue providing the hours. Petitioner's parents were approved to get twenty (20) PDO personal care hours and 7 homemaker PDO hours. So, in total, Petitioner was receiving eighty-seven (87) hours of total care per week. Dr. Chenchugalla agreed that Petitioner's conditions have not changed or approved.

13. As of March 1, 2023, Petitioner's authorized eighty (80) hours of attendant care were reduced to sixty (60) hours and Petitioner was approved for twenty (20) hours of personal care PDO. Respondent recommended that the case manager reach out to provider relations to search for home health providers who may be able to provide the sixty (60) hours of attendant care, since the Petitioner was not receiving the full attendant care hours due to lack of staff from the provider. RCE 1 at 9, 17.

14. ██████ testified that Petitioner was receiving one hundred (100) hours per week of attendant care under Simply Health. PCE 1 at 4. Petitioner's cropped document states that

Petitioner was receiving one hundred (100) hours of attendant care but, even rotated, the end date on the left side cannot be fully seen. In comparison, Humana submitted a Simply Healthcare Comprehensive Plan of Care which states Petitioner was receiving eighty (80) hours of attendant care under Simply Health, with a date of enrollment of February 1, 2019 and an effective date of December 7, 2021. Humana's document also did not have an end date for the attendant care services.

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 section 409.285(2), Florida Statutes. This order is the final administrative decision of AHCA under section 409.285(2)(a).

16. This hearing was held as a *de novo* proceeding pursuant to Rule 59G-1.100(17)(b), Florida Administrative Code ("F.A.C.").

17. The burden of proof in this proceeding is governed by Rule 59G-1.100(17)(g), F.A.C., 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 new services, Rule 59G-1.100(17)(g), F.A.C., assigns the burden of proof to the Petitioner regarding homemaker services and personal care services. Because Respondent is reducing services, Rule 59G-1.100(17)(g), F.A.C., assigns the burden of proof to the Respondent regarding attendant care services. 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. Rule 59G-1.100(18)(f), F.A.C., states, “[t]he Final Order may prescribe corrective action retroactively to the date the incorrect action was taken.”

20. 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 Rule 59G-4.192, F.A.C. 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:

4.2.1.1 Adult Companion Care

The provision of non-medical care, supervision when necessary to protect the health, safety, and well-being of the enrollee, or social enrichment of a functionally impaired enrollee. This includes assistance or supervision with meal preparation, laundry, and light housekeeping tasks incidental to the care and supervision of the enrollee.

...

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.

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:

...

4.2.2.2 Attendant Nursing Care

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

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.

RCE 1, SMMC LTC Policy, pages 316 – 324.

21. The Florida Medicaid Definitions Policy (August 2017) ("Definitions Policy"), which is incorporated by reference in Rule 59G-1.010, F.A.C, 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.

22. The Agency’s Florida Medicaid Personal Care Services Coverage Policy (November 2016)

(“PC Policy”) has been incorporated, by reference, into Rule 59G-4.215, F.A.C. 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

Coverage Policy at page 1, 3 – 5.

A. Denial of Homemaker Services

23. In the instant case, Respondent denied ten (10) hours weekly of homemaker PDO hours.

See supra ¶ 8, 9. As established on the record by the evidence and testimony, Respondent denied

Petitioner’s request because the documentation submitted in support of Petitioner’s request failed to establish that the requested services were medically necessary. *See supra* ¶ 8, 9.

24. 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* ¶ 20.

25. The evidence presented in this case does not reflect that ten (10) hours weekly of homemaker PDO services are warranted. Specifically, regarding ADLs, Petitioner needs total assistance (cannot do at all) [REDACTED]

[REDACTED]; needs assistance (but not total help) with [REDACTED]
[REDACTED]. *See supra* ¶ 6.

According to the 710B Assessment, Petitioner never has assistance with heavy chores; rarely has assistance with light housekeeping, preparing meals and shopping; has assistance most of the time with [REDACTED]; always has assistance with [REDACTED]
[REDACTED] needs no assistance with using the telephone. *See supra* ¶ 6.

26. Petitioner has multiple medical conditions, including [REDACTED]
[REDACTED]. *See supra* ¶ 3.

Petitioner is not receiving any assistance or therapy other than the PDO. *See supra* ¶ 11.

27. The SMMC LTC Policy require that the additional homemaker 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 sixty (60) hours of attendant care services, twenty (20) hours of personal care PDO services, and seven (7) hours of homemaker PDO services. See supra ¶ 14.

28. Here, Petitioner bears the burden of proof regarding the denial of ten (10) hours weekly of homemaker PDO services. See supra ¶ 19. Petitioner provided no time estimates to explain the amount of time Petitioner requires for each of [REDACTED] ADLs. Further, Petitioner provided no evidence (e.g., a daily schedule, a schedule of ADLs and IADLs, the amount of time needed for each ADL and IADL) to support the approval of ten (10) hours weekly of homemaker PDO services per week. The definition of homemaker services most closely aligns with IALD tasks. Petitioner’s 701B Assessment, which was completed with input from [REDACTED] indicates that Petitioner rarely has assistance with most of his ADLs and IADLs. See supra ¶ 6 – 7. However, Petitioner did not explain which ADLs or IADLs would no longer be covered if the requested homemaker care PDO services were not approved in this matter.

29. Considering the totality of Petitioner’s circumstances, including [REDACTED] diagnoses, level of functional need for assistance with ADLs and IADLs, amount of currently approved services, and the natural support provided by [REDACTED] mother and father, Petitioner failed to prove by a preponderance of the evidence that ten (10) hours weekly of homemaker PDO services are not “in excess of [Petitioner’s] needs.” See supra ¶ 20.

30. In light of both parties’ testimony, Petitioner’s Composite Exhibit 1, Respondent’s Composite Exhibit 1, Respondent’s Exhibit 2, and the applicable laws and policies, the

undersigned Hearing Officer finds that Petitioner failed to meet his burden of proving that ten (10) hours weekly of homemaker PDO services are medically necessary. Accordingly, the undersigned Hearing Officer concludes that Petitioner failed to prove by a preponderance of the evidence that Respondent's denial of personal care PDO services was incorrect.

B. Denial of Personal Care Services

31. In the instant case, Respondent denied thirty-five (35) hours weekly of personal care PDO hours. *See supra* ¶ 8, 9. As established on the record by the evidence and testimony, Respondent denied Petitioner's request because the documentation submitted in support of Petitioner's request failed to establish that the requested services were medically necessary. *See supra* ¶ 8, 9.

32. 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. The LTC Policy states that personal care services are intended 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." *See supra* ¶ 20.

33. The evidence presented in this case does not reflect that an additional thirty-five (35) hours weekly of personal care PDO services are warranted. Specifically, regarding ADLs, Petitioner needs total assistance (cannot do at all) with [REDACTED] [REDACTED] needs assistance (but not total help) with [REDACTED]

See supra ¶ 6. According to the 710B Assessment, Petitioner never has assistance with heavy chores; rarely has assistance with light housekeeping, preparing meals and shopping; has assistance most of the time with [REDACTED]; always has assistance with [REDACTED] needs no assistance with using the telephone. See supra ¶ 6.

34. Petitioner has multiple medical conditions, [REDACTED] See supra ¶ 3. Petitioner is not receiving any assistance or therapy other than [REDACTED] See supra ¶ 11.

35. The SMMC LTC Policy and the Definitions Policy require that the additional 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 ¶ 20. Here, Petitioner is currently authorized to receive sixty (60) hours of attendant care services, twenty (20) hours of personal care PDO services, and seven (7) hours of homemaker PDO services. See supra ¶ 14.

36. Here, Petitioner bears the burden of proof regarding the denial of thirty-five (35) hours weekly of personal care PDO services. See supra ¶ 19. Petitioner provided no time estimates to explain the amount of time Petitioner requires for each of [REDACTED] ADLs. Further, Petitioner provided no evidence (e.g., a daily schedule, a schedule of ADLs and IADLs, the amount of time needed for each ADL and IADL) to support the approval of thirty-five (35) hours weekly of personal care PDO services per week. The definition of personal care services most closely aligns with ADL tasks. Petitioner’s 701B Assessment, which was completed with input from [REDACTED], indicates that Petitioner rarely has assistance with most of [REDACTED] ADLs and IADLs. See supra ¶ 6.

However, Petitioner did not explain which ADLs or IADLs would no longer be covered if the requested hours personal care PDO services were not approved in this matter.

37. Considering the totality of Petitioner's circumstances, including ■ diagnoses, level of functional need for assistance with ADLs and IADLs, amount of currently approved services, and the natural support provided by ■ mother and father, Petitioner failed to prove by a preponderance of the evidence that thirty-five (35) hours weekly of personal care PDO services are not "in excess of [Petitioner's] needs." See supra ¶ 20 and 21.

38. In light of both parties' testimony, Petitioner's Composite Exhibit 1, Respondent's Composite Exhibit 1, Respondent's Exhibit 2, and the applicable laws and policies, the undersigned Hearing Officer finds that Petitioner failed to meet ■ burden of proving that an thirty-five (35) hours weekly of personal care PDO services are medically necessary. Accordingly, the undersigned Hearing Officer concludes that Petitioner failed to prove by a preponderance of the evidence that Respondent's denial of personal care PDO services was incorrect.

C. Reduction of Attendant Care Services

39. In an NABD, dated March 1, 2023, Respondent reduced Petitioner's attendant care services from eighty (80) hours weekly to sixty (60) hours weekly. See ¶ 8. Respondent explained that attendant care services were not medically necessary for Petitioner but did not identify the prong of medical necessity used to make its decision. *Id.*

40. As provided in the LTC Policy, attendant care services are intended to provide "nursing care of both a supportive and health-related nature, specific to the needs of a medically stable, physically handicapped enrollee age 21 and older who requires more individual and continuous care than an intermittent nursing visit." See ¶ 21. As provided in the record, Petitioner needs

total assistance (cannot do at all) with [REDACTED]
[REDACTED] needs assistance (but not total help) with
[REDACTED] See supra
¶ 6. According to the 710B Assessment, Petitioner never has assistance with heavy chores; rarely has assistance with light housekeeping, preparing meals and shopping; has assistance [REDACTED]
[REDACTED]; always has assistance [REDACTED]
[REDACTED]; and needs no assistance with using the telephone. See supra ¶ 6. Petitioner is currently authorized to receive sixty (60) hours of attendant care services, twenty (20) hours of personal care PDO services, and seven (7) hours of homemaker PDO services. See supra ¶ 14.

41. As Respondent bears the burden of proof for the reduction of attendant care hours, Respondent must show that it is not medically necessary for Petitioner to receive eighty (80) hours of attendant care hours. Respondent argued the service hours that Petitioner receives are sufficient for his needs. However, Respondent did not proffer testimony regarding how the service hours were sufficient for Petitioner; whether Petitioner's needs involved supervision and observation (not by a nurse) as opposed to skilled nursing interventions; and whether Petitioner's mother who is also [REDACTED] PDO, is trained in administering skilled interventions. Respondent testified that Petitioner requested to reduce attendant care from eighty (80) hours in exchange for PDO hours. See supra ¶ 8. However, Petitioner denied making such a request and asked for proof. Based on the record, Respondent has not demonstrated that the eighty (80) hours of attendant care are in excess of Petitioner's needs. Thus, the Respondent has not shown that Petitioner's eighty (80) hours of attendant care services no longer meet the following Medical Necessity

standard: Services must 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.

42. In light of both parties' testimony, Petitioner's Composite Exhibit 1, Respondent's Composite Exhibit 1, Respondent's Exhibit 2, and the applicable laws and policies, the undersigned Hearing Officer finds that Respondent failed to meet its burden of proving that eighty (80) hours of attendant care services are no medically necessary. Accordingly, the undersigned Hearing Officer concludes that Respondent failed to prove by a preponderance of the evidence that Respondent's reduction of attendant care services was correct.

IT IS THEREFORE ORDERED AND ADJUDGED THAT:

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

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

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

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



Kameisha Presley
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FH0970
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KAMEISHA PRESLEY, 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]
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