



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

FILED

Dec 15, 2023, 11:33 am

OFFICE OF FAIR HEARINGS

[Redacted]

PETITIONER,

vs.

AHCA Case No.: 23-FH2174

Plan ID No.: [Redacted]

MOLINA HEALTH CARE OF FLORIDA, INC.,

RESPONDENT.

_____ /

[Redacted]

PETITIONER,

vs.

AHCA Case No.: 23-FH2177

Plan ID No.: [Redacted]

MOLINA HEALTH CARE OF FLORIDA, 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 November 27, 2023, at 2:01 p.m. Eastern Standard Time (“EST”).

APPEARANCES

For the Petitioner:

[Redacted]

Counsel for the Petitioner

For the Respondent:

Melissa Hedrick, Esq.
Counsel for the Respondent
Molina Health Care of Florida, Inc.

STATEMENT OF ISSUE

The first issue is whether the Respondent proved by a preponderance of the evidence that the reduction of two (2) hours of personal care services per week for the Petitioner (Case No. 23-FH1474) was correct.

The second issue is whether the Respondent proved by a preponderance of the evidence that the reduction of five (5) hours of homemaker services per week for the Petitioner (Case No. 23-FH2177) was correct.

PRELIMINARY STATEMENT

All parties and witnesses appeared telephonically. [REDACTED] (“[REDACTED]”), appeared as Counsel for the Petitioner. [REDACTED] (“[REDACTED]”), the Petitioner’s [REDACTED] and Authorized Representative appeared and testified at the Fair Hearing on behalf of the Petitioner.

Ms. Melissa Hedrick, Esq., (Ms. Hedrick) appeared as Counsel for the Respondent, Molina Health Care of Florida, Inc., (“Molina” or “Respondent”). Ms. Katia Matos, (“[REDACTED]”), Utilization Review Management Director, and Nyda Lopez, M.D., Medical Director (“Dr. Lopez”) both appeared and testified on behalf of the Respondent. Ms. Yunesi Cruz, Long Term Care Director of Healthcare Services, Ms. Yanni Veliz, Director of Appeals and Grievances, and Ms. Melissa Dominguez, Manager of Government Contracts also attended the Fair Hearing on behalf of Molina.

Leanne Williams, Medical Healthcare Program Analyst for the Agency for Health Care Administration (“Agency” or “AHCA”), appeared at the Fair Hearing for observational purposes.

Prior to the hearing, the Petitioner sent to the Office of Fair Hearings and the Petitioner five (5) distinct packets of proposed evidence. The first package of proposed evidence is a seventeen (17) page package of documents consisting of a January 2023, Molina grievance submitted by the Petitioner that was admitted into evidence without objection, is identified as "Petitioner's Composite Exhibit 1", and is maintained in the Office of Fair Hearings document management system as "23-FH2174 and 23-FH2177 Grievance and Appeal Form.pdf". The second package of proposed evidence consists of a single page with two (2) photographs that was admitted into evidence without objection, is identified as "Petitioner's Exhibit 2", and is maintained in the Office of Fair Hearings document management system as "23-FH2174 and 23-FH2177 Photo Evidence.pdf". The third piece of proposed evidence that was admitted into evidence without objection consists of a nineteen (19) second video of the Petitioner, was admitted into evidence without objection, is identified as "Petitioner's Exhibit 3" and is maintained in the Office of Fair Hearings document management system as "IMG.0871.MOV". The Petitioner's fourth proposed evidence package consists of a twenty-seven (27)-page composite exhibit comprised of the Petitioner's medical records, was admitted into evidence without objection, is identified as "Petitioner's Composite Exhibit 4", and is maintained in the Office of Fair Hearings document management system as "23-FH2174 and 23-FH2177 Additional Documents.pdf". The Petitioner's fifth proposed evidence package is an eight (8) page composite exhibit principally consisting of the Petitioner's August 2023, Molina grievance, was admitted into evidence without objection, is identified as "Petitioner's Composite Exhibit 5", and is maintained in the Office of Fair Hearings document management system as "23-FH2174 and 23-FH2177 Additional Documents (3).pdf".

Prior to the hearing, Respondent sent to the Office of Fair Hearings and Petitioner two (2) proposed document packages that were admitted into evidence without objection. The first document package consists of one hundred and thirty-seven (137)-page evidence packet that is identified herein as “Respondent’s Composite Exhibit 1” and is recorded in the OFH document management system and designated as follows: “MFH Office Packet [Petitioner]_1.pdf”, “MFH Office Packet [Petitioner]_2.pdf”, and “MFH Office Packet [Petitioner]_3.pdf”. The Petitioner’s second document package consists of a thirty-eight (38)-pages, was admitted into evidence without objection, is identified as “Respondent’s Composite Exhibit 2”, and is maintained in the Office of Fair Hearings document management system as “Additional Evidence Packet [Petitioner].pdf”.

FINDINGS OF FACT

1. The Petitioner is an enrolled member of Molina’s LTC plan. See Respondent’s Composite Exhibit 1, page 1. Molina is a managed care organization contracted by AHCA to provide services to eligible Medicaid recipients in Florida.

2. The Petitioner is an [REDACTED] ([REDACTED]) [REDACTED] [REDACTED] who lives in a private home with [REDACTED], who does not speak and requires total assistance due to [REDACTED]. See Respondent’s Composite Exhibit 1, page 71 and Respondent’s Composite Exhibit 2, page 28.

3. The Petitioner has the following health conditions: [REDACTED]
[REDACTED],
[REDACTED],
[REDACTED]
[REDACTED]. See Respondent’s Composite

Exhibit 2, pages 3, 7, 8, 10, 11, 35, and 36. In addition, the Petitioner has been enrolled in hospice since April 7, 2023, and has been to the emergency room April 15, 2023. See Respondent's Composite Exhibit 2, pages 3 and 8.

4. The most recent Florida Department of Elder Affairs 701B Comprehensive Assessment ("701B"), admitted into evidence is dated November 2, 2023, and reflects the following regarding Petitioner's Activities of Daily Living ("ADLs"). The Petitioner requires total assistance (cannot do at all) with [REDACTED]. See Respondent's Composite Exhibit 2, page 5. The 701B further reflects the Petitioner requires some assistance (but not total help) with [REDACTED] and always has assistance performing [REDACTED] ADLs. *Id.*

5. Regarding the Petitioner's Instrumental Activities of Daily Living ("IADLs"), the 701B reflects the Petitioner needs total assistance (cannot do at all) with all of [REDACTED] IADLs, including [REDACTED], [REDACTED], [REDACTED]. See Respondent's Composite Exhibit 2, page 6. The 701B also reflects the Petitioner now requires [REDACTED] and always has assistance with the performance of [REDACTED] IADLs. *Id.*

6. Petitioner is currently authorized to receive the following home and community-based services: eighteen (18) hours per week of personal care services per week, seven (7) hours per week of homemaker services, seven (7) home delivered meals per week, and three (3) days of adult daycare per week. See Respondent's Composite Exhibit 1, pages 36 and Respondent's Composite Exhibit 2, page 20.

7. On August 1, 2023, the Respondent issued a Notice of Adverse Benefit Determination ("NABD") in Case Number 23-FH2174 reducing the Petitioner's personal care hours from twenty

(20) hours per week to eighteen (18) hours per week. See Respondent's Composite Exhibit 1, pages 22-29. In their NABD reducing the Petitioner's personal care hours two (2) hours per week, the Respondent stated the reason for their determination as follows:

We made our decision because:
(Check all boxes that apply)

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.

The facts that we used to make our decision are: This decision was based on medical necessity (as defined by Agency for Health Care Administration's Medical Necessity as defined in Rule 59G-4, 192 and reflects the application of Molina Clinical Policy (332)

The reason why the request was not approved is: There is a reduction Effective 08/11/2023 of Personal care from 20 hours per week to 18 hours per week decision made by the Medical Director because the additional services are not medically necessary. You are already receiving other services that should meet

your needs. You are going to receive 26 hours per week of assistance with this new changes. This determination by the Medical Director has been made based on medical necessity (as defined by Florida law) and reflects the application of Molina Healthcare's approved review criteria and guidelines.

Id.

8. On August 1, 2023, the Respondent issued a Notice of Adverse Benefit Determination (“NABD”) in Case Number 23-FH2177 reducing the Petitioner’s homemaker hours from twelve (12) to seven (7) hours per week. See Respondent’s Composite Exhibit 1, pages 14-20. In their NABD reducing the Petitioner’s homemaker hours, the Respondent stated the reason for their determination as follows:

We made our decision because:
(Check all boxes that apply)

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.

The facts that we used to make our decision are: This decision was based on medical necessity (as defined by Agency for Health Care Administration's Medical Necessity as defined in Rule 59G-4, 192 and reflects the application of Molina Clinical Policy (332) The reason why the request was not approved is: There is a reduction Effective 08/11/2023 of Homemaker services from 12 hours per week to 7 hours per week decision made by the Medical Director because the additional services are not medically necessary. You are already receiving other services that should meet your needs. You are going to receive 26 hours per week of assistance with this new changes. This determination by the Medical Director has been made based on medical necessity (as defined by Florida law) and reflects the application of Molina Healthcare's approved review criteria and guidelines.

Id.

9. The Petitioner timely requested an appeal of Respondent's reduction of the personal care and homemaker hours per week and on August 4, 2023, Respondent sent Petitioner a Notice of Plan Appeal Resolution letter ("NPAR"), upholding the reduction of two (2) hours of personal care services per week (Case Number 23-FH2174) and the reduction of five (5) hours of homemaker services per week (Case Number 23-FH2177). See Respondent's Composite Exhibit 1, pages 126-129. The NPAR stated as follows:

On August 23, 2023, after consideration of the information you provided to Molina Healthcare of Florida in support of your plan appeal, Molina Healthcare of Florida hereby denies your plan appeal. As a result, [Petitioner] will not receive the extra 5 hours a week of Homemaker Services and the extra 2 hours a week of Personal Care Services, effective August 23, 2023. The decision was made by a Molina Healthcare of Florida Medical Director, a Board Certified Family Medicine Physician.

We made our decision based on the Florida Agency for Health Care Administration's Long-Term Care (LTC) Program Policy (Rule 59G-4.192) and the Molina Clinical Policy for Medically Necessary Services (332). It shows rules that you have to meet to show medical necessity (need). Part of the rules is having an evaluation (test) to find out what you need. These tests are done the first time a member needs a test. They are also done annually (every year), and when there is a significant (big) change in the member's care. A significant (big) change may involve a change in the member's state of health or the person taking care of

them. Your recent test does not show a significant (big) change in your care. Your doctor has not told us of a significant (big) change in your care to show that you need a change to your plan of care. You are already receiving services that should meet your needs. For this reason, the request for the extra 5 hours a week of Homemaker Services and the extra 2 hours a week of Personal Care Services is not approved. Please talk to your doctor and/or Case Manager about your options.

While we are denying the extra 5 hours a week of Homemaker Services and the extra 2 hours a week of Personal Care Services, you are already receiving services that should meet your needs. You will still receive 7 hours a week of Homemaker Services and 18 hours a week of Personal Care Services.

Id.

10. On September 1, 2023, the Petitioner requested a Fair Hearing due to the reduction of two (2) hours of personal care services per week and a reduction of five (5) hours of homemaker services per week. The undersigned scheduled the Fair Hearing to occur on November 6, 2023, at 9:00 a.m. EST. An unopposed continuance was requested by the Petitioner and the Fair Hearing was rescheduled and occurred on November 27, 2023, at 2:01 p.m. EST.

11. During the Fair Hearing, the Petitioner's Authorized Representative testified [REDACTED] [REDACTED], and both [REDACTED] [REDACTED], including [REDACTED] [REDACTED]. [REDACTED] testified that [REDACTED] is caring for both [REDACTED] bedridden [REDACTED] and [REDACTED] [REDACTED], both of whom have entered Hospice. [REDACTED] further testified that [REDACTED] requested a decrease in [REDACTED] [REDACTED] adult day care services from five (5) days per week to three (3) days per week due to [REDACTED] declining health and the physical difficulties of getting [REDACTED] [REDACTED] out of the house five (5) days per week. The Authorized Representative further testified that [REDACTED] [REDACTED] is typically picked-up for adult day care around 7:30 a.m. and arrives back home sometime around 3:00 p.m. on Monday, Wednesday, and Friday. Finally, the Petitioner's testimony and evidence reflects that the Petitioner works full-time Monday through Fridays and

has both physical limitations and lifting restrictions due to medical conditions. See Respondent's Composite Exhibit 1, pages 47-57, and Respondent's Composite Exhibit 2, pages 20-21.

12. [REDACTED] testified for the Respondent that based on the Petitioner's 701B assessment and the Molina Functional Level Review Tool, the Petitioner is currently receiving an appropriate level of home health hours and any additional hours are not medically necessary. In fact, [REDACTED] testified that the Molina Functional Level Review Tool indicates that the current level of home health hours are still somewhat excessive but the Respondent elected to not further reduce the hours to avoid "burnout" of the primary caregiver. [REDACTED] further testified that when a recipient is enrolled in adult daycare and have assistance in their ADLs and IADLs, there is a corresponding and appropriate decrease in home health services because there would be a duplication of services for the time in which the recipient is in adult daycare.

13. Dr. Lopez testified for the Respondent that the current level of home health hours is appropriate and meets the definition of medical necessity, and that any additional hours would be excessive and not medically necessity.

14. An August 29, 2023, Dr. Enrique Huertas, M.D., submitted a letter in this matter requesting the maximum number of hours for the Petitioner's home health care. See Petitioner's Composite Exhibit 5, page 7.

CONCLUSIONS OF LAW

15. 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).

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

17. 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.

18. Because the Respondent is reducing existing services, Fla. Admin. Code R. 59G-1.100(17)(g) assigns the burden of proof to the Respondent to demonstrate their decisions were correct. 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.).

19. 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:

- [REDACTED]
- 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.

...

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.

...

4.2.2 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.

20. 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.

21. 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
	
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,  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.

22. In the instant case, Respondent reduced the Petitioner’s personal care services by two (2) hours per week and the Petitioner’s homemaker services five (5) hours per week. See supra ¶ 7, 8, and 9. As established on the record by the evidence and testimony, Respondent reduced the Petitioner’s personal care and homemaker hours because the additional hours were not medically necessary. See supra ¶ 7 and 8.

23. 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.

REDUCTION OF PERSONAL CARE HOURS

24. The evidence presented in this case does not reflect that the Respondent’s decision to reduce the Petitioner’s personal care services two (2) hours per week was correct. Specifically, Petitioner lives in a residence with [REDACTED], the Petitioner’s primary caregiver works full time and also has physical limitations. See supra ¶ 11.

25. Regarding ADLs, the 701B reflects the Petitioner needs total assistance with [REDACTED], [REDACTED], and requires some assistance (but not total help) with [REDACTED]. See supra ¶ 4. In addition, the Petitioner is having difficulty in [REDACTED], [REDACTED] and there is evidence that the Petitioner’s [REDACTED]. See supra ¶ ¶ 4 and 12. Regarding the Petitioner’s Instrumental Activities of Daily Living (“IADLs”), the 701B reflects the Petitioner needs total assistance (cannot do at all) with performing all [REDACTED] IADLs, including [REDACTED]

Molina Clinical Policy for Medically Necessary Services (332). It shows rules that you have to meet to show medical necessity (need). Part of the rules is having an evaluation (test) to find out what you need. These tests are done the first time a member needs a test. They are also done annually (every year), and when there is a significant (big) change in the member's care. A significant (big) change may involve a change in the member's state of health or the person taking care of them. Your recent test does not show a significant (big) change in your care. Your doctor has not told us of a significant (big) change in your care to show that you need a change to your plan of care.

See supra ¶ 9. In this case, it has been established that the Petitioner's [REDACTED]. See supra ¶ 3, 4, 5, and 11. The decision by the Respondent that there has not been a "... significant (big) change..." is subjective in the determination of whether additional home health hours or a reduction in home health hours are justified as medically necessary. It has been established that there as been no improvement in the Petitioner's health, and coupled with the reduction of adult daycare services, there is insufficient justification to support the reduction of two (2) hours of personal care services per week in this matter.

29. Considering the totality of Petitioner's circumstances, including [REDACTED] medical condition and diagnoses, level of need for ADLs and IADLs, and the amount of currently approved services, the Respondent failed to prove by a preponderance of the evidence that a reduction of two (2) hours per week of personal care services was correct." See supra ¶ ¶ 19, 20 and 21.

30. In light of the testimony and evidence in this matter, the SMMC LTC Policy, the PC Policy, and the Definitions Policy, the undersigned Hearing Officer finds that Respondent failed to meet their burden of proving that a reduction of two (2) hours personal care services per week was 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 and were not medically necessary. Accordingly, the undersigned Hearing Officer concludes that Respondent failed to

prove by a preponderance of the evidence that their reduction of two (2) hours of personal care services per week was correct.

REDUCTION OF HOMEMAKER SERVICES

31. The evidence presented in this case does not reflect that the Respondent's decision to reduce the Petitioner's homemaker services five (5) hours per week was correct. Specifically, Petitioner lives in a residence with [REDACTED], the Petitioner's primary caregiver works full time and also has physical limitations. See supra ¶ 11.

32. Regarding ADLs, the 701B reflects the Petitioner needs total assistance with [REDACTED], and requires some assistance (but not total help) with [REDACTED]. See supra ¶ 4. In addition, the Petitioner is having difficulty in [REDACTED] and there is evidence that the Petitioner's [REDACTED]. See supra ¶ ¶ 4 and 12. Regarding the Petitioner's Instrumental Activities of Daily Living ("IADLs"), the 701B reflects the Petitioner needs total assistance (cannot do at all) with performing all [REDACTED] IADLs, including [REDACTED]. See supra ¶ 5.

33. 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", not for the convenience of the recipient, and enable the enrollee to have access to live in the setting of his or her choice. See supra ¶ 19. Here, the Petitioner is currently authorized to receive eighteen (18) hours of personal care services per week. See supra ¶ 6. Petitioner's currently authorized personal care services

are “[t]o provide assistance with ADLs which are incidental to the care furnished or are essential to the health and welfare of the enrollee.” See supra ¶ 21.

34. The Authorized Representative has established that the Petitioner’s health has declined and that the adult daycare services were reduced from five (5) days per week to three (3) days per week because of the physical difficulties in getting the Petitioner out of the home five (5) days per week. See supra ¶ 11. The Respondent testified that when a recipient is enrolled in adult daycare and have assistance in their ADLs and IADLs, there is a corresponding and appropriate decrease in home health services because there would be a duplication of services for the time in which the recipient is in adult daycare. In the converse, when there is a decrease in adult daycare services, it is reasonable to conclude that there should be a corresponding increase in the recipient’s home healthcare hours. That has not occurred in this case, and in-fact, there was a decrease in adult daycare followed by a decrease in home healthcare hours.

35. In addition, the Respondent’s NPAR states in-part as follows:

We made our decision based on the Florida Agency for Health Care Administration’s Long-Term Care (LTC) Program Policy (Rule 59G-4.192) and the Molina Clinical Policy for Medically Necessary Services (332). It shows rules that you have to meet to show medical necessity (need). Part of the rules is having an evaluation (test) to find out what you need. These tests are done the first time a member needs a test. They are also done annually (every year), and when there is a significant (big) change in the member’s care. A significant (big) change may involve a change in the member’s state of health or the person taking care of them. Your recent test does not show a significant (big) change in your care. Your doctor has not told us of a significant (big) change in your care to show that you need a change to your plan of care.

See supra ¶ 9. In this case, it has been established that the Petitioner’s [REDACTED] [REDACTED]. See supra ¶ 3, 4, 5, and 11. The decision by the Respondent that there has not been a “... significant (big) change....” is subjective in the determination of whether additional home

health hours or a reduction in home health hours are justified as medically necessary. It has been established that there as been no improvement in the Petitioner’s health, and coupled with the reduction of adult daycare services, there is insufficient justification to support the reduction of five (5) hours of homemaker services in this matter.

36. Considering the totality of Petitioner’s circumstances, including [REDACTED] medical condition and diagnoses, level of need for ADLs and IADLs, and the amount of currently approved services, the Respondent failed to prove by a preponderance of the evidence that a reduction of five (5) hours of homemaker services was correct.” See supra ¶¶ 19, 20 and 21.

37. In light of the testimony and evidence in this matter, the SMMC LTC Policy, the PC Policy, and the Definitions Policy, the undersigned Hearing Officer finds that Respondent failed to meet their burden of proving that a reduction of five (5) hours of homemaker services per week was 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 and were not medically necessary. Accordingly, the undersigned Hearing Officer concludes that Respondent failed to prove by a preponderance of the evidence that their reduction of five (5) hours of homemaker services per week was correct.

DECISION

Respondent’s reduction of two (2) hours of personal care services per week (Case No. 23-FH2174) is **REVERSED**. Petitioner’s appeal based on Respondent’s reduction of two (2) hours of personal care services per week is **APPROVED**.

Respondent's reduction of five (5) hours of homemaker services per week (Case No. 23-FH2177) is **REVERSED**. Petitioner's appeal based on Respondent's reduction of five (5) hours of homemaker services per week is **APPROVED**.

DONE AND ORDERED this 15th day of December, 2023, in Tallahassee, Leon County, Florida.



Alan J. Leifer
23-FH2174 & 23-FH2177
2023.12.15 09:22:09
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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:



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