



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

FILED

Oct 04, 2023, 11:20 am

OFFICE OF FAIR HEARINGS

[REDACTED]

PETITIONER,

AHCA Case No.: 23-FH1218

Plan ID No.: [REDACTED]

vs.

CHILDREN'S MEDICAL SERVICES,

RESPONDENT.

\_\_\_\_\_ /

**FINAL ORDER**

Pursuant to notice, the undersigned convened a telephonic Fair Hearing on the instant case on September 14, 2023, at 9:00 a.m. EST.

**APPEARANCES**

For the Petitioner:

[REDACTED]

Petitioner's Authorized Representative

For the Respondent:

Kimberly Bouchette  
Clinical Appeals Coordinator  
CMS Health Care Plans, Inc.

**STATEMENT OF ISSUE**

By agreement of the parties, the first issue is whether Petitioner proved by a preponderance of the evidence that Respondent's decision to deny Petitioner's request for an additional one hundred and twenty-eight (128) hours per week of personal care services was incorrect.

By agreement of the parties, the second issue is whether Petitioner's caregiver should be reimbursed for personal care services [REDACTED] provided to Petitioner from April 17, 2023, through June 14, 2023.

### **PRELIMINARY STATEMENT**

All parties appeared telephonically. Petitioner appeared at the hearing but did not testify.

[REDACTED] (" [REDACTED]"), Petitioner's [REDACTED], appeared as a witness on Petitioner's behalf.

[REDACTED] (" [REDACTED]"), Petitioner's caregiver, appeared as a witness for Petitioner.

Kimberly Bouchette, Clinical Appeals Coordinator for Children's Medical Services ("CMS") appeared on behalf of Respondent. Dr. Don Fillipps ("Dr. Fillipps"), Long Term Care Medical Director for CMS, attended as a witness for Respondent. Kelsey Brown, case manager with CMS, testified on behalf of Respondent. The following employee of CMS attended as witnesses but did not testify at the Fair Hearing: Anita Melton, ombudsman with CMS; Alicia Giles, CMS supervisor; and Jasmine Giovenco, manager of region 6 for CMS.

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

Prior to the Fair Hearing, Petitioner sent to the Office of Fair Hearings a thirteen (13)-page evidence packet. The evidence appears in the Office of Fair Hearings' case management system as "7944310679\_[Petitioner's name]-FAX-MFH Request.pdf." Absent an objection from Petitioner, the undersigned admitted the evidence packet into evidence as Petitioner's Composite Exhibit 1.

Prior to the Fair Hearing, Respondent sent to the Office of Fair Hearings and Petitioner a two hundred and ninety-five (295)-page evidence packet. The evidence appears in the Office of

Fair Hearings' case management system as "MFH Packet [Petitioner's name].pdf." Absent an objection from Petitioner, the undersigned admitted the evidence packet into evidence as Respondent's Composite Exhibit 1.

**FINDINGS OF FACT**

1. Petitioner is an enrolled member of CMS. See Respondent's Composite Exhibit 1 at page 2. CMS is a managed care organization contracted by the Agency to provide services to eligible Medicaid recipients in Florida.

2. As of the date of the Fair Hearing, Petitioner is a [REDACTED] who lives with [REDACTED]. *Id.* at 20. Petitioner's diagnoses [REDACTED]  
[REDACTED]  
[REDACTED] *Id.*

3. Petitioner requested one hundred and sixty-eight (168) hours per week (or "24/7") of personal care services. In the Notice of Adverse Benefit Determination ("NABD"), Respondent authorized eighty-four (84) hours per week (or "12/7") of personal care services and denied the balance of Petitioner's request. *Id.* at 4-8. The NABD explained the basis of the decision as follows:

We determined that your requested services are not medically necessary because the services do not meet either of the reasons checked below: (See Rule 59G-1.100).

...

Must be individualized, specific, consistent with symptoms or diagnosis of illness or injury and not be in excess of your child's needs.

The facts that we used to make our decision are:

Florida Medicaid Personal Care Services Coverage Policy Handbook, Home Health Services Coverage and Limitations Handbook, Sunshine Health Policy on Personal Care Services Requests, FL.UM.25.00, and Children's Medical Services Health Plan Florida Medicaid Member Handbook Section: Accessing Services. These services

have also been reviewed under EPSDT (Early and Periodic Screening, Diagnostic and Treatment).

Rationale: Your request for home health aide services (a trained person that provides help in the home with personal care) is being partially approved because the information we were provided for our review does not support the medical need for home health aide services for 24 hours per day, 7 days per week. Your request is being partially approved for, 12 hours per day, 7 days per week, because the information provided to us does not show the medical need for the requested hours of service based on the clinical information (medical records) reported regarding your child's clinical condition and the parent or guardian work schedule provided. Please contact your child medical services care manager (a person that helps coordinate your child's care) should you have any questions regarding this decision.

However, we have approved home health aide services 12 hours per day, 7 days per week, using authorization number [REDACTED] from December 17, 2022 through June 14, 2023, which will be serviced by [REDACTED]

*Id.* at 4-5.

4. Petitioner requested a plan appeal and provided additional documentation including a Personal Care Services Plan of Care, a Referral Order and letter of medical necessity from [REDACTED], and a parent work schedule. See Petitioner's Composite Exhibit 1 at pages 2-11.

5. Respondent issued a Notice of Plan Appeal Resolution ("NPAR"), dated February 3, 2023, reducing Petitioner's the previously authorized amount of personal care services from eighty-four (84) to forty (40) hours per week. See Respondent's Composite Exhibit 1 at page 10. The NPAR states, in pertinent part:

On 01/30/2023, after consideration of the information you provided to Children's Medical Services Health Plan in support of your plan appeal, Children's Medical Services Health Plan hereby Partially Denies your plan appeal. As a result, [Petitioner] will not receive all services, effective 01/30/2023.

The facts that we used to make our decision are: the previous decision to authorize a home health aide for your child for 168 hours per week is partially overturned/approved and partially upheld/denied. We are approving 40 hour er week based on the clinical information and work/school schedules we received. The clinical information submitted with this request does not support the medical need for a home health aide outside of the parent work schedule. The excessive 128 hours per week are therefore upheld/ denied.

Criteria: SUNSHINE POLICY AND PROCEDURE Review for Personal Care Services Requests FL.UM.25; Personal Care Services Coverage Policy, Agency for Health Care Administration, November 2016. This decision was made with regards to EPSDT. The reasons for this decision are based on a set of standards. This included SUNSHINE POLICY AND PROCEDURE Review for Personal Care Services Requests FL.UM.25; Personal Care Services Coverage Policy, Agency for Health care Administration, November 2016.

*Id.* at 10-11.

6. On May 18, 2023, Petitioner requested a Fair Hearing to challenge the denial of additional personal care services. On July 14, 2023, the Hearing Officer issued an Order Scheduling Fair Hearing by Telephone and Prehearing Instructions, setting the hearing for August 3, 2023, at 1:00 p.m. EST. At the request of the Petitioner, the undersigned re-scheduled the Fair Hearing for September 14, 2023.

7. Dr. Fillipps' testimony established the following:

a. On December 17, 2023, Respondent authorized eight-four (84) hours per week (or "12/7") of personal care services for the authorization period of December 17, 2022, to June 17, 2023, with the personal care services to be provided by [REDACTED]

[REDACTED] *Id.* at 21.

b. On January 23, 2023, Petitioner appealed the decision and provided documentation in support of the appeal. See Petitioner's Composite Exhibit 1 at 2-13. The

documentation included [REDACTED]'s work schedule, which states that [REDACTED] works forty (40) hours per week. See Petitioner's Composite Exhibit 1 at 11.

c. On January 30, 2023, and based on the documentation submitted, CMS reduced the personal care services from eighty-four (84) to forty (40) hours per week for the authorization period of December 17, 2022, to June 17, 2023. CMS also notified [REDACTED] of the reduction. See Petitioner's Composite Exhibit 1 at 2-3.

d. Subsequent to June 17, 2023, and pursuant to a different authorization request that is not at issue in this case, CMS approved one hundred and four (104) hours per week of personal care services as follows: sixteen (16) hours per day on Monday through Friday; and twelve (12) hours per day on Saturday and Sunday. The current authorization period is June 15, 2023, through December 2023.

e. Dr. Fillipps asserted that the request for reimbursement involves a dispute between [REDACTED] and its employee and is outside of the scope of the Fair Hearing request.

8. [REDACTED] testified that [REDACTED] accepts the currently-authorized one hundred and four (104) hours of personal care services per week in resolution of Petitioner's request for personal care services in this case. [REDACTED] agreed on the record that issue one is resolved.

9. [REDACTED] testified that [REDACTED] works for [REDACTED]. [REDACTED] stated that [REDACTED] did not pay [REDACTED] for the personal care services [REDACTED] performed for Petitioner between the dates of April 17, 2023, and June 14, 2023. [REDACTED] requested back pay for the work performed. No supporting documentation was provided to show the amount [REDACTED] is owed for [REDACTED] work during this time.

10. In making a medical necessity determination, CMS relied upon Sunshine Health Policy and Procedure: Review for Personal Care Requests, FL.UM.25.00 (“Sunshine PC Policy”). *Id.* at 140-

151. Sunshine PC Policy states as follows, in pertinent part:

**PURPOSE:** To establish clinical criteria on which to review requests for Personal Care Services to provide medically necessary assistance with activities of daily living (ADL) and age appropriate instrumental activities of daily living (IADL) that enable a member to accomplish tasks that they would normally be able to do for themselves if they did not have a medical condition or disability. This service will assist in maintaining the member in their home and community environment, in a safe manner.

**POLICY:** Sunshine Health’s Review of Personal Care Services Requests clinical policy supports the utilization management review process for the MMA and Child Welfare benefits described in the Florida Provider’s Handbook entitled, Personal Care Services Coverage Policy.

**Definition**

- **Personal Care Services** are services that assist a member with ADLs or IADLs. These services can be provided to members up to the age of 21. Personal care service assistance can be in the form of hands on assistance (actually performing the task for the member) or cuing along, with supervision, to ensure the member performs the personal care task properly. The personal care services must be prescribed by a treating physician, provided by a home health aide or independent personal care provider, and supervised by a registered nurse if provided through a home health agency, or supervised by the parent or legal guardian if provided by a non-home health agency, or supervised by the member, if the services are provided by a nonhome health agency and the member is a legal adult between the ages of 18 up to 21 with no legal guardian.

**PROCEDURE:**

**Personal Care Services Criteria:**

Personal care services are covered for members who are under the age of 21. In order to be considered for approval, the member’s treating physician must order the service. The member must meet all of the following criteria:

- Member must have one of the functional impairments noted in the “Level of Functional Impairment” section below.
- Member has a documented medical condition or disability that substantially limits the member’s ability to perform their Activities of Daily Living (ADL) and Instrumental Activities of Daily Living (IADL), or has a

documented cognitive impairment which prevents him/her from knowing when or how to carry out the personal care task.

- Member has a documented functional limitation and evidence is provided for one of the following:
  - There is documentation that the member is incapable of learning despite efforts to train in personal care task(s)
  - Member has a documented memory deficit(s) which prevents him/her from managing a personal care task
- Member requires more individual and continuous care than can be provided through a home health aide visit
- Member does not have a parent or legal guardian able to provide ADL or IADL care
- Member would normally perform the age appropriate personal care task without the medical condition or disability, and his/her parent or legal guardian is not able to provide ADL or IADL care

...

#### **Limitations and Exclusions**

- Members, who may benefit from personal care services, include those eligible members who are under the age of 21, only.
- Banking or flex hours of approved personal care service hours, is not allowed. Only the number of hours that are approved as medically necessary can be approved. The total number of hours per week, hours per day, and days per week approved must be followed. Any variations would need to be requested and approved in advance by Sunshine Health.
- Personal care services are not covered in the following locations:
  - a. Hospitals
  - b. Nursing facilities
  - c. Intermediate care facilities for individuals with intellectual disabilities
  - d. Physician offices
  - e. Clinics
  - f. Prescribed pediatric extended care centers
- Personal care services can be covered outside the member's residence if the services are unavailable through other public or private resources, including schools (with documentation of such) and the services are medically necessary while the member is outside his/her home.
- **Personal care services can be provided to a member whose parent or legal guardian is not able to provide ADL or IADL care. Supporting documentation must be provided to substantiate a parent or legal guardian's inability to participate in the care of the member.**
- Personal care services can be authorized to supplement care provided by parents and legal guardians. Parents and legal guardians must participate in providing care to the fullest extent possible. Where needed, the home

health service provider must offer training to enable parents and legal guardians to provide care they can safely render without jeopardizing the health or safety of the recipient. The home health services provider must document the methods used to train a parent or legal guardian in the medical record.

Personal care services do not include:

- Social services
- Transportation services (except when necessary to protect the health and safety of the recipient and no other transportation service is available or when provided as an IADL for recipients under the age of 21 years)
- Escort services
- Care, grooming, or feeding of pets and animals
- Yard work, gardening, or home maintenance work
- Day care or after school care
- Assistance with homework
- Companion sitting or leisure activities
- Housekeeping (except light housekeeping), homemaker, and chore services, including any shopping except grocery shopping when provided as an IADL for recipients under the age of 21 years
- Respite care
- Services which can be effectively and efficiently obtained outside the recipient's place of residence without any medical contraindications
- Baby-sitting

Respondent's Composite Exhibit 1, pages 140-143. (Emphasis added)

### **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 (2019). 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 Petitioner is requesting additional personal care services, Fla. Admin. Code R. 59G-1.100(17)(g) assigns the burden of proof to Petitioner. The standard of proof in an administrative hearing is a preponderance of the evidence. The preponderance of the evidence

standard requires proof by “the greater weight of the evidence” (Black’s Law Dictionary at 1201, 7<sup>th</sup> Ed.)

14. The Florida Medicaid Personal Care Services Coverage Policy (November 2016) (“PC Policy”), incorporated by reference in Rule 59G-4.215, F.A.C., establishes the provision and coverage of personal care services under Florida Medicaid. The PC Policy states 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.

...

**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 (ADL)**

As defined in Rule 59G-1.010, F.A.C.

**1.3.2 Babysitting**

Custodial care, daycare, afterschool care, supervision, or similar childcare unrelated to the services that are documented to be medically necessary for the recipient.

...

**1.3.6 Home Health Services**

Medically necessary services that can be safely provided to the recipient in their home or in the community that include home health visits (skilled nursing and home health aide services), private duty nursing, and personal care services.

...

**2.0 Eligible recipient**

**2.1 General Criteria**

An eligible recipient must be enrolled in the Florida Medicaid program on the date of service and meet the criteria provided in this policy. Provider(s) must verify each recipient's eligibility each time a service is rendered.

## **2.2 Who can receive**

Florida Medicaid recipients under the age of 21 years requiring medically necessary personal care services. Some services may be subject to additional coverage as specified in section 4.0.

Respondent's Composite Exhibit 1 at page 154-155.

16. The PC Policy provides the following general and specific criteria for coverage of personal care services:

### **4.0 Coverage Information**

#### **4.1 General Criteria**

**Florida Medicaid reimburses for services that meet all of the following:**

- Are determined to be 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

...

##### **4.2.1 Parental Responsibility**

Florida Medicaid reimburses for personal care services rendered to a recipient whose parent or legal guardian is not able to provide ADL or IALS care, and to supplement care provided by parents and legal guardians. Parents and legal guardians must participate in providing care to the fullest extent possible. Providers must offer training to enable parents and legal guardians to provide care they can safely render without jeopardizing the health or safety of the recipient when needed.

*Id.* at 156.

15. The Florida Medicaid Definitions Policy (“Definitions Policy”) (August 2017), incorporated by reference in Fla. Admin. Code R. 59G-1.010, “contains definitions of commonly used terms that are applicable to all sections of Rule Division 59G, Florida Administrative Code (F.A.C.), unless specifically stated otherwise in a service-specific coverage policy or rule.” The Definitions Policy provides the following definitions relevant to this case:

### **2.2 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

...

### **2.64 Instrumental Activities of Daily Living (IADLs)**

IADLs include:

- 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)

Definitions Policy at page 1 and 6.

16. States must provide Early and Periodic Screening, Diagnostic, and Treatment (“EPSDT”)

services to Medicaid-eligible children under age 21 when requested under the Medicaid state plan. See 42 U.S.C. § 1396a(a)(43); 42 U.S.C. § 1396d(a)(4). According to 42 U.S.C. § 1396d(r)(5), EPSDT services mean, in relevant part, the following items and services:

Such other necessary health care, diagnostic services, treatment, and other measures described in subsection (a) of this section to correct or ameliorate defects and physical and mental illness and conditions discovered by the screen services, whether or not such services are covered under the state plan.

17. Petitioner is under age 21, and therefore eligible for EPSDT services. However, a state may place medical necessity limitations on EPSDT services. See 42 C.F.R. §§ 440.230(a), (b), (d).

18. Section 409.905(2), Florida Statutes, limits EPSDT services with a medical necessity standard:

The [Agency] shall pay for early and periodic screening and diagnosis of a recipient under age 21 to ascertain physical and mental problems and conditions and all services determined by the agency to be medically necessary for the treatment, correction, or amelioration of these problems and conditions, including personal care, private duty nursing, durable medical equipment, physical therapy, occupational therapy, speech therapy, respiratory therapy, and immunizations.

19. The Definitions Policy defines “Medically Necessary” or “Medical Necessity” as follows:

The medical or allied care, goods, or services furnished or ordered must meet the following conditions:

- Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate pain
- Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient’s needs
- Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational
- Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available statewide

- Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider

The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services does not, in itself, make such care, goods or services medically necessary or a medical necessity or a covered service.

Definitions Policy at page 7.

### **Personal Care Services**

20. Pursuant to Rule 59G-1.100(9)(b)(6), Florida Administrative Code, the Hearing Officer is authorized to dismiss a request for a Fair Hearing because it is moot. The Florida Supreme Court explained in *Godwin v. State*, 593 So.2d 211 (1992) (citing *Dehoff v. Imeson*, 153 Fla. 553 (1943)) that “[a]n issue is moot when the controversy has been so fully resolved that a judicial determination can have no actual effect. . . . A case is ‘moot’ when it presents no actual controversy or when the issues have ceased to exist.” See also *J.W. v. Agency for Health Care Admin.*, 178 So. 3d 542, 544–45 (Fla. 1st DCA 2015) (explaining that because J.W. received the requested treatment, “DCF was correct to dismiss J.W.’s fair hearing request under these circumstances because, once he received the continued psychiatric treatment he’d asked for, *he* no longer needed agency review of Magellan’s decision not to authorize the treatment. Rather, the issue at that point became whether Flagler Hospital could be paid by Medicaid for the services it had rendered *without prior authorization.*”) (emphasis in original).

21. For the current authorization period of June 15, 2023, through December 2023, Petitioner is approved for one hundred and four (104) hours per week of personal care services as follows: sixteen (16) hours per day on Monday through Friday; and twelve (12) hours per day on Saturday and Sunday. See supra ¶ 7. [REDACTED] testified that [REDACTED] accepts the currently-authorized one

hundred and four (104) hours of personal care services per week, for the authorization period of June 15, 2023 – December 11, 2023, in resolution of Petitioner’s request for personal care services in this case. See supra ¶ 8. [REDACTED] agreed that issue one is resolved. See supra ¶ 8.

22. Based on the testimony of the parties, the undersigned concludes that there is no relief that can be granted at a Fair Hearing at this time with regard to issue number one.

### **Request for Back Pay**

18. Pursuant to Florida Administrative Code Rule (“Fla. Admin. Code R.”) 59G-1.100(3), the Agency for Health Care Administration (“AHCA” or “Agency”) has jurisdiction and must provide a Fair Hearing for:

- (a) A [Fee-For-Service] recipient who makes a hearing request regarding:
  - 1. The reduction, suspension, or termination by the Agency of a previously authorized service,
  - 2. The denial, in whole or in part, of a requested service or supply by the Agency, or
  - 3. The failure of the Agency to provide a timely [Notice of Action] subsequent to the Agency’s failure to provide all medically necessary services to the recipient with reasonable promptness.
- (b) An enrollee who makes a hearing request regarding:
  - 1. A notice of plan appeal resolution indicating that the plan appeal did not result in the reversal of a prior denial of a new service, or the reduction, suspension, or termination of a previously authorized service, if timely challenged by the enrollee in accordance with the plan appeal procedures following the timely issuance of the plan’s [Notice of Adverse Benefit Determination] to the enrollee,
  - 2. The failure of the plan to adhere to notice and timing requirements applicable to plan appeals, or
  - 3. The failure of the plan to timely notice the enrollee through a [Notice of Adverse Benefit Determination], subsequent to the plan’s failure to provide medically necessary services requested by the enrollee to the enrollee with reasonable promptness.
- (c) An enrollee who makes a hearing request regarding a disenrollment denial.
- (d) A recipient who receives notification from the Agency pursuant to rule 59G-5.110, F.A.C., that a reimbursement request is denied in whole or in part.
- (e) A recipient entitled to a fair hearing pursuant to section 409.285(2), F.S.
- (f) The Agency need not grant a fair hearing if the sole issue is a federal or state law requiring an automatic change adversely affecting some or all recipients.

**(g) A recipient who makes a hearing request regarding a denial or reduction to a medically necessary Florida Medicaid service and seeks corrective action.**  
(emphasis added)

19. Pursuant to Fla. Admin. Code R. 59G-1.100(17)(p), if the Fair Hearing involves corrective action, the recipient must demand the corrective action and submit record evidence of the recipient's liability or potential liability for payment of the already-provided service.

20. Here, [REDACTED] testified that [REDACTED] works for [REDACTED]. See supra ¶ 9. The record reflects that CMS issued an NABD notifying Petitioner that it reduced the approved level of personal care services to forty (40) hours per week, and also notified [REDACTED] of the reduction. See supra ¶ 7. Based on the testimony, it appears that [REDACTED] did not inform [REDACTED] that [REDACTED] should modify [REDACTED] hours nor does it appear that [REDACTED] paid [REDACTED] for all of the hours [REDACTED] performed between the dates of April 17, 2023, and June 14, 2023. See supra ¶ 9. At the Fair Hearing, [REDACTED] requested back pay for April 17, 2023, through June 14, 2023. However, no supporting documentation was provided to show the amount [REDACTED] would be owed for [REDACTED] work during this time. Further, as Dr. Fillipps testified, this is a regrettable situation; however, the request for back pay is a dispute between [REDACTED] and its employee, and it is outside of the scope of the Fair Hearing request.

21. Fla. Admin. Code R. 59G-1.100(9)(b)(1) authorizes a Hearing Officer to deny or dismiss a request for a Fair Hearing if the Office lacks jurisdiction over the subject matter of the Fair Hearing request. Based on Fla. Admin. Code R. 59G-1.100(3) and 59G-1.100(17)(p), the undersigned concludes that the Office of Fair Hearings lacks jurisdiction over [REDACTED]'s request for back pay from [REDACTED] employer, [REDACTED].

### **DECISION**

With regard to issue one, Respondent's denial of an additional one hundred and twenty-eight (128) hours per week of personal care services is **DISMISSED AS MOOT**.

With regard to issue two, Petitioner's request for back pay is **DISMISSED** for failure lack of jurisdiction.

**DONE** and **ORDERED** this 4th day of October 2023, in Tallahassee, Leon County, Florida.

Laura Gallagher  
23-FH1218  
2023.10.04 08:58:43  
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**LAURA GALLAGHER, 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:**

  


**Children's Medical Services**  
**CMSPlanContract@flhealth.gov**

**AHCA Medicaid Hearing Unit**  
**MedicaidHearingUnit@ahca.myflorida.com**