



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

FILED

Oct 03, 2023, 10:24 am

OFFICE OF FAIR HEARINGS

[REDACTED]

PETITIONER,

AHCA Case No.: 23-FH1805

Plan ID No.: [REDACTED]

vs.

SIMPLY HEALTH CARE PLANS, INC.,

RESPONDENT.

_____ /

[REDACTED]

PETITIONER,

AHCA Case No.: 23-FH1806

Plan ID No.: [REDACTED]

vs.

SIMPLY HEALTH CARE PLANS, INC.,

RESPONDENT.

_____ /

[REDACTED]

PETITIONER,

AHCA Case No.: 23-FH1807

Plan ID No.: [REDACTED]

vs.

SIMPLY HEALTH CARE PLANS, INC.,

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the Office of Fair Hearings convened a telephonic Medicaid Fair Hearing in the above styled case on September 7, 2023, at 9:00 a.m. Eastern Standard Time (“EST”).

APPEARANCES

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

For the Respondent: Sharon Nealy
Fair Hearing Coordinator
Simply Healthcare Plans, Inc.

STATEMENT OF ISSUE

The first issue is whether Petitioner proved by a preponderance of the evidence that Respondent’s denial of thirteen (13) 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 eight (8) hours per week of personal care services was incorrect.

The third issue is whether Petitioner proved by a preponderance of the evidence that Respondent’s denial of nineteen (19) hours per week of respite care services was incorrect.

PRELIMINARY STATEMENT

All parties and witnesses appeared telephonically.

[REDACTED] Petitioner’s Authorized Representative and adult [REDACTED] appeared at the Fair Hearing and provided testimony on Petitioner’s behalf.

Sharon Nealy, Fair Hearing Coordinator for Simply Healthcare Plans, Inc. (“Simply Healthcare”), represented Respondent. Dr. Marc Kaprow (“Dr. Kaprow”), Medical Director with Simply Healthcare, provided testimony on behalf of the Respondent.

Diana Herrod, Medical Healthcare Program Analyst for the Agency for Health Care Administration (“Agency” or “AHCA”), appeared for observational purposes.

Spanish Translator Bigly appeared for the Fair Hearing but disconnected after Ms. Genao, Petitioner’s Authorized Representative, stated she did not require translation services.

Prior to the hearing, Petitioner sent to the Office of Fair Hearings and Respondent a thirty (30) page evidence packet. The evidence packet appears in the Office of Fair Hearings’ Case Management system as “Initial FH request [Petitioner] 30 pgs.pdf”. Absent an objection from Respondent, the undersigned admitted Petitioner’s 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 one hundred and forty-four (144)-page evidence packet. The evidence packet appears in the Office of Fair Hearings’ Case Management system as “FL Simply Packet – [Petitioner] (Updated).pdf”. Absent an objection from Petitioner, the undersigned admitted Respondent’s packet into evidence as Respondent’s Composite Exhibit 1 (“RCE 1”).

FINDINGS OF FACT

1. Petitioner is an enrolled member of Simply Healthcare’s LTC plan. See RCE 1 at 1. Simply Healthcare 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 Fair Hearing, Petitioner is [REDACTED] and lives with [REDACTED]. *Id.* at 15 – 16.
3. [REDACTED] provided the responses to the questions on Petitioner’s Florida Department of Elder Affairs: 701B Comprehensive Assessment, dated May 3, 2023 (“701B Assessment”), see

RCE 1 at 15 – 32, and Petitioner’s other [REDACTED] provided the responses to the questions on the 701B dated June 8, 2023. See RCE 1 at 64 – 81. Petitioner did not answer any questions for either 701B Assessment. *Id.* at 17, 72.

4. According to the 701B Assessment dated June 8, 2023, Petitioner has the following health conditions: [REDACTED]

[REDACTED]

[REDACTED]. *Id.* at 70 – 71. Petitioner has been diagnosed with [REDACTED]. *Id.* at 72. In the last month prior to the 701B Assessment dated June 8, 2023, Petitioner was [REDACTED] nearly every day. *Id.* at 73. Petitioner needs supervision. *Id.* Petitioner is currently receiving skilled nursing specialty care daily and wound care/lesion irrigation specialty care several times a day. *Id.* at 71.

5. According to the 701B Assessment dated June 8, 2023, regarding Petitioner’s Activities of Daily Living (“ADLs”), Petitioner needs total assistance (cannot do at all) with all of [REDACTED] ADLs:

[REDACTED]. *Id.* at 68.

Petitioner always has assistance with all of [REDACTED] ADLs. *Id.*

6. According to the 701B Assessment dated June 8, 2023, regarding Petitioner’s Instrumental Activities of Daily Living (“IADLs”), Petitioner needs total assistance (cannot do at all) with all of her IADLs: [REDACTED]

[REDACTED]. *Id.* at 20.

Petitioner always has assistance with all of [REDACTED] IADLs. *Id.*

7. The notes and summary of the 701B Assessment observe dated June 8, 2023, in pertinent part:

...

[Petitioner] resides with [REDACTED] where this Significant Change was completed. [REDACTED] answered questions on [Petitioner's] [behalf].

[Petitioner's] cognitive impairments limit [REDACTED] ability to complete or assist with [REDACTED] daily activities for which [REDACTED] requires guidance, assistance with all ADLs, and constant supervision.

Members diagnosis are [REDACTED]
[REDACTED]
[REDACTED]. [REDACTED] has also been diagnosed with [REDACTED]
[REDACTED] [Petitioner] was diagnosed with [REDACTED]
[REDACTED] Because of this, [REDACTED] was approved for 2 hrs per day of home health for antibiotic therapy, [REDACTED] was provided a hospital bed, a wheelchair with footrest. This following a hospitalization from [REDACTED]. All in-home

[Petitioner] requires supervision given [REDACTED] and inability to [REDACTED].

All of [Petitioner] meals are prepared by [REDACTED] family members. [REDACTED] is unable to operate any kitchen equipment due to [REDACTED]

[Although] [Petitioner] has other children, [REDACTED] primary caregiver. [REDACTED] indicated that [REDACTED] is willing and able to care for [REDACTED] for as long as it is necessary.

RCE 1 at 65 – 80.

8. Respondent issued a Notice of Adverse Benefit Determinations (“NABD”) partially denying services to Petitioner as of May 11, 2023. *Id.* at 48 – 51. The NABD stated 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: We will cover some of the care you asked for (APPROVE - T1019- PC- 21 HOURS/WEEK Approve - S5130- HMK- 7 HOURS/WEEK Approve -S5150- RESPITE- 7 HOURS/WEEK Approve - T4526U2- PULL-UPS- 4 CHANGES/DAY=124 UNITS/MONTH Approve - T4522U2- BRIEFS- 2 CHANGES/DAY=62 UNITS/MONTH Approve - A4554U2- UNDERPADS- 150 UNIT/MONTH). We cannot cover some of the care that was asked for (DENY - T1019- PC-19 HOURS/WEEK Deny -S5130- HMK- 13 HOURS/WEEK Deny - S5150- RESPITE-43 HOURS/WEEK Deny - T4522U2- BRIFS- 2 CHANGES/DAY=62 UNITS/MONTH). We have reviewed your records. You do not live alone. You need total care for some tasks. With the care approved, you are getting enough care for your needs (combined 35 hours of weekly care). This is based on the Florida Medicaid Statewide Managed Care Long Term Care Program Coverage Policy, 4.0, 6.2. A peer to peer reconsideration may be requested by your physician/health care provider within 2 days of the adverse determination. A formal appeal must be filed after this time frame. To request a peer to peer please call 833-414-3639.

...

Id. at 48 – 49.

9. Petitioner requested plan appeals regarding Respondent's denials of the requested services. On June 23, 2023, Respondent issued a Notice of Plan Appeal Resolution ("NPAR"), that approved eleven (11) additional hours of personal care services, weekly, and ten (10) hours of

respite care, weekly; but upheld the denial of thirteen (13) additional hours weekly of homemaker services, eight (8) additional hours weekly of personal care services, and thirty-three (33) additional hours of respite care services *Id.* at 87 – 89. The NPAR stated the reason for Respondent’s denials as follows, in pertinent part:

On 06/09/2023, we received your timely plan appeal request regarding Simply Healthcare Plans, Inc.’s Notice of Adverse Benefit Determination dated 06/03/2023, NABD Number 113101913, SUSPENDING the home based services provided to [Petitioner]. The facts that we used to make our decision are: You were admitted to the hospital on [REDACTED].

On 06/23/2023, after consideration of the information you provided to Simply in support of your plan appeal, Simply hereby PARTIALLY APPROVES your plan appeal. As a result, [Petitioner] will receive APPROVE – T1019: Personal care, 11 more hours weekly; S5150: Respite Care, 10 more hours weekly, effective 06/23/2023. Based on your records and the Florida Medicaid Statewide Managed Care Long Term Care Program Coverage Policy, 6.2 the denial of care (T1019: Personal care, 19 more hours weekly, S5130: Homemaker Care, 13 more hours weekly; S5150: Respite Care, 43 more hours weekly) is PARTIALLY OVERTURNED. We looked at your state forms. We know you live with several family members. We know you need total care. We did not see a large unmet need in your care plan. We will cover some of the care that was denied (APPROVE – T1019: Personal care, 11 more hours weekly; S5150: Respite Care, 10 more hours weekly). All of the care you get can help around the home. All of the care you get can help relieve your family. With the care approved, you are getting enough care to meet these needs (combined 56 hours of weekly care). The extra care is not needed. That is why it is still not approved (UPHOLD DENIAL – T1019: Personal care, 8 extra hours weekly; S5130: Homemaker Care, 13 extra hours weekly; S5150: Respite Care, 33 extra hours weekly). You may arrange this care in shifts to make sure your needs are met. You may arrange this care as you wish to relieve your family. More care is not needed. Your case was looked at by a specialist in Internal Medicine, Hospice & Palliative Medicine for Simply.

...

RCE 1 at 87 – 88.

10. On July 20, 2023, Petitioner requested a Fair Hearing due to the denial of homemaker services, denial of personal care services, and denial of respite care services. On August 11, 2023, the undersigned issued an Order Scheduling Fair Hearing by Telephone and Prehearing Instructions, setting the Fair Hearing for September 7, 2023, at 9:00 a.m. EST.

11. Petitioner’s authorized representative and adult child, Ms. Genao, testified as follows:

- a. Petitioner's care was interrupted for a few months because [REDACTED] visited family in the Dominican Republic.
- b. Petitioner lives with [REDACTED].
- c. Petitioner's family members work different schedules, but typically the family leaves the home by 7:30 a.m. and return home between 7:30 p.m. and 8:00 p.m. Petitioner is never left alone. Petitioner is cared for by friends from the church between 7:30 a.m. and the arrival of the home health aide ("HHA"). The HHA is typically with Petitioner Monday through Sunday, 12:30 p.m. to 8:30 p.m.
- d. [REDACTED] stated [REDACTED] is a [REDACTED] and needs to take care of [REDACTED] family. [REDACTED] does not work on Saturdays or Sundays. [REDACTED] cannot only dedicate herself to Petitioner on the weekend because there is no one else to do things for the family. [REDACTED] also needs to do things for [REDACTED] needs. The other family members in the home give limited help. [REDACTED] cannot ask [REDACTED] to help bathe or do private things for Petitioner.
- e. [REDACTED] did discuss allocating Petitioner's current fifty-six (56) hours of care each week to cover the time frame of 7:30 a.m. to 12:30 p.m. [REDACTED] declined to reallocate the service hours because [REDACTED] needs time for [REDACTED] on the weekends.
- f. Petitioner's health has deteriorated a great deal over the last year. Petitioner was hospitalized from [REDACTED]. [REDACTED] did not provide documents from this hospital stay.

12. Dr. Kaprow is a Medical Director for Simply Health. Dr. Kaprow testified as follows:
- a. Personal care assistance is specially defined to provide assistance with ADLs, such as dressing, bathing, toileting, diaper changes, transferring in and out of bed, and spoon feeding if needed.
 - b. Homemaker care services are to provide a clean and safe environment.
 - c. Respite care services are based on what the caregiver's needs are. There is a general understanding that if a person who is nursing home appropriate, such as Petitioner, maintaining a member at home takes an extraordinary effort by family. There is a need to have services in place to prevent caregiver burnout. Dr. Kaprow recommended that Petitioner receive an additional fourteen (14) hours per week of respite care services.
 - d. Dr. Kaprow reviewed Petitioner's ADLs and IADLs. *See* RCE 1 at 68 – 69. Petitioner has a substantial need with [REDACTED] ADLs but always has assistance. There is a need for constant supervision because of Petitioner's [REDACTED]. IADLs are normally performed by a homemaker and can be performed by a personal care person. Any care that can be provided by a homemaker caregiver or personal care caregiver can be provided by a respite caregivers. Both personal care givers and respite care givers can provide hands on needs. Homemaker hours are specifically to be used for non-hands on needs and are to be used for housekeeping, preparing meals, shopping, or doing other chores around the house.
 - e. There is not a substantial gap between Petitioner's needs and Petitioner's assistance.

- f. None of the care being requested is medical care.
- g. [REDACTED] is providing approximately seventy (70) hours per week of care for Petitioner. See RCE 1 at 78. [REDACTED] is experiencing mental or emotional strain caring for Petitioner. *Id.* at 79. Dr. Kaprow recommends that the other family members become more involved in the care of Petitioner.
- h. Dr. Kaprow is concerned that the family is out of the home for sixty (60) hours per week, Monday to Friday.

13. During the Fair Hearing, Dr. Kaprow approved for Petitioner to receive an additional fourteen (14) hours of respite care services. Absent an objection from Petitioner, the undersigned admitted the additional thirteen (13) pages into evidence as Respondent's Composite Exhibit 2 ("RCE 2"). Respondent continues to deny an additional nineteen (19) hours per week of respite care services. In light of the additional correspondence, Petitioner is authorized to receive the following services each week: thirty-two (32) hours of personal care services, seven (7) hours of homemaker services, and twenty-nine (29) hours of respite care services, for a total sixty-eight (68) hours of care services each week.

CONCLUSIONS OF LAW

14. 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).

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

16. 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.

17. 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, personal care services, and respite 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.).

18. 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.

...

1.3.16 Natural Supports

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

...

2.2 Who Can Receive

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

...

4.0 Coverage Information

4.1 General Criteria

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

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

4.2 Specific Criteria

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

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

...

4.2.1 Home and Community-Based Supportive Services

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

4.2.1.1 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.

...

4.2.1.15 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:

...

4.2.2.6 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 at 125 – 132.

19. 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.

RCE 1 at 126 – 127.

20. The Personal Care Services Coverage Policy ("PCS Policy"), which is incorporated by reference in Rule 59G-4.215, F.A.C., 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.

...

1.3.6 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.

...

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	15–30 minutes day for all monitoring tasks performed

recipient with pre-poured medications, monitoring vital signs, and measurement of intake/output.	
--	--

PC Policy at 1, 3 – 5.

A. Denial of Homemaker Services

21. In the instant case, Respondent denied thirteen (13) hours per week of homemaker services. 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.

22. 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 ¶ 18. 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 ¶ 18.

23. The evidence presented in this case does not reflect that thirteen (13) hours per week of homemaker services are warranted. Dr. Kaprow testified that homemaker care services are to provide a clean and safe environment. See supra ¶ 12. Regarding [REDACTED] IADLs, Petitioner needs total assistance (cannot do at all) with all of [REDACTED] IADLs: [REDACTED]

[REDACTED]

[REDACTED]. See supra ¶ 6. Petitioner always has assistance with all of [REDACTED] IADLs. See supra

¶ 6. [REDACTED] testified that Petitioner is never alone. See supra ¶ 11. Dr. Kaprow testified that there are no gaps in Petitioner's care. See supra ¶ 12.

24. Petitioner has multiple medical conditions, including [REDACTED]
[REDACTED]
[REDACTED]. See supra ¶ 4, 7. Petitioner is currently receiving skilled nursing specialty care daily and wound care/lesion irrigation specialty care several times a day. See supra ¶ 4. Although Petitioner's medical conditions impact [REDACTED] assistance needs with [REDACTED] ADLs and IADLs, Petitioner is received sixty-eight (68) hours of care services each week.

25. The SMMC LTC Policy requires 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 ¶ 18. Here, Petitioner is currently authorized to receive thirty-two (32) hours of personal care services, seven (7) hours of homemaker services, and twenty-nine (29) hours of respite care services, for a total sixty-eight (68) hours of care services each week. See supra ¶ 13.

26. Here, Petitioner bears the burden of proof regarding the denial of thirteen (13) hours per week of homemaker services. See supra ¶ 17. Neither Petitioner nor [REDACTED] provided evidence (e.g., a daily schedule, a schedule of ADLs and IADLs, the amount of time Petitioner requires for each of her ADLs and IADLs) to support the request for additional homemaker service care hours. The definition of homemaker services most closely aligns with IALD tasks. According to the 710B Assessment dated June 8, 2023, Petitioner always has assistance with all of [REDACTED] IADLs. See supra ¶ 6. [REDACTED] did not explain which ADLs or IADLs Petitioner needs

assistance with and is not receiving said assistance. Again, Dr. Kaprow testified that there are no gaps in Petitioner's care. *See supra* ¶ 12.

27. Considering the totality of Petitioner's circumstances, including [REDACTED] medical diagnoses, level of functional need for assistance with IADLs, amount of currently approved services, and the natural support provided by [REDACTED] family that [REDACTED] lives with, Petitioner failed to prove by a preponderance of the evidence that request for an additional thirteen (13) hours per week of homemaker services are not "in excess of [Petitioner's] needs." *See supra* ¶ 18.

28. In light of both parties' testimony, Petitioner's Composite Exhibit 1, Respondent's Composite Exhibit 1, and the applicable laws and policies, the undersigned Hearing Officer finds that Petitioner failed to meet the burden of proving that thirteen (13) hours per week of homemaker 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 homemaker services was incorrect.

B. Denial of Personal Care Services

29. In the instant case, Respondent denied eight (8) hours per week of personal care services. *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.

30. 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* ¶ 18. 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 ¶ 18.

31. The evidence presented in this case does not reflect that an additional eight (8) hours per week of personal care services are warranted. Dr. Kaprow testified that personal care services are specially defined to provide assistance with ADLs. See supra ¶ 12. Further, personal care services also align with IADLs. See supra ¶ 20. The notes and summaries in the 701B assessment observe that Petitioner’s [REDACTED] limit [REDACTED] ability to complete or assist with [REDACTED] ADLs. See supra ¶ 8. Regarding [REDACTED] ADLs, Petitioner needs total assistance (cannot do at all) with all of [REDACTED] ADLs: [REDACTED] [REDACTED] See supra ¶ 5. Regarding [REDACTED] IADLs, Petitioner needs total assistance (cannot do at all) with all of [REDACTED] IADLs: [REDACTED] [REDACTED]. See supra ¶ 6. [REDACTED] testified that Petitioner is never alone. See supra ¶ 11. Dr. Kaprow testified that there are no gaps in Petitioner’s care. See supra ¶ 12.

32. Petitioner has multiple medical conditions, including [REDACTED] [REDACTED] [REDACTED]. See supra ¶ 4.

4. Petitioner is currently receiving skilled nursing specialty care daily and wound care/lesion irrigation specialty care several times a day. See supra ¶ 4.

33. The SMMC LTC Policy requires 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 ¶ 18. Here, Petitioner is currently authorized to receive thirty-two (32) hours of personal care services, seven (7) hours of homemaker services, and twenty-nine (29) hours of respite care services, for a total sixty-eight (68) hours of care services each week. See supra ¶ 13.

34. Here, Petitioner bears the burden of proof regarding the denial of thirteen (13) hours per week of personal care services. See supra ¶ 17. Neither Petitioner nor [REDACTED] provided evidence (e.g., a daily schedule, a schedule of ADLs and IADLs, the amount of time Petitioner requires for each of her ADLs and IADLs) to support the request for additional personal care service hours. See supra ¶ 20. According to the 710B Assessment, Petitioner always has assistance with all of [REDACTED] ADLs and all of [REDACTED] IADLs. See supra ¶ 3 – 4. [REDACTED] did not explain which ADL or IADL tasks Petitioner needs assistance with and is not receiving said assistance. Again, Dr. Kaprow testified that there are no gaps in Petitioner's care. See supra ¶ 12.

35. Considering the totality of Petitioner's circumstances, including [REDACTED] medical diagnoses, level of functional need for assistance with ADLs, amount of currently approved services, and the natural support provided by her family that [REDACTED] lives with, Petitioner failed to prove by a preponderance of the evidence that request for an additional eight (8) hours per week of personal care services are not "in excess of [Petitioner's] needs." See supra ¶ 18.

36. In light of both parties' testimony, Petitioner's Composite Exhibit 1, Respondent's Composite Exhibit 1, and the applicable laws and policies, the undersigned Hearing Officer finds that Petitioner failed to meet [REDACTED] burden of proving that an additional eight (8) hours weekly of personal care 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 services was incorrect.

C. Denial of Respite Care Services

37. In the instant case, Respondent denied thirty-three (33) hours per week of respite care services. See supra ¶ 6 and 7. 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. Dr. Kaprow recommended that Petitioner receive an additional fourteen (14) hours per week of respite care services. See supra ¶ 12. Respondent authorized an additional fourteen (14) hours of respite care services each week. See supra ¶ 13. As such, an additional nineteen (19) hours, weekly, of respite care services are at issue.

38. 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 ¶ 18. Section 4.2.1.9 of the SMMC LTC Policy defines respite care services as 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." See supra ¶ 18.

39. Section 1.3.14 of the LTC Policy requires that "LTC supportive 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," "[b]e 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," "[b]e furnished in a manner not primarily intended

for the convenience of the recipient, the recipient's caretaker, or the provider,” and “[e]nable the enrollee to maintain or regain functional capacity;” or “[e]nable 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.” See supra ¶ 19.

40. The evidence presented in this case does not reflect that an additional nineteen (19) hours per week of respite care services are warranted. Dr. Kaprow testified that respite care services are in place to prevent caregiver burnout. See supra ¶ 12. As discussed, see supra ¶ 23, Petitioner needs total assistance with ADLs and IADLs. Ms. Genao testified that Petitioner is never alone. See supra ¶ 11. Ms. Genao also testified that she did discuss allocating Petitioner’s current service care hours to cover the time frame of 7:30 a.m. to 12:30 p.m. to cover the time friends from the church care for Petitioner before the HHA arrives. See supra ¶ 11 Monday through Friday, but that [REDACTED] declined to reallocate the service hours because [REDACTED] needs time for [REDACTED] on the weekends. Dr. Kaprow testified that there is a need for constant supervision for Petitioner because of [REDACTED] cognitive impairments and that there are no gaps in Petitioner’s care. See supra ¶ 12.

41. [REDACTED] testified that the requested additional hours of respite care are because [REDACTED] needs to do things for [REDACTED] and that other family members in the home give limited help. See supra ¶ 11. However, as stated above, services may not be furnished in a manner primarily intended for the convenience of the recipient, *the recipient’s caretaker*, or the provider. See supra ¶ 8, 18, 19. (Emphasis added). As Petitioner is never alone, has family and church friends for additional help, and receives sixty-eight (68) hours of care services each week, the requested service hours are primarily intended for the convenience of the caretaker and are in excess of

Petitioner's medical needs. Petitioner failed to show how the requested services are medically necessary, not intended primarily for the convenience of the caretaker, and are not excess of Petitioner's medical needs.

42. In light of both parties' testimony, Petitioner's Composite Exhibit 1, Respondent's Composite Exhibit 1, and the applicable laws and policies, the undersigned Hearing Officer finds that Petitioner failed to meet [REDACTED] burden of proving that an additional nineteen (19) hours weekly of respite care 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 respite care services was incorrect.

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

DONE AND ORDERED this 3rd day of October, 2023 in Tallahassee, Leon County, Florida.



Kameisha Presley
23-FH1805 23-FH1806
23-FH1807
2023.10.03 09:48:50
-04'00'

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:



**Simply Health Care Plans, Inc.
MedicaidFairHearings@simplyhealthcareplans.com**

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