



FILED

Aug 01, 2023, 10:21 am

OFFICE OF FAIR HEARINGS

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

[REDACTED],

PETITIONER,

AHCA Case No.: 23-FH1010

Plan ID No.: [REDACTED]

vs.

MOLINA HEALTH CARE OF FLORIDA, INC.,

RESPONDENT.

_____ /

Pursuant to notice, the undersigned Hearing Officer convened a telephonic Fair Hearing on the instant case on June 21, 2023, at 10:02 a.m. Eastern Standard Time ("EST").

APPEARANCES

For the Petitioner: [REDACTED]
Counsel for Petitioner

For the Respondent: Melissa Hedrick
Counsel for Respondent

STATEMENT OF ISSUE

The issue is whether Respondent proved by a preponderance of the evidence that Respondent's decision to reduce Petitioner's personal care services was correct.

PRELIMINARY STATEMENT

All parties appeared for the scheduled Fair Hearing telephonically. Joel Magolnick, Esq. ("Mr. Magolnick"), appeared for the Fair Hearing as Counsel for Petitioner. [REDACTED] [REDACTED], [REDACTED] appeared for the Fair Hearing as a witness for Petitioner.

Melissa Hedrick, appeared for the Fair Hearing as Counsel for Molina Health Care of Florida, Inc. (“Molina”). The following individuals appeared for the Fair Hearing as witnesses for Respondent: Katia Matos (“Ms. Matos”), Utilization Management Director; Dr. Gabriel Novoa, Medical Director; Caridad Bello, Government Contracts Specialist; Yunesy Cruz, Director of Health Care Services for the Long-term Care Program; and Ms. Estevez, Authorization Manager.

The following appeared for the Fair Hearing as observers: Nicole Vega, Associate General Counsel for Molina; and Lee Ann Williams, Medical Health Care Program Analyst for the Agency for Health Care Administration (“Agency” or “AHCA”).

Prior to the Fair Hearing, Petitioner sent to the Office of Fair Hearings and Respondent an eighty-one (81)-page evidence packet. The evidence packet appears in the Office of Fair Hearings’ case management system as the file title “23-FH1010 Authorization and supporting documents.pdf.” Absent an objection from Respondent, the eighty-one (81)-page evidence packet was admitted 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 one hundred and fifty (150)-page evidence packet. The evidence packet appears in the Office document management system as the file titles “MFH Package Office [REDACTED] 23FH1010_1.pdf,” “MFH Package Office [REDACTED] 23FH1010_2.pdf,” “MFH Package Office [REDACTED] 23FH1010_3.pdf,” “MFH Package Office [REDACTED] 23FH1010_4.pdf,” “MFH Package Office [REDACTED] 23FH1010_5.pdf,” “MFH Package Office [REDACTED] 23FH1010_6.pdf,” “MFH Package Office [REDACTED] 23FH1010_7.pdf,” “MFH Package Office [REDACTED] 23FH1010_8.pdf,” “MFH Package Office [REDACTED] 23FH1010_9.pdf,” “MFH Package Office [REDACTED] 23FH1010_10.pdf,” “MFH Package Office [REDACTED] 23FH1010_11.pdf,” “MFH Package Office [REDACTED] 23FH1010_12.pdf,” and “MFH Package Office [REDACTED] 23FH1010_13.pdf.” Absent an objection from

the Petitioner, the one hundred and fifty (150)-page evidence packet was admitted into evidence as Respondent’s Composite Exhibit 1 (“RCE 1”).

The undersigned Hearing Officer held the record open until June 28, 2023, for Petitioner to submit medical documentation (e.g., a letter of medical necessity, a referral, etc.) from their provider. On June 21, 2023, Petitioner sent to the Office of Fair Hearings a five (5)-page evidence packet that includes the following documents: a letter from Dr. Linda Zamora; and a medical appointment summary. The evidence packet appears in the Office of Fair Hearings’ case management system as the file title “23-FH1010 Post Hearing Documents Submitted.pdf.” The undersigned Hearing Officer held the record open until July 5, 2023, for Respondent to file any comments or objections to Petitioner’s submitted documentation. Absent an objection from Respondent, the five (5)-page evidence packet was admitted into evidence as Petitioner’s Composite Exhibit 2 (“PCE 2”).

FINDINGS OF FACT

1. Petitioner is an enrolled member of Molina’s Long-term Care (“LTC”) program. Molina is a managed care organization contracted by the Agency to provide services to eligible Medicaid recipients in the state of Florida. *See* RCE 1 at page 1, 28.

2. As of the date of the Fair Hearing, Petitioner is [REDACTED]. *Id.* at 28. Petitioner resides in the community with [REDACTED] primary caregiver and [REDACTED]. *Id.* at 29.

[REDACTED] works full-time outside of the home. *Id.* at 55. Petitioner has the following health conditions: [REDACTED]

[REDACTED]

[REDACTED] *Id.* at

9, 34 – 35. Petitioner is diagnosed with [REDACTED]. *Id.* at 37. According to [REDACTED] testimony, Petitioner is also diagnosed with [REDACTED].

3. According to Petitioner’s Florida Department of Elder Affairs: 701B Comprehensive Assessment (“701B”), dated March 21, 2023, Petitioner needs assistance (but not total help) with the following Activities of Daily Living (“ADLs”): [REDACTED]

[REDACTED] *Id.* at 32. Petitioner needs no assistance with [REDACTED]. *Id.* With regard to Instrumental Activities of Daily Living (“IADLs”), Petitioner needs total assistance (cannot do at all) with [REDACTED]. *Id.* at

33. Petitioner needs assistance (but not total help) with [REDACTED]. *Id.* Petitioner needs no assistance with [REDACTED].

Id.

4. In a Notice of Adverse Determinations (“NABD”), dated March 24, 2023, Respondent reduced Petitioner’s personal care services. *Id.* at 97 – 100. The NABD explained the basis of the reduction 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 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:

The facts that we used to make our decision are: This decision was based on medical necessity (as defined by Agency for Health Care Administration's Medical Necessity as defined in Rule 59G-4, 192 and reflects the application of Molina Clinical Policy (332).

The reason why the request was not approved is: There is a reduction Effective 04/03/2023 of Personal Care Services from 21 hours per week to 15 hours per week by the Medical Director because the service is not medically necessary. You are already receiving other services that should meet your needs. You are going to receive 29 hours of home care assistance per week based on Care Plan Reviewed and your current needs. This determination by the Medical Director has been made based on medical necessity (as defined by Florida law) and reflects the application of Molina Healthcare's approved review criteria and guidelines.

Id. at 97 – 98.

5. On April 10, 2023, Petitioner requested a plan appeal. *Id.* at 115. On April 24, 2023, Respondent issued a Notice of Plan Appeal Resolution (“NPAR”) upholding the reduction of personal care services. *Id.* at 124 – 126. The NPAR states the following, in pertinent part:

We made our decision based on the Florida Agency for Health Care Administration’s Long-Term Care (LTC) Program Policy (Rule 59G-4.192) and the Molina Clinical Policy for Medically Necessary Services (332). It shows rules that you have to meet to show medical necessity (need). Part of the rules is having an evaluation (test) to find out what you need. These tests are done the first time a member needs a test. They are also done annually (every year), and when there is a significant (big) change in the member’s care. A significant (big) change may involve a change in the member’s state of health or the person taking care of them. Your recent test does not show a significant (big) change in your care. Your doctor has not told us of a significant (big) change in your care to show that you need a change to your plan of care. You are already receiving services that should meet your needs. For this reason, the request for the extra 6 hours a week of Personal Care Services is not approved. Please talk to your doctor and/or Case Manager about your options.

While we are denying the extra 6 hours a week of Personal Care Services, you are already receiving services that should meet your needs. You will still receive 15 hours a week of Personal Care Services, 7 hours a week of Homemaker Services and 7 hours a week of Adult Companion Care.

...

Id. at 124.

6. Petitioner's primary care physician, Dr. Linda Zamora, at Conviva Care Solutions wrote a reconsideration letter dated April 17, 2023, in support of Petitioner's request to restore the remaining six (6) hours of personal care services. The letter states as follows:

[Petitioner] had [REDACTED] that resulted on a [REDACTED] and [REDACTED].

[REDACTED] had surgery on [REDACTED] [REDACTED] [REDACTED]. Since this event patient[s] mental and physical status [REDACTED] [REDACTED]

[REDACTED] is currently on LTC program with home health assistance. [REDACTED] has 7 hours for homemaker assistance, 7 hours for companion assistance and 15 hours for personal care.

Due to this new event of [REDACTED] we are requesting to reinstall [REDACTED] 21 hours of personal care he had previously approved.

...

See PCE 1 at 8.

7. On May 1, 2023, [REDACTED] requested a Fair Hearing on behalf of Petitioner to challenge the reduction. On May 15, 2023, the undersigned issued an Order Scheduling Fair Hearing by Telephone and Prehearing Instructions, setting the hearing for June 21, 2023, at 10:00 a.m. EST.

8. Accordingly, as of the date of the Fair Hearing, Petitioner is authorized to receive the following Florida Medicaid LTC services: fifteen (15) hours per week of personal care services; seven (7) hours per week of homemaker services; seven (7) hours per week of adult companion care services; and seven (7) home delivered meals. *See* RCE 1 at 51, 124.

9. Ms. Matos testified at the Fair Hearing as follows:

a. Molina uses the 701B as required by contract to determine the medically necessary hours and services for the member. Given the responses in the 701B, Molina determined Petitioner's needs for assistance, including ADLs and IADLs. *Id.* at 28 – 46. Molina conducted a supplemental assessment and determined that the member required twenty (29) total hours of home health services, which reflects the current number of Petitioner's approved services. *Id.* at 55 – 69. The information from the medical records and the letter from Petitioner's primary care physician regarding Petitioner's medical conditions were captured in the 701B and supplemental assessments.

10. [REDACTED] testified at the Fair Hearing as follows:

- a. Petitioner suffers from multiple medical and mental issues, including [REDACTED]. Prior to Petitioner's [REDACTED] in [REDACTED], [REDACTED] had [REDACTED]. After the [REDACTED] [REDACTED] suffered [REDACTED]. [REDACTED] contends that since that time, Petitioner's health has declined substantially. [REDACTED] argues that the remaining six (6) hours are needed because Petitioner needs assistance [REDACTED], and cannot care for [REDACTED].
- b. [REDACTED] lives with Petitioner and has employment full-time outside of the home and some weekends. *Id.* at 55. [REDACTED] confirmed [REDACTED] was present during the 701B assessment in March of 2023 taken by the care coach, Camilo Hernandez. [REDACTED] believes the care coach was aware of Petitioner's declining health but his notes on the 701B did not reflect this.

CONCLUSIONS OF LAW

11. The Agency’s Office of Fair Hearings has jurisdiction over the subject matter of this proceeding and the parties pursuant to section 409.285(2), Florida Statutes (2022). This order is the final administrative decision of AHCA under section 409.285(2)(a).

12. This hearing was held as a *de novo* proceeding pursuant to Florida Administrative Code Rule (“Fla. Admin. Code R.”) 59G-1.100(17)(b).

13. Because Respondent is reducing a previously approved service, Fla. Admin. Code R. 59-1.100(17)(g) assigns the burden of proof to Respondent. The standard of proof in an administrative hearing is a preponderance of the evidence. The preponderance of the evidence standard requires proof by “the greater weight of the evidence” (Black’s Law Dictionary at 1201, 7th Ed.)

14. The Florida Medicaid Statewide Managed Care Long-term Care Program Coverage Policy (March 2017) (“LTC Policy”), incorporated by reference in Fla. Admin. Code R. 59G-4.192, governs Long-Term Care services available under Florida Medicaid. *Id. at* 129 – 150. The Florida Medicaid LTC Policy provides the following, in pertinent part:

1.0 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.

...

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 restrictive setting

...

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.

Id. at 125 – 146. (Emphasis added).

15. The Florida Medicaid Definitions Policy (August 2017) (“Definitions Policy”), incorporated by reference in Fla. Admin. Code R. 59G-1.010, defines “Medically Necessary” or “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 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.

Definitions Policy at page 7. (Emphasis added).

16. 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

PC Policy at pages 3 – 8, and 10.

17. In the instant case, in the NABD dated March 24, 2023, Respondent reduced Petitioner’s personal care services from twenty-one (21) hours weekly to fifteen (15) hours weekly. *See supra* ¶ 4. As established on the record by the evidence and testimony, Respondent reduced the additional personal care services due to a lack of medically necessary. *See supra* ¶ 4 – 5, 9. However, Respondent did not specify which prong of medical necessity it used to makes its decision. *See supra* ¶ 4 – 5. Respondent has the burden of proof to show by a preponderance of evidence that the Respondent’s determination was correct. *See supra* ¶ 13.

18. Section 4.1 of the LTC Policy provides that Florida Medicaid LTC plans cover services that: (a) are determined medically necessary, as defined in the LTC Policy; (b) do not duplicate another service; and (c) meet the criteria as specified in the LTC Policy. *See supra* ¶ 14. The Definitions Policy requires 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* ¶ 15. Under Florida Medicaid, the purpose of personal care services is “[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* ¶ 14.

19. Petitioner is currently authorized to receive fifteen (15) hours per week of personal care services; seven (7) hours per week of homemaker services; seven (7) hours per week of adult companion care services; and seven (7) home delivered meals per week. *See supra* ¶ 8. Petitioner has multiple medical conditions, including [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]. *See supra* ¶ 2. Specifically, regarding ADLs, Petitioner needs assistance (but not total help) with [REDACTED] *See supra* ¶ 3.

Petitioner needs no assistance with [REDACTED]. *See supra* ¶ 3. Regarding IADLs, Petitioner needs total assistance (cannot do at all) with [REDACTED]

[REDACTED]. *See supra* ¶ 3. Petitioner needs assistance (but not total help) with [REDACTED]

See supra ¶ 3.

20. The evidence presented in this case does not support a finding that Respondent’s reduction of personal care services was incorrect. At Fair Hearing, Ms. Matos explained that Respondent used the 701B to determine the medically necessary hours and services for Petitioner, as well as [REDACTED] need for assistance including ADLs and IADLs. *See supra* ¶ 9. Further, Respondent conducted a supplemental assessment and determined that Petitioner required twenty (29) total hours of home health services, which reflects the current number of Petitioner’s approved services. *See supra* ¶ 9. Petitioner resides in the home with [REDACTED]

█. *See supra* ¶ 2. █ was present during the 701B assessment in March of 2023. *See supra* ¶ 10.

21. Although the PC Policy provides general guidance for general allowances for ADLs, *supra* ¶ 16, Petitioner did not clearly identify specific unmet needs due to the reduction of personal care services. █ argued that the remaining six (6) hours are needed because Petitioner needs assistance █. *See supra* ¶ 10. It appears from the record that the Respondent included time approximations for each ADL and IADL to account for this support which is unrefuted by Petitioner. *See supra* ¶ 9 and RCE 1 at 67 – 68.

22. Petitioner’s primary care physician, Dr. Linda Zamora, wrote a reconsideration letter following the reduction, stating Petitioner’s medical status due to Petitioner’s █. █. *See supra* ¶ 6. Dr. Zamora stated “[d]ue to this new event of physical and cognitive decline we are requesting to reinstall █ 21 hours of personal care █ had previously approved.” *See supra* ¶ 6. However, 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. *See supra* ¶ 16. Therefore, a letter from Dr. Zamora does not, in itself, make the requested additional services medically necessary. Moreover, as Ms. Matos testified, the information in the 701B and supplemental assessments are reflected in the medical records and the letter from Petitioner’s primary care physician regarding Petitioner’s medical conditions. *See supra* ¶ 9. Accordingly, Respondent provided sufficient evidence to demonstrate that the reduction of personal care services was warranted.


23. Considering the totality of Petitioner’s circumstances, including [redacted] diagnoses, level of need with ADLs and IADLs, amount of currently approved services, and the fact that [redacted] resides with [redacted] primary caregiver, Respondent proved by a preponderance of the evidence that the remaining six (6) hours of personal care services per week is “in excess of Petitioner’s needs” at this time. *See supra* ¶ 15, 19 – 20.

24. In light of both parties’ testimony and evidence, the LTC Policy, the PC Policy, and the Definitions Policy, the undersigned finds that Respondent proved by a preponderance of the evidence that Respondent’s reduction of personal care services from twenty-one (21) hours to fifteen (15) hours weekly was medically necessary. In light of all the evidence relevant to the particular needs of Petitioner, Respondent has shown that the requested services are in excess of the Petitioner’s needs. Accordingly, the undersigned finds that Respondent’s reduction of personal care services was correct.

IT IS THEREFORE ORDERED AND ADJUDGED THAT:

Respondent’s reduction of personal care services is **AFFIRMED**. Petitioner’s appeal based on Respondent’s reduction of personal care services is **DENIED**.

DONE AND ORDERED this 1st day of August, 2023 in Tallahassee, Leon County, Florida.

 Kimberly Roche
23-FH1010
2023.08.01
08:17:57 -04'00'

KIMBERLY ROCHE, Hearing Officer
Agency for Health Care Administration
Office of Fair Hearings
2727 Mahan Drive, Mail Stop # 11
Tallahassee, FL 32308-5407

NOTICE OF A RIGHT TO JUDICIAL REVIEW

A PARTY WHO IS ADVERSELY AFFECTED BY THIS FINAL ORDER IS ENTITLED TO JUDICIAL REVIEW, WHICH SHALL BE INSTITUTED BY FILING THE ORIGINAL NOTICE OF APPEAL WITH THE AGENCY CLERK OF AHCA, AND A COPY, ALONG WITH THE FILING FEE PRESCRIBED BY LAW, WITH THE DISTRICT COURT OF APPEAL IN THE APPELLATE DISTRICT WHERE THE AGENCY MAINTAINS ITS HEADQUARTERS OR WHERE A PARTY RESIDES. REVIEW PROCEEDINGS SHALL BE CONDUCTED IN ACCORDANCE WITH THE FLORIDA APPELLATE RULES. THE NOTICE OF APPEAL MUST BE FILED WITHIN 30 DAYS OF THE RENDITION OF THE ORDER TO BE REVIEWED.

COPIES FURNISHED TO:



Counsel for Petitioner
magolnick@mm-pa.com

Melissa Hedrick
Counsel for Respondent
mhedrick@lombard.law

Molina Health Care of Florida, Inc.
MedicaidFairHearings@MolinaHealthCare.com

AHCA Medicaid Hearing Unit
MedicaidHearingUnit@ahca.myflorida.com