

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



FILED

Oct 31, 2023, 9:14 am
OFFICE OF FAIR HEARINGS

[REDACTED],

PETITIONER,

AHCA Case No.: 23-FH1981

Plan ID No.: [REDACTED]

vs.

SUNSHINE STATE HEALTH PLAN, INC.,

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the Office of Fair Hearings (“OFH”) convened a telephonic Medicaid Fair Hearing in the above styled case on October 6, 2023, at 10:04 a.m. Eastern Standard Time (“EST”).

APPEARANCES

For the Petitioner:

[REDACTED]

Petitioner’s Authorized Representative

For the Respondent:

Kimberly Bouchette
Clinical Appeals Coordinator
Sunshine State Health Plan, Inc.

STATEMENT OF ISSUE

The issue is whether Petitioner proved by a preponderance of the evidence that Respondent’s denial of an additional fourteen (14) hours per week of personal care services was incorrect.

PRELIMINARY STATEMENT

All parties and witnesses appeared telephonically. [REDACTED] the Petitioner's Authorized Representative, appeared at the hearing and provided testimony on the Petitioner's behalf.

Kimberly Bouchette ("Ms. Bouchette"), Clinical Appeals Coordinator for Sunshine State Health Plan, Inc. ("Sunshine"), appeared for the hearing and represented Respondent. Dr. John Carter ("Dr. Carter"), Long Term Care Medical Director for Sunshine, provided testimony on behalf of the Respondent. The following individuals also appeared on behalf of Respondent but did not provide testimony: Ishara Howard, Care Coordinator 2; Samantha Sutton, Case Management Supervisor; and Kelly Wood, Long Term Care Case Manager. Sandra Durden, Medical Healthcare Program Analyst and Fair Hearing Liaison ("Ms. Durden") for the Agency for Health Care Administration ("Agency" or "AHCA"), appeared for observational purposes.

Prior to the hearing, the Petitioner a two (2) page Fair Hearing Request that was admitted into evidence without objection, is identified as "Petitioner's Exhibit 1" and is recorded in the Office of Fair Hearings document management system as "[Petitioner] Fair Hearing Request.pdf".

Prior to the hearing, Respondent sent to the Office of Fair Hearings and Petitioner a one hundred and fifty-three (153)-page evidence packet that was admitted into evidence without objection, identified herein as "Respondent's Composite Exhibit 1", and is recorded in the Office of Fair Hearings document management system and designated as file "MFH Packet [Petitioner's last name].pdf."

FINDINGS OF FACT

1. Petitioner is an enrolled member of Sunshine’s Long-Term Care (“LTC”) plan effective on June 1, 2023, and October 1, 2021, for the Sunshine Medicaid (MMA) line of business. See Respondent’s Composite Exhibit 1, page 2. The Petitioner also has Medicare with another insurance carrier. *Id.* Sunshine is a managed care organization contracted by AHCA to provide services to eligible Medicaid recipients in Florida.

2. As of the time of the hearing, Petitioner is a [REDACTED], is [REDACTED] and lives in a private residence with [REDACTED]. See Respondent’s Composite Exhibit 1, page 29. The Petitioner’s [REDACTED] also serves as the primary caregiver See Respondent’s Composite Exhibit 1, page 77.

3. The Petitioner has the following health conditions: [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED] See Respondent’s Composite Exhibit 1, pages 67, 69–70. The Petitioner has not been diagnosed with any [REDACTED]
[REDACTED] See Respondent’s Composite Exhibit 1, page 65.

4. The Florida Department of Elder Affairs 701B Comprehensive Assessment (“701B”), dated August 7, 2023 (the “8/7/23 701B”), which is the most recent 701B on the record, reflects the following regarding the Petitioner’s Activities of Daily Living (“ADLs”). See Respondent’s Composite Exhibit 1, Page 67. The Petitioner needs total assistance (cannot do at all) with [REDACTED]. *Id.* The Petitioner needs some assistance (but not total help) with [REDACTED] and requires no assistance with [REDACTED]. *Id.* In addition, the

Petitioner is [REDACTED] and the 8/7/23, 701B reflects the Petitioner's only [REDACTED] [REDACTED] *Id* and Respondent's Composite Exhibit 29. Finally, the 8/7/23 701B, reflects the Petitioner always has assistance performing [REDACTED] ADLs, except for [REDACTED] for which no assistance is required. See Respondent's Composite Exhibit 1, page 67.

5. Regarding Petitioner's Instrumental Activities of Daily Living ("IADLs"), the 8/7/23 701B, reflects that Petitioner requires total assistance (cannot do at all) with [REDACTED] [REDACTED] [REDACTED] See Respondent's Composite Exhibit 1, page 68. The 8/7/23 701B further reflects the Petitioner requires some assistance (but not total help) with [REDACTED] and no assistance with [REDACTED]. *Id.*

6. Petitioner is currently authorized to receive the following home and community-based services: sixteen (16) hours per week of Participant Directed Option ("PDO") personal care services by [REDACTED] and four (4) hours per week of PDO homemaker services by [REDACTED]. See Respondent's Composite Exhibit 1, page 35 and *Dr. Carter Testimony*.

7. On May 22, 2023, the Petitioner requested an additional twenty-four (24) hours of personal care services per week. See Respondent's Composite Exhibit 1, pages 4. On May 24, 2023, the Respondent issued a NABD approving ten (10) additional hours of personal care hours per week and denying the remaining additional fourteen (14) hours per week of personal care services. See Respondent's Composite Exhibit 1, pages 4-12. The NABD stated the reason for Respondent's determination as follows:

- We determined that your requested services are **not medically necessary** because the services do not meet 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: The request for an extra 24 hours per week of Personal Care Services is partially approved. The member's present care plan includes 6 hours per week of Personal Care Services and 4 hours per week of Homemaker Services. Based on the assessment of the member's care needs and household and caregiver status, Sunshine Health will approve an extra 10 hours per week of Personal Care Services and will deny the remaining 14 hours per week of Personal Care Services. The updated care plan approved by Sunshine Health will include 16 hours per week of Personal Care Services and 4 hours per week of Homemaker Services. This decision was made with Sunshine Health Policy LT.UM.09 Long Term Care Ancillary Service Criteria.

Id.

8. On June 20, 2023, the Petitioner requested an appeal of Respondent's May 24, 2023, denial. See Respondent's Composite Exhibit 1, page 107. On July 15, 2023, Respondent sent Petitioner a Notice of Plan Appeal Resolution ("NPAR"), denying Petitioner's plan appeal. *Id.* at 107-110. The NPAR stated as follows:

The reason for our decision was based on medical necessity. On appeal Sunshine Health will deny the requested 14 hours per week of Personal Care Services as not

medically needed. The care plan approved by Sunshine Health will include: 16 hours per week of Personal Care Services and 4 hours per week of Homemaker Services. The prior decision is upheld. This decision was made with Sunshine Health Policy LT.UM.09 Long Term Care Ancillary Service Criteria. This decision was made by a Medical Director who is Board Certified Physician in Internal Medicine.

Id.

9. Respondent relied upon the Sunshine Long Term Care (LTC) Ancillary Service Criteria, Policy ID: FL.LT.UM.09 to make its determination in this case, which states in pertinent part, as follows:

PURPOSE:

To establish clinical criteria on which to review Sunshine Health Long Term Care (LTC) line of business ancillary services for members residing in a home and community based environment. The goal of the ancillary services is to provide these supportive services in the home to address the member’s cognitive and functional deficits, which may be a result of their medical conditions. The services will assist in maintaining the members in their home and community environment, in a safe manner, to avoid the risk for nursing home placement.

...

7. Personal Care Services

In accordance with Rule 59G-4.215, F.A.C., for member 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 member. The scope and nature of these services do not otherwise differ from personal care services furnished to persons under the age of 21 years. A service that provides assistance with eating, bathing, dressing and personal hygiene, and other activities of daily living. The service includes assistance with preparation of meals, but does not include the cost of meals. The service may also include housekeeping tasks such as bed making, dusting and vacuuming, which are incidental to the care furnished or are essential to the health and welfare of the member, rather than the member’s family. Personal care services include the following:

- a. Assistance to the member to complete personal hygiene (bathing, grooming, mouth care, etc.)
- b. Assistance with bladder and bowel requirements that include assisting the member to and from the bathroom or with bedpan routines
- c. Assisting the member in following through with physician orders
The Personal Care provider cannot not administer any medications, but

may bring medications to the member and remind the member to take the medicine at specific times

- d. Assisting with food, nutrition, and diet activities, including preparing meals, when required and other incidental services, (i.e. housekeeping chores) essential to the health and welfare of the member
- e. Performing household services (changing bed linen or arranging furniture), when such services are essential to the member's health and comfort.

...

d) Transferring Considerations

Transferring is the member's ability to move horizontally and/or vertically between the bed, chair, wheelchair, commode, etc. It includes an assessment of the member's:

- Ability to use any mechanical devices such as a walker, cane, handrails, or wheelchair to assist with transfers
- Ability to safely transfer without the assistance of another person
- Ability to physically participate in the transfer by pivoting, holding on, or bracing themselves to assist the caregiver

e) Mobility Considerations

Mobility is the extent of the member's purposeful movement within their residence. It includes an assessment of the member's:

- Ability to purposely move about his/her residence independently with or without the use of assistive devices, this includes the ability of a member to move around in a wheelchair
- Movements being unsafe without the assistance of another person in ambulating
- Muscle weakness, unstable gait or unstable

...

Approval Criteria

Personal Care Services reviews include four (4) criteria:

- a) Activity of Daily Living (ADL) limitations
- b) Living situation
- c) Supervision needs
- d) Available Supports

...

Respondent's Composite Exhibit 1, pages 128 and 142.

10. The Petitioner requested a Fair Hearing due to the denial of an additional fourteen (14) hours per week of personal care services. The undersigned scheduled the Fair Hearing that was convened on October 6, 2023, at 10:04 a.m. EST.

11. During the Fair Hearing, the Petitioner's Authorized Representative testified in the past the Petitioner had forty (40) hours of personal care services per week, that the Petitioner's current request was for less than forty (40) hours, and that it's unfair that [REDACTED], as the principal caregiver, must provide all the Petitioner's services. Therefore, the additional fourteen (14) hours of personal care services disputed in this matter should be granted as a matter of fairness. The Authorized Representative also testified [REDACTED] and the principal caregiver is [REDACTED], has no adverse health conditions, and does not work outside of the household.

12. Dr. Carter is the Long-Term Care Medical Director for Sunshine and testified the Petitioner became a member of Sunshine in 2023. Dr. Carter testified very specifically as to the Petitioner's medical conditions, living situation, natural supports, and the Petitioner's abilities to perform ADLs and IADL's. Dr. Carter further testified that Sunshine approved ten (10) of the requested twenty-four (24) hours of personal care services per week for a current total of sixteen (16) hours per week, and that additional personal care service hours are not medically necessary.

CONCLUSIONS OF LAW

13. The Agency's Office of Fair Hearings has jurisdiction over the subject matter of this proceeding and the parties pursuant to Fla. Stat. § 409.285(2). This order is the final administrative decision of AHCA under Fla. Stat. § 409.285(2)(a).

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

15. The burden of proof in this proceeding is governed by Fla. Admin. Code R. 59G-1.100(17)(g), which provides as follows:

The burden of proof is on the party asserting the affirmative of an issue, except as otherwise required by statute. The burden of proof is on the Agency or plan, whichever is applicable, when the issue presented is the suspension, reduction, or termination of a previously authorized service. The burden of proof is on the recipient or enrollee, when the issue presented is the denial or a limited authorization of a service. The party with the burden of proof shall establish its position to the satisfaction of the Hearing Officer by a preponderance of the evidence.

16. Because Petitioner is requesting additional services, Fla. Admin. Code R. 59G-1.100(17)(g) assigns the burden of proof to the Petitioner. The standard of proof in an administrative hearing is a preponderance of the evidence. The preponderance of the evidence standard requires proof by “the greater weight of the evidence” (Black’s Law Dictionary at 1201, 7th Ed.).

17. The Florida Medicaid policy that applies to the requested services is the Florida Medicaid Statewide Medicaid Managed Care Long-term Care Program Coverage Policy (“March 2017”) (“SMMC LTC Policy”). The Agency’s SMMC LTC Policy has been incorporated, by reference, into Florida Administrative Code Rule 59G-4.192. The SMMC LTC Policy provides as follows:

1.1 Description and Program Goal

Under the Statewide Medicaid Managed Care Long-term Care (LTC) program, managed care plans (LTC plans) are required to provide an array of home and community-based services that enable enrollees to live in the community and to avoid institutionalization.

...

1.3 Definitions

The following definitions are applicable to this policy. For additional definitions that are applicable to all sections of Rule Division 59G, F.A.C., please refer to the Florida Medicaid definitions policy.

1.3.1 Activities of Daily Living (ADLs)

ADLs include:

- Bathing
- Dressing
- Eating (oral feedings and fluid intake)
- Maintaining continence (examples include taking care of a catheter or colostomy bag or changing a disposable incontinence product when the recipient is unable to control bowel or bladder functions)

- Toileting
- Transferring

...

1.3.5 701-B Comprehensive Assessment

An individualized, complete assessment of an individual's medical, developmental, behavioral, social, financial, and environmental status. The assessment is conducted by a trained individual employed by the Department of Elder Affairs Comprehensive Assessment and Review for Long-Term Care Services (CARES) program or the LTC plan, to determine eligibility for the LTC program based on the need for a nursing facility level of care.

...

1.3.9 Instrumental Activities of Daily Living (IADLs)

When necessary for the recipient to function independently, including:

- Grocery shopping
- Laundry
- Light housework
- Meal preparation
- Medication management
- Money management
- Personal hygiene
- Transportation
- Using the telephone to take care of essential tasks (examples include paying bills and setting up medical appointments)

...

1.3.14 Medically Necessary or Medical Necessity

For the purposes of this policy, the service must meet either of the following criteria:

- (a) Nursing facility services and mixed services must meet the medical necessity criteria defined in Rule 59G-1.010, F.A.C.
- (b) All other LTC supportive services must meet all of the following:
 - Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs
 - Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available statewide
 - Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider

And, one of the following:

- Enable the enrollee to maintain or regain functional capacity; or
- Enable the enrollee to have access to the benefits of community living, to achieve person-centered goals, and to live and work in the setting of his or her choice.

...

1.3.16 Natural Supports

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

...

2.2 Who Can Receive

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

...

4.0 Coverage Information

4.1 General Criteria

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

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

4.2 Specific Criteria

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

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

...

4.2.1 Home and Community-Based Supportive Services

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

...

4.2.1.9 Homemaker Services

The provision of general household activities (such as meal preparation) and routine household care (including laundry and pest control) by a trained homemaker, when the individual regularly responsible for these activities is temporarily absent or unable to manage these activities.

...

4.2.2 Mixed Services

Mixed services may exceed State Plan limits on those services in accordance with this policy. The Long-term Care benefit includes coverage of the following mixed services:

...

4.2.2.6 Personal Care

In accordance with Rule 59G-4.215, F.A.C., for enrollees under the age of 21 years. To provide assistance with ADLs and IADLs, including assistance with preparation of meals, and housekeeping chores which are incidental to the care furnished or are essential to the health and welfare of the enrollee. The scope and nature of these services do not otherwise differ from personal care services furnished to persons under the age of 21 years.

...

6.0 Documentation

...

6.2 Specific Criteria

In order to receive LTC services, services must be documented on an individualized plan of care based upon a comprehensive needs assessment. The comprehensive assessment includes the completion of the 701-B Comprehensive Assessment and the LTC Supplemental Assessment.

SMMC LTC Policy, pages 1-8, 16.

18. The Florida Medicaid Definitions Policy (August 2017) (“Definitions Policy”), which is incorporated by reference in Fla. Admin. Code R. 59G-1.010, defines “medical necessity” as follows:

2.83 Medically Necessary or Medical Necessity

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

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

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

Definitions Policy at page 7.

19. The Agency's Florida Medicaid Personal Care Services Coverage Policy (November 2016)

("PC Policy") has been incorporated, by reference, into Fla. Admin. Code R. 59G-4.215. The PC

Policy provides as follows:

1.1 Description

Florida Medicaid personal care services provide medically necessary assistance, in the home or in the community, with activities of daily living (ADL) and age appropriate instrumental activities of daily living (IADL) to enable recipients to accomplish tasks they would normally be able to do for themselves if they did not have a medical condition or disability.

...

1.1.2 Statewide Medicaid Managed Care Plans

Florida Medicaid managed care plans must comply with the coverage requirements outlined in this policy, unless otherwise specified in the AHCA contract with the Florida Medicaid managed care plan. The provision of services to recipients enrolled in a Florida Medicaid managed care plan must not be subject to more stringent coverage limits than specified in Florida Medicaid policies.

...

4.0 Coverage Information

4.1 General Criteria

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

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

4.2 Specific Criteria

Florida Medicaid reimburses for up to 24 hours of personal care services per day, per recipient, in order to provide assistance with ADLs and age appropriate IADLs when the recipient meets the following criteria:

- Has a medical condition or disability that substantially limits their ability to perform ADLs or IADLs and do not have a parent or legal guardian able to provide the required care
- Is under the care of a physician and has a physician's order for personal care services

- Requires more extensive and continual care than can be provided through a home health visit
- Requires services that can be safely provided in their home or the community
- . . .

5.1 General Non-Covered Criteria

Services related to this policy are not reimbursed when any of the following apply:

- The service does not meet the medical necessity criteria listed in section 1.0.
- The recipient does not meet the eligibility requirements listed in section 2.0.
- The service unnecessarily duplicates another provider's service.

5.2 Specific Non-Covered Criteria

Florida Medicaid does not reimburse for the following:

- A skill level other than what is prescribed in the physician order and approved plan of care (POC)
- Assistance with homework
- Babysitting
- Care, grooming, or feeding of pets and animals
- Certification of the POC by a physician
- Companion sitting or leisure activities
- Escort services
- Housekeeping (except light housekeeping to make the environment safe), homemaker, and chore services
- Nursing assessments related to the POC
- Professional development training or supervision of home health staff or other home health personnel
- Respite care to facilitate the parent or legal guardian attending to personal matters
- Services funded under section 110 of the Rehabilitation Act of 1973 or under the provisions of the Individuals with Disabilities Educational Act
- Services furnished by relatives as defined in section 429.02(18), F.S., household members, or any person with custodial or legal responsibility for the recipient. (Except when a recipient is enrolled in the Consumer-Directed Care Plus program)
- Services provided in any of the following locations:
 - Hospitals
 - Intermediate care facility for individuals with intellectual disabilities – Nursing facilities
 - Prescribed pediatric extended care centers
 - Residential facilities or assisted living facilities when the services duplicate those provided by the facility
- Services rendered prior to the development and approval of the POC
- Travel time to or from the recipient's place of residence
- Yard work, gardening, or home maintenance work

Florida Medicaid may reimburse for some services listed in this section through a different service benefit.

...

PC Policy, pages 3 – 7.

20. In the instant case, Respondent denied an additional fourteen (14) hours per week of personal care services. *See supra* ¶ 7 and 8. As established on the record by the evidence and testimony, Respondent denied Petitioner’s request, stating the additional personal care hours were not medically necessary because the presently approved skilled and non-skilled services are enough to meet [REDACTED] care needs. *Id.*

21. 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* ¶ 17. The evidence presented in this case does not reflect unmet needs or that the Petitioner needs an additional fourteen (14) hours per week of personal care services. Specifically, the Petitioner resides in a private home with [REDACTED] who does not work outside the home and is approved for sixteen (16) hours of personal care services per week. *See supra* ¶ 2 and 6.

22. Section 1.3.14 of the SMMC LTC Policy mandates that the requested services must “[b]e individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient’s needs.” *See supra* ¶ 17. Here, Petitioner is currently authorized to receive the following home and community-based services: sixteen (16) hours per week of personal care services and four (4) hours per week of homemaker services. *See supra* ¶ 6. Petitioner’s currently authorized home healthcare services are “[t]o provide

assistance with ADLs and IADLs, including assistance with preparation of meals, and housekeeping chores which are incidental to the care furnished or are essential to the health and welfare of the enrollee.” See supra ¶ 17. Although the PC Policy provides guidance for general allowances for ADLs, *supra* ¶ 19, Petitioner provided no time estimates for each ADL to explain the amount of time Petitioner requires for [REDACTED] ADLs. Further, Petitioner neglected to explain how the requested additional hours personal care services, will be utilized to meet Petitioner’s needs if approved in this matter. Petitioner’s currently authorized homemaker services are “[t]he provision of general household activities (such as meal preparation) and routine household care (including laundry and pest control). See supra ¶ 19. Given the fact that Petitioner already has personal care services to assist with [REDACTED] ADLs and homemaker services to assist with [REDACTED] IADLs, the Petitioner has not established that [REDACTED] currently authorized services are insufficient to meet [REDACTED] needs. The Petitioner has not demonstrated by a preponderance of the evidence that fourteen (14) additional hours of personal cares services per week are medically necessary.

23. Considering the totality of Petitioner’s circumstances, including her medical condition and diagnoses, level of need for ADLs and IADLs, and the amount of currently approved services, Petitioner failed to prove by a preponderance of the evidence that an additional fourteen (14) hours per week of personal care services are individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the Petitioner’s patient’s needs. See supra ¶ 17, 18, and 19.

24. In light of the testimony and evidence, the SMMC LTC Policy, the PC Policy, and the Definitions Policy, the undersigned Hearing Officer finds that Petitioner failed to meet [REDACTED] burden of proving that an additional fourteen (14) hours per week 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 the requested additional fourteen (14) hours of personal care services per week was incorrect.

DECISION

Respondent's denial of an additional fourteen (14) hours per week of personal care service is **AFFIRMED**.

Petitioner's appeal based on Respondent's denial in this matter is **DENIED**.

DONE AND ORDERED this 31st day of October, 2023, in Tallahassee, Leon County, Florida.


Laura Gallagher
for Alan Leifer
23-FH1981
2023.10.31 08:21:16 -04'00'

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

NOTICE OF A RIGHT TO JUDICIAL REVIEW

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

COPIES FURNISHED TO:

[REDACTED]

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