



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

FILED

Nov 16, 2023, 10:29 am

OFFICE OF FAIR HEARINGS

[REDACTED],

PETITIONER,

AHCA Case No.: 23-FH2068

Plan ID No.: [REDACTED]

vs.

HUMANA MEDICAL 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 September 22, 2023, at 10:00 a.m. Eastern Standard Time (“EST”).

APPEARANCES

For the Petitioner:

[REDACTED]

Authorized Representative

For the Respondent:

Joshua Mitchell

Grievance and Appeals Fair Hearing Specialist

Humana Medical Plan, Inc.

STATEMENT OF ISSUES

The issue in this matter is whether Petitioner proved by a preponderance of the evidence that Respondent’s denial of an additional twenty (20) hours per week of homemaker services was incorrect.

PRELIMINARY STATEMENT

All parties and witnesses appeared telephonically. [REDACTED], (“[REDACTED]”), the Petitioner’s [REDACTED] and designated Authorized Representative appeared and testified on behalf of the Petitioner. The Petitioner appeared and testified at the Fair Hearing, as well as Damaris Sierra, (“Ms. Sierra”), the Petitioner’s home health aide from Senior Nannys Home Care Services, LLC in Jacksonville, Florida. Spanish translator Lorena, Identification Number 702560, by agreement from the Authorized Representative, provided Spanish translation services only for the testimony of Ms. Sierra, whose principal language is Spanish.

Joshua Mitchell (“Mr. Mitchell”), Humana Medical Plan, Inc., (“Humana”), Grievance and Appeals Fair Hearing Specialist appeared at the hearing and represented Respondent. Dr. Wayne Sherman, Humana Medical Director (“Dr. Sherman”), provided testimony on behalf of the Respondent.

Diana Hearod, Medical Healthcare Program Analyst & Fair Hearing Liaison for the Agency for Health Care Administration (“Agency” or “AHCA”), (“Ms. Hearod”) appeared at the Fair Hearing for observational purposes.

The Petitioner did not submit any proposed evidence for the Fair Hearing. Prior to the hearing, Respondent sent to the Office of Fair Hearings and Petitioner a two hundred and ninety (290)-page evidence packet as proposed evidence. The Authorized Representative objected to the Respondent’s proposed evidence, citing factual errors and the omission of certain medical records. The Respondent’s proposed evidence package was admitted into evidence over the objection of the Authorized Representative, is identified herein as “Respondent’s Composite Exhibit 1” and is recorded in the OFH document management system as follows: “Evidence

Packet_Part1.pdf”; “Evidence Packet_Part2.pdf”; “Evidence Packet_Part3.pdf”, “Evidence Packet_Part4.pdf”; “Evidence Packet_Part5.pdf”; and “Evidence Packet_Part6.pdf”.

FINDINGS OF FACT

1. The Petitioner is an enrolled member of Humana’s Long Term Care (“LTC”) plan. See Respondent’s Composite Exhibit 1, page 1. Humana 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] who lives in a private residence with [REDACTED], who also serves as the Petitioner’s Designated Representative and primary caregiver. See Respondent’s Composite Exhibit 1, page 60.

3. Petitioner has the following health conditions: [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]. See Respondent’s Composite Exhibit 1, pages 56 and 57. The Authorized Representative testified that the Respondent’s principal health condition is [REDACTED] which does not appear in the Respondent’s Composite Exhibit 1. *Testimony of the Authorized Representative*. The Authorized Representative further testified that the Petitioner is a [REDACTED]. *Id.*

4. The Florida Department of Elder Affairs 701B Comprehensive Assessment, dated July 18, 2023, which is the most recent 701B on the record (the “7/18/23 701B”), reflects the following regarding Petitioner’s Activities of Daily Living (“ADLs”). Petitioner [REDACTED]

and always has assistance in performing ■ IADLs. See Respondent's Composite Exhibit 1, page 55.

6. The Petitioner is currently authorized to receive the following home and community-based services from the Respondent: fifteen (15) hours of personal care services per week and ten (10) hours of homemaker services per week. See Respondent's Composite Exhibit 1, pages 78 and 79.

7. On July 13, 2023, the Petitioner requested thirty (30) hours of homemaker services per week. See Respondent's Composite Exhibit 1, pages 10-17. On July 19, 2023, the Respondent issued a Notice of Adverse Benefit Determination ("NABD") approving ten (10) hours of homemaker hours per week and denying twenty (20) of the requested homemaker hours. *Id.*

The July 19, 2023, NABD states the reason for Respondent's determination as follows:

- 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 criteria as defined in Rule 59G-1.010(166), F.A.C., for all nursing facility services and mixed services; OR
 - 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 requested service is not a covered benefit.

■ **Other authority**

The facts that we used to make our decision are:

This determination of the Medical Director has been made based on medical necessity (as defined by Florida law – specifically see checked box above) and reflects the application of the Plan’s approved review criteria and guidelines.

You have requested 30 hours of homemaker service each week.

You have [REDACTED]. You do not have trouble [REDACTED]. You do not have trouble [REDACTED].

You have not had any recent changes in your health. You have not recently been in the hospital.

You currently live in a skilled nursing facility. You plan to transition home and live with your spouse. You use an [REDACTED]. You need help [REDACTED]. You need some help [REDACTED]. You need help with [REDACTED].

You are being approved for 10 hours of homemaker service each.

The hours you are receiving should be enough to meet your medical needs and can be divided into shifts to better meet your medical needs.

Id.

8. Petitioner timely requested an appeal of Respondent’s denial of an additional twenty (20) hours of homemaker services. *See* Respondent’s Composite Exhibit 1, pages 19-21. On August 22, 2023, the Respondent sent the Petitioner a Notice of Plan Appeal Resolution (“NPAR”) letter upholding the denial of twenty (20) additional hours of homemaker services per week and stated as follows:

The reason for the decision was based on the information received. You are appealing the denial of 20 hours of the requested 30 hours of homemaker (HMK) service each week. We have reviewed [Petitioner's] documents and reassessed [redacted] needs. [redacted] lives with you, [redacted] spouse, where house chores and meals are completed for the benefit of the household and not as an additional task for you.

[Petitioner] currently was approved for 10 hours of HMK service weekly, and [redacted] aide can help prepare additional meals for [redacted] along with light housekeeping of the room and doing laundry for [redacted]. We are therefore, upholding the decision of the medical director and denying your appeal.

This determination of the Medical Director has been made based on medical necessity (as defined by Florida law) and reflects the application of the Plan's approved review criteria and guidelines, defined in Chapter 59G-1.010 (2.83) Florida Administrative Code.

Id.

9. On August 23, 2023, the Petitioner requested a Fair Hearing due to the denial of an additional twenty (20) hours per week of homemaker services. On September 1, 2023, the undersigned hearing officer scheduled a Fair Hearing that was held on September 22, 2023, at 10:00 a.m. EST.

10. During the Fair Hearing, the Authorized Representative testified that the facts forming the basis of the denial in the Respondent's NABD are not correct and therefore the Respondent's decision was incorrect. The Authorized Representative testified the Petitioner's [redacted] on [redacted] [redacted] was not considered or reflected in the NABD or NPAR, that the Petitioner is not able to [redacted], [redacted], [redacted], [redacted], [redacted], and requires total assistance for [redacted] ADLs and IADLs.

11. The Authorized Representative testified that the Petitioner's needs are not being met with the current home health hours. The Petitioner testified the Petitioner needs more frequent bathing because of [redacted], has no home health hours on Saturday, that [redacted] works

outside the home during the week and sometimes on Saturdays, and recently had to take time off of work on a Saturday to bathe the Petitioner.

12. Ms. Sierra, the Petitioner's home health aide testified the Petitioner is disabled due to [REDACTED], and [REDACTED] in [REDACTED]. Ms. Sierra testified she does all the housework, personal hygiene, that she's with the Petitioner by [REDACTED] side in and out of the home, and always accompanies the Petitioner to medical appointments.

13. Dr. Sherman testified for the Respondent that the Authorized Representative was with the Petitioner and assisted in providing answers to questions used to complete the July 18, 2023, 701B, and that the Petitioner needing total assistance with the performance of [REDACTED] IADLs was the basis for approving ten (10) of the requested thirty (30) homemaker hours per week. Finally, Dr. Sherman testified that it is not medically necessary for the Petitioner to have thirty (30) hours of homemaker hours per 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 Fla. Stat. § 409.285(2). This order is the final administrative decision of AHCA under Fla. Stat. § 409.285(2)(a).

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

16. 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.

17. 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.).

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 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.

...

4.2.1.14 Personal Emergency Response Systems

For installation and service monitoring of an electronic device connected to an enrollee’s phone that includes a portable “help” button, when provided to an enrollee at high risk of institutionalization to secure help in an emergency.

4.2.1.15 Respite Care

The provision of services on a short-term basis due to the absence of, or need to relieve, the enrollee's natural supports on a planned or an emergency basis. (Emphasis added.)

...

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.

19. 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.

20. 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.

...

7.0 Authorization

7.1 General Criteria

The authorization information described below is applicable to the fee-for-service delivery system. For more information on general authorization requirements, please refer to Florida Medicaid’s General Policies on authorization requirements.

...

Personal Care Task	General Time Allowances
Bathing	
Full-body Bath: Tub, shower or sponge/bed bath.	Up to 30 minutes. May rotate with partial bath based on recipient’s needs
Partial Bath: A sponge bath includes, at a minimum, bathing of the face, hands, and perineum.	15–20 minutes per partial bath
Dressing	
Laying out clothing, handing and retrieving clothing, putting clothes on and taking them off, including handling fasteners, zippers, and buttons.	15 minutes
Application of prosthetic devices or application of therapeutic stockings.	May add 15 minutes for applying hose and/or Prosthesis
Grooming and Skin Care	

Brushing teeth, denture care, shaving, washing and drying face and hands. Applying lotion to non-broken skin.	15–30 minutes
Shampoo and comb hair, basic hair care, basic nail care.	15 minutes
Positioning	
Moving recipient to and from a lying position, turning side to side, and positioning recipient in bed.	10 minutes/every 2 hours when medically indicated
Transfers	
Moving recipient into and out of a bed, chair, or wheelchair. May include the use of assistive devices.	15 minutes/every 2 hours when medically indicated
Toileting and Maintaining Continence	
Includes transfer on or off the toilet, bedside commode, urinal, or bedpan. Includes cleaning the perineum and cleaning after an incontinent episode. Includes taking care of a catheter or colostomy bag or changing a disposable incontinence product.	15–45 minutes
Eating	
Taking in food by any method. Extra time may be allowed for preparing a special diet.	30 minutes per meal
Delegated Medical Monitoring and Activities	
Non-skilled medical tasks that are delegated to the aide by the RN, in accordance with Florida laws and practice acts. The tasks include, but are not limited to, assisting recipient with pre-poured medications, monitoring vital signs, and measurement of intake/output.	15–30 minutes day for all monitoring tasks performed

PC Policy, pages 3 – 8, and 10.

21. In the instant case, Respondent denied an additional twenty (20) hours of homemaker services per week. *See supra* ¶¶ 7 and 8. As established on the record by the evidence and

testimony, Respondent denied Petitioner's request, because the Petitioner's request failed to establish that the requested homemaker services were medically necessary. *Id.*

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." *Id.*

23. The evidence presented in this case does not reflect that Petitioner needs an additional twenty (20) hours per week of homemaker services. Regarding IADLs, which most closely align with the definition of homemaker services, Petitioner needs total assistance (cannot do at all) with all of the IADLs including [REDACTED]. *See supra* ¶ 5. The record reflects that the Petitioner always has assistance in completing [REDACTED] IADL's. *Id.*

24. Petitioner currently has ten (10) hours of homemaker services per week for homemaker. *See supra* ¶ 6. The Authorized Representative has not presented evidence demonstrating unmet needs regarding the performance of IADLs, and in-fact the testimony and evidence presented at the hearing by the Authorized Representative and the Petitioner's home health aide reflects the assistance that is required by the Petitioner is addressed to the ADLs, such as [REDACTED], which more closely align with the definition of personal care services. *See supra* ¶ ¶ 10, 11, 12 and 20.

25. 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 ¶ 18. Here, the Petitioner is currently authorized to receive the following home and community-based services: fifteen (15) hours of personal care services per week and ten (10) hours of homemaker services per week. See supra ¶ 6.

26. The record does not establish by a preponderance of the evidence that there are unmet homemaker needs, what homemaker services would no longer be performed if the requested services are not authorized, specifically how the requested additional services would be utilized, or that Petitioner’s currently authorized homemaker hours are insufficient to meet [REDACTED] homemaker needs.

27. Considering the totality of Petitioner’s circumstances, including [REDACTED] medical condition and diagnoses, level of need for ADLs and IADLs, natural support, and the amount of currently approved services by Medicaid, the Petitioner has failed to prove beyond a preponderance of the evidence that an additional twenty (20) hours per week of homemaker services in addition to the already approved ten (10) hours of homemaker services are not “in excess of [Petitioner’s] needs”. See supra ¶¶ 18 and 19.

28. In light of the testimony and evidence in this matter, the definition of “medically necessary” and the SMMC LTC Policy, the undersigned Hearing Officer finds that the Petitioner failed to prove by a preponderance of the evidence that an additional twenty (20) hours of homemaker services are medically necessary.

DECISION

Respondent's denial of an additional twenty (20) hours of homemaker services per week is **AFFIRMED**. Petitioner's appeal based on Respondent's denial of an additional twenty (20) hours of homemaker services is **DENIED**.

DONE AND ORDERED this 16th day of November, 2023, in Tallahassee, Leon County, Florida.

Alan J. Leifer
Alan J. Leifer
23-FH2068
2023.11.16
08:00:18 -05'00'

ALAN J. 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]
[REDACTED]

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