



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

**FILED**

Nov 27, 2023, 11:24 am

OFFICE OF FAIR HEARINGS

[REDACTED]

**PETITIONER,**

**AHCA Case No.: 23-FH2093**

**Plan ID No.: [REDACTED]**

**vs.**

**HUMANA MEDICAL PLAN, INC.,**

**RESPONDENT.**

\_\_\_\_\_ /

**FINAL ORDER**

Pursuant to notice, the Office of Fair Hearings convened a telephonic Medicaid Fair Hearing in the above styled case on October 24, 2023, at 9:33 a.m. Eastern Standard Time ("EST").

**APPEARANCES**

For the Petitioner:

[REDACTED]

Petitioner's Authorized Representative

For the Respondent:

Joshua Mitchell

Grievance and Appeals Fair Hearing Specialist

Humana Medical Plan, Inc.

**STATEMENT OF ISSUE**

The issue is whether Respondent proved by a preponderance of the evidence that Respondent's decision to reduce Petitioner's personal care Participant Direction Option ("PDO") service hours per week from one hundred and sixteen (116) hours to seventy-four (74) hours per week was correct.

**PRELIMINARY STATEMENT**

All parties appeared telephonically. Petitioner's Authorized Representative and Direct Service Worker, [REDACTED] (" [REDACTED] ") appeared on behalf of the Petitioner. Petitioner, [REDACTED], appeared to offer testimony.

Joshua Mitchell, Grievance and Appeals Fair Hearing Specialist for Humana Medical Plan, Inc. ("Humana") appeared on behalf of Respondent. Dr. Wayne Sherman ("Dr. Sherman"), Medical Director for Humana, attended as a witness for Respondent.

Lee Ann Williams, Medical Healthcare Program Analyst and Fair Hearing Liaison for the Agency for Health Care Administration ("Agency" or "AHCA"), appeared as an observer.

Prior to the Fair Hearing, Petitioner sent to the Office of Fair Hearings and Respondent an eight (8)-page evidence packet. The evidence packet appears in the Office of Fair Hearings' document management system as the file titled "23-FH2093 Additional Supporting Documents.pdf". Absent any objections from Respondent, the undersigned admitted the eight (8)-page evidence packet as Petitioner's Composite Exhibit 1 ("PCE 1").

Prior to the Fair Hearing, Respondent sent to the Office of Fair Hearings and Petitioner a two hundred and eighty-five (285)-page evidence packet. The evidence appears in the Office of Fair Hearings' document management system as "Evidence Packet 23-FH2093\_Part1.pdf", and "Evidence Packet 23-FH2093\_Part2.pdf". Petitioner's Authorized Representative objected to the admission of Respondent's evidence. The undersigned overruled the objection and admitted the two hundred and eighty-five (285)-page evidence packet into evidence as Respondent's Composite Exhibit 1 ("RCE 1").

During the Fair Hearing, Petitioner's Authorized Representative requested time to submit Petitioner's hospital discharge paperwork from recent hospitalizations. The Fair Hearing record

remained open until Tuesday, October 31, 2023, at 5:00 p.m. Respondent had until Tuesday, November 7, 2023, at 5:00 p.m. to submit a response or objection to Petitioner’s doctors’ letters/documents. On October 29, 2023, Petitioner’s Authorized Representative submitted a fifteen (15) page document regarding Petitioner’s hospitalization on October 10, 2023. The additional evidence appears in the Office of Fair Hearings’ document management system as “23-FH2093 Evidence.pdf”. Absent an objection from Respondent, the undersigned admitted the fifteen (15) page document into evidence as Petitioner’s Composite Exhibit 1 (“PCE 2”).

**FINDINGS OF FACT**

1. Petitioner is an enrolled member of Humana. See RCE 1 at page 1. Humana is a managed care organization contracted by the Agency to provide services to eligible Medicaid recipients in Florida.

2. As of the date of the Fair Hearing, Petitioner is [REDACTED] ([REDACTED]) [REDACTED]. *Id.* Petitioner lives in a private residence with [REDACTED], [REDACTED], and [REDACTED]. *Id.* at 10, 19, 34. Petitioner’s other DSWs are [REDACTED], [REDACTED]; [REDACTED] [REDACTED]; and [REDACTED], [REDACTED]. *Id.* at 34. Petitioner has the following health conditions: [REDACTED]

[REDACTED]  
[REDACTED]  
[REDACTED]  
[REDACTED].

*Id.* at 39 – 40. Petitioner’s health is currently poor and is worse when compared to [REDACTED] health a year ago. *Id.* at 36.

3. [REDACTED] assisted Petitioner with answering the questions to the Florida Department of Elder Affairs 701B Comprehensive Assessment, dated August 31, 2023, (“701B Assessment”). *Id.* at 34. The 701B Assessment states Petitioner needs the following assistance with activities of daily living (“ADLs”): needs total assistance (cannot do at all) with [REDACTED]; needs assistance (but not total help) with [REDACTED]. *Id.* at 37. The 701B also states Petitioner always assistance with all of [REDACTED] ADLs. *Id.* However, [REDACTED] testified that Petitioner also uses an [REDACTED]; that Petitioner needs to be fed because [REDACTED]; that Petitioner’s [REDACTED]; and that Petitioner needs total assistance with [REDACTED].

4. The 701B Assessment states Petitioner needs the following assistance with instrumental activities of daily living (“IADLs”): needs total assistance (cannot do at all) with [REDACTED]; needs assistance (but not total help) [REDACTED]. *Id.* at 38. The 701B Assessment also states Petitioner always assistance with all of [REDACTED] IADLs. *Id.* However, [REDACTED] testified that Petitioner needs total assistance with [REDACTED] because [REDACTED] cannot [REDACTED]; and needs total assistance with medication.

5. The notes and summary of the 701B Assessment observe:  
...  
[Petitioner] declined need for community resources.  
...  
[Petitioner] continues to appear alert and oriented x 3. CM [case manager] observes no cognitive issues.  
...

[Petitioner's] needs are due to [REDACTED].

...

[Petitioner] is reported to be [REDACTED].

...

[Petitioner] has multiple family/friends that provide [REDACTED] companionship and care.

...

RCE 1 at 34 – 35, 38, and 42.

6. Respondent reviewed Petitioner's personal care PDO hours and reduced the aide from one hundred and sixteen (116) hours to seventy-four (74) hours per week. *Id.* at 10. In the Notice of Adverse Benefit Determination ("NABD"), Respondent reduced Petitioner's personal care PDO hours as of May 26, 2023. *Id.* at 9 – 16. The NABD explained the basis of the decision as follows:

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

...

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.

...

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 currently receive 10 hours of direct service worker (DSW) homemaker service each week; 116 hours of direct service worker (DSW) personal care services each week; and a [REDACTED] each month. The services and items you receive are reviewed on a regular basis. The review is based on your current medical status. You have [REDACTED]. You are [REDACTED]. You do not have [REDACTED]. You do not have [REDACTED].

You live with your [REDACTED]. Your [REDACTED] helps to care for you and is one of your direct service worker (DSW). You use an [REDACTED]. You use a [REDACTED]. You need help [REDACTED]. You need help with [REDACTED].

Your direct service worker (DSW) personal care service is being decreased to 74 hours each week. This will provide you with 12 hours of service each day which should be enough to meet your medical needs and can be divided into shifts to better meet your needs.

...

RCE 1 at 9 – 10.

7. Petitioner requested a plan appeal and received a Notice of Plan Appeal Resolution (“NPAR”), dated June 29, 2023, upholding the reduction of personal care PDO services. *Id.* at 21 – 23. The NAPR states, in pertinent part:

On May 30, 2023, we received your timely plan appeal request regarding Humana Healthy Horizons Long-Term Care Plan’s Notice of Adverse Benefit Determination dated May 16, 2023, [REDACTED], reducing the Personal Care (PDO) services from 116 hours to 74 hours each week provided to you.

On June 28, 2023, after consideration of the information you provided to Humana Long-Term Care Plan in support of your plan appeal, was reviewed by a medical director who is a DO and board certified in Internal Medicine hereby denies your plan appeal.

The reason for the decision was based on the information received. You have requested that the 42 hours of direct service worker (DSW) personal care service each week that was reduced be reconsidered (appeal).

You have [REDACTED]. You do not have [REDACTED]. You do not have [REDACTED]. You live with your caregiver. You use a [REDACTED]. You need help [REDACTED]. You need help [REDACTED]. You need help with [REDACTED].

The reduction of 42 hours of direct service worker (DSW) personal care service each week is being upheld. The hours you are currently receiving should be enough to meet your medical needs and can be divided into shifts to better meet your needs.

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.

...

RCE 1 at 21.

8. On August 25, 2023, Petitioner requested a Fair Hearing to challenge the reduction of personal care PDO services. On September 28, 2023, the Hearing Officer issued an Order Scheduling Fair Hearing by Telephone and Prehearing Instructions, setting the hearing for October 24, 2023, at 9:30 a.m. EST.

9. Dr. Sherman testified as follows:

- a. The annual review of Petitioner's personal care hours determined there was not a medical need for the 116 personal care DSW hours.
- b. The 701B was used during the review. There is always someone with Petitioner at night.
- c. Dr. Sherman testified that it is his opinion that 74 hours of personal care PDO services are enough to meet medical necessity for Petitioner.
- d. Petitioner is receiving skill hours from Medicare.

10. [REDACTED] testified as follows:

- a. Petitioner's DSWs assist [REDACTED] as follows:
- i. [REDACTED] – cleans the house for five (5) hours twice per week for a total of ten (10) hours of homemaker services. [REDACTED] is providing zero (0) hours of personal care services.
  - ii. [REDACTED] – assists the Petitioner on week days; forty (40) hours of personal care service hours per week; from 4:00 a.m. to 2:00 p.m.
  - iii. [REDACTED] – assist the Petitioner in the evenings; from 2:30 p.m. to 10:30 p.m., two to three times per week, for a total of thirty-two (32) hours of personal care service hours per week.
- b. Petitioner's case manager informed Petitioner and [REDACTED] that if someone did not stay with Petitioner at all times, then Petitioner would be taken away.
- c. [REDACTED] reviewed the 701B Assessment, *see* RCE 1 at 33 – 50, noting the following inaccuracies in the information provided to the case manager on August 31 2023, and what was reported by the case manager:
- i. Page 33, question 11 – Petitioner does have limited ability [REDACTED].
  - ii. Page 34, question 24 – Petitioner is enrolled [REDACTED].
  - iii. Page 34, question 31 – Petitioner is receiving [REDACTED].
  - iv. Page 34, question 32 – Petitioner does need [REDACTED].
  - v. Page 35, question 36 – A doctor or health care professional has told Petitioner that [REDACTED].
  - vi. Page 35, question 38 – the case manager never asked Petitioner to [REDACTED].

- vii. Page 35, question 43 - the case manager never asked Petitioner to [REDACTED].
- viii. Page 35, question 44 – Petitioner’s friends and family members have expressed concerns about Petitioner’s [REDACTED].
- ix. Page 35, question 45 – Petitioner has become concerned about [REDACTED] and [REDACTED] has problems [REDACTED].
- x. Page 35, question 44 – the case manager left this question blank.
- xi. Page 36, question 49 – Petitioner stated [REDACTED] health is much worse, not just worse.
- xii. Page 36, question 57 – in the last year Petitioner visited the [REDACTED].
- xiii. [REDACTED] reviewed Petitioner’s ADL and IADL needs.
- xiv. Page [REDACTED], question 74 – Petitioner is [REDACTED]; Petitioner currently has [REDACTED]; Petitioner currently has [REDACTED].
- xv. Page 40, question 75 – Petitioner receives [REDACTED] daily, not weekly.
- xvi. Page 41, Section G – the case manager did not complete this section even though Petitioner was answering questions and always expresses [REDACTED] problems.
- xvii. Page 41, question 81 – Petitioner was also diagnosed with [REDACTED].

- xviii. Page 42, question 82 – Petitioner is [REDACTED] nearly every day; Petitioner [REDACTED] nearly every day.
- xix. Page 42, question 83 - [REDACTED] disagreed with the case manager’s assertion that Petitioner does not need supervision.
- xx. Page 48, question 129 – [REDACTED] has been providing care to Petitioner for two or more years.
- xxi. Page 48, question 130 – [REDACTED] provides Petitioner with ten hours of care per week, not 42.
- xxii. Page 48, question 132- [REDACTED] stated [REDACTED] has a lot of mental or emotional strain, not just some strain.
- xxiii. Page 48, question 133(c) – [REDACTED] is having a lot of difficulty maintaining relationships with friends.
- xxiv. Page 49, question 136(a) to (h) – The case manager never asked [REDACTED] [REDACTED] these questions.
- d. [REDACTED] also disagreed with the case manager’s notes in the “notes & summary” sections.
- e. Petitioner had [REDACTED] [REDACTED].
- f. [REDACTED] has multiple jobs outside of the home, 9:00 a.m. to 5:00 p.m.
- g. [REDACTED] assisted Petitioner with completing the 701B Assessment in person.

11. Petitioner testified as follows:

- a. Petitioner needs help from people to rotate [REDACTED].

### **CONCLUSIONS OF LAW**

12. 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)(2019). This order is the final administrative decision of AHCA under Fla. Stat. § 409.285(2)(a).

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

14. 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.

15. Because Respondent is reducing previously authorized services, Fla. Admin Code R. 59G-1.100(17)(g) assigns the burden of proof to Respondent. The standard of proof in an administrative hearing is a preponderance of the evidence. The preponderance of the evidence standard requires proof by "the greater weight of the evidence" (Black's Law Dictionary at 1201, 7th Ed.)

16. The Statewide Medicaid Managed Care Long-term Care Program Coverage Policy (March 2017) ("LTC Policy"), incorporated by reference in Fla. Admin. Code R. 59G-4.192, governs Long-

Term Care services available under Florida Medicaid. See RCE 1 at 83 – 104. The LTC Policy provides the following with respect to personal care services:

### **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.

...

#### **1.3.1 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

...

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

When necessary for the recipient to function independently, including:

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

...

### **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

...

#### **4.2.2.6 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.

...

### **6.2 Specific Criteria**

**In order to receive LTC services, services must be documented on an individual 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. [emphasis supplied]

RCE 1, LTC Policy at pages 96 – 97, 99 – 100.

17. The LTC Policy also provides the following regarding medical necessity:

#### **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.

*Id.* at 97 – 98.

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

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

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

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

Definitions Policy at page 7.

19. 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
<b>Bathing</b>	
<b>Full-body Bath:</b> Tub, shower or sponge/bed bath.	Up to 30 minutes. May rotate with partial bath based on recipient’s needs
<b>Partial Bath:</b> A sponge bath includes, at a minimum, bathing of the face, hands, and perineum.	15–20 minutes per partial bath

<b>Dressing</b>	
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
<b>Grooming and Skin Care</b>	
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
<b>Positioning</b>	
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
<b>Transfers</b>	
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
<b>Toileting and Maintaining Continence</b>	
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
<b>Eating</b>	
Taking in food by any method. Extra time may be allowed for preparing a special diet.	30 minutes per meal
<b>Delegated Medical Monitoring and Activities</b>	
Non-skilled medical tasks that are delegated to the aide by the RN, in accordance with	15–30 minutes day for all monitoring tasks performed

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.	
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PC Policy at 1, 3 – 5

20. Respondent reduced Petitioner’s personal care PDO services from one hundred and sixteen (116) hours per week to seventy-four (74) hours per week based on medical necessity. *See supra* ¶ 6. Respondent explained that Petitioner’s approved twelve (12) hours per day of services should be enough to meet [REDACTED] medical needs. *See supra* ¶ 6.

21. Section 4.1 of the LTC Policy provides that Florida Medicaid LTC plans cover services that: (a) are determined medically necessary, as defined in the LTC Policy; (b) do not duplicate another service; and (c) meet the criteria as specified in the LTC Policy. *See supra* ¶ 16. Further, in order to receive LTC services, services must be documented on an individual plan of care based upon a comprehensive needs assessment. *See supra* ¶ 16. The comprehensive assessment includes the completion of the 701-B Comprehensive Assessment and the LTC Supplemental Assessment. *See supra* ¶ 16.

22. The evidence admitted and testimony presented reflects that Respondent’s reduction of Petitioner’s personal care PDO service hours is not warranted under the circumstances of this case. As provided in the LTC Policy, *see supra* ¶ 20, services are to be based on the comprehensive assessment including the completion of a 701B. Here, Petitioner demonstrated that the 701B assessment included in Respondent’s Composite Exhibit 1 was riddled with inaccuracies. *See supra* ¶ 10. [REDACTED] provided convincing and unrefuted

testimony regarding these inaccuracies. *See supra* ¶ 10. Respondent failed to demonstrate that its decision to reduce Petitioner’s personal care service PDO hours was based upon a credible comprehensive needs assessment.

23. Section 4.2.2.6 of the SMMC LTC Policy states personal care services are 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* ¶ 19. The record reflects that Petitioner lives in a private residence with [REDACTED] and [REDACTED]. *See supra* ¶ 2. Petitioner has multiple health conditions, including [REDACTED]. *See supra* ¶ 2. These health conditions impede Petitioner’s ability to complete [REDACTED] ADLs and IADLs. The 701B Assessment states that Petitioner needs total assistance (cannot do at all) with [REDACTED]; needs assistance (but not total help) with [REDACTED]. *See supra* ¶ 3. Further, [REDACTED] testified that Petitioner also uses an [REDACTED]; that Petitioner needs to be fed because [REDACTED]; that Petitioner’s [REDACTED]; and that Petitioner needs total assistance with [REDACTED]. *See supra* ¶ 3. The 701B states that Petitioner needs total assistance (cannot do at all) with [REDACTED]; needs assistance (but not total help) [REDACTED]. *See supra* ¶ 4. Further, [REDACTED] testified that Petitioner needs total assistance with [REDACTED] because [REDACTED] cannot [REDACTED]; and needs total assistance with medication. *See supra* ¶ 4. Petitioner always has assistance with all of

█ ADLs and IADLs because █ cannot be left alone. *See supra* ¶ 3, 4, and 10. Petitioner currently receives a total of seventy-four (74) hours per week of personal care PDO services and ten (10) hours per week of homemaker PDO services. *See supra* ¶ 9, 10.

24. As Respondent bears the burden of proof, Respondent must show that the previously approved level of personal care services are no longer medically necessary. Appendix 9.1 of the Florida Medicaid Personal Care Services Coverage Policy (November 2016) (“PCS Policy”), which is incorporated by reference in Fla. Admin. Code R. 59G-4.215, provides general guidance concerning the time allotted for personal care tasks. On behalf of Respondent, Dr. Sherman testified that Petitioner’s needs are met with █ currently approved services. *See supra* ¶ 9. However, █ testified that Petitioner requires more assistance with █ ADLs and IADLs because Petitioner’s condition has changed, namely Petitioner recently had █  
█. *See supra* ¶ 10.

25. The record does not support a reduction of personal care PDO services. For example, Petitioner’s condition has not improved – here, Petitioner’s condition is “worse” when compared to █ health a year ago. *See supra* ¶ 2. Thus, logically, Petitioner should continue to receive the same level of care as in the previous authorization period. Respondent failed to provide any testimony or evidence to show that Petitioner requires less assistance with █ ADLs or IADLs, or that █ is able to provide more assistance with Petitioner’s ADLs or IADLs as █ caregiver. Based on the foregoing, Respondent did not demonstrate that Petitioner’s previous amount of personal care was in excess of █ needs, and thus not medically necessary.


26. In light of both parties’ testimony, Petitioner’s Composite Exhibit 1, Petitioner’s Composite Exhibit 2, Respondent’s Composite Exhibit 1, and the applicable laws and policies, the

undersigned Hearing Officer finds that Respondent failed to meet its burden of proving that Respondent reduced Petitioner's personal care PDO services from one hundred and sixteen (116) hours to seventy-four (74) hours per week based on medical necessity. Accordingly, the undersigned Hearing Officer concludes that Respondent failed to prove by a preponderance of the evidence that Respondent's reduction of personal care PDO services was correct.

**DECISION**

Respondent's reduction of Petitioner's personal care PDO services is **REVERSED**.  
Petitioner's appeal based on Respondent's reduction of personal care PDO services is **GRANTED**.

**DONE AND ORDERED** this 27th day of November, 2023 in Tallahassee, Leon County,  
Florida.

 Kameisha Presley  
23-FH2093  
2023.11.27  
08:41:12 -05'00'

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**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:**



**Humana Medical Plan, Inc.**  
**GAMedicaidRightFax@humana.com**

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