



**FILED**

Dec 20, 2023, 12:09 pm

OFFICE OF FAIR HEARINGS

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

[REDACTED]

**PETITIONER,**

**AHCA Case No.: 23-FH2227**

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

**vs.**

**HUMANA MEDICAL PLAN, INC.,**

**RESPONDENT.**

\_\_\_\_\_ /

[REDACTED]

**PETITIONER,**

**AHCA Case No.: 23-FH2228**

**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 31, 2023, at 1:01 p.m. Eastern Standard Time (“EST”).

**APPEARANCES**

For the Petitioner:

[REDACTED]

Petitioner’s Authorized Representative

For the Respondent:

Joshua Mitchell  
Grievance & Appeals Fair Hearing Specialist  
Humana Medical Plan, Inc.

**STATEMENT OF ISSUE**

The first issue is whether Petitioner proved by a preponderance of the evidence that Respondent's denial of homemaker services was incorrect.

The second issue is whether Petitioner proved by a preponderance of the evidence that Respondent's denial of personal care services was incorrect.

**PRELIMINARY STATEMENT**

All parties and witnesses appeared telephonically. [REDACTED] ("[REDACTED]"), Petitioner's Authorized Representative and [REDACTED], appeared at the Fair Hearing and provided testimony on Petitioner's behalf.

Joshua Mitchell, Grievance & Appeals Fair Hearing Specialist for Humana Medical Plan, Inc. ("Humana") represented Respondent. Dr. Wayne Sherman ("Dr. Sherman"), Medical Director for Humana, provided testimony on behalf of the Respondent.

Linda Latson, Fair Hearing Liaison for the Agency for Health Care Administration ("Agency" or "AHCA"), appeared for observational purposes.

Prior to the hearing, Petitioner sent to the Office of Fair Hearings and Respondent seven (7) pdfs, totaling three hundred and [REDACTED]-five (395) pages; a three (3) page document; and a twenty-eight (28) page document as and for evidence packets. The three hundred and [REDACTED]-five (395) page evidence packet appears in the Office of Fair Hearings' Case Management system as files titled "23-FH2227, 23-FH2228 Mailed Evidence.pdf", "23-FH2227, 23-FH2228 Mailed Evidence(2).pdf", "23-FH2227, 23-FH2228 Mailed Evidence(3).pdf", "23-FH2227, 23-FH2228 Mailed Evidence(4).pdf", "23-FH2227, 23-FH2228 Mailed Evidence(5).pdf", "23-FH2227, 23-FH2228 Mailed Evidence(6).pdf", "23-FH2227, 23-FH2228 Mailed Evidence(7).pdf." The three (3) page evidence packet appears in the Office of Fair Hearings' Case Management system as "23-

FH2227 and 23-FH2228 Supporting Documents.pdf". The twenty-eight (28) page evidence packet appears in the Office of Fair Hearings' Case Management system as "23-FH2227 23-FH2228 Mailed Evidence(3b).pdf." Absent an objection from Respondent, the undersigned admitted the seven (7) pdfs, totaling three hundred and [REDACTED]-five (395) pages into evidence as Petitioner's Composite Exhibit 1 ("PCE 1"); the three (3) page document as Petitioner's Composite Exhibit 2 ("PCE 2"); and the twenty-eight (28) page document as Petitioner's Composite Exhibit 3 ("PCE 3").

Prior to the hearing, Respondent sent to the Office of Fair Hearings and Petitioner a six hundred and eighty-three (683)-page evidence packet. The evidence packet appears in the Office of Fair Hearings' Case Management system as files titled "Evidence Packet 223-FH2227 23-FH2228 \_Part1.pdf," "Evidence Packet 223-FH2227 23-FH2228 \_Part2.pdf," "Evidence Packet 223-FH2227 23-FH2228 \_Part3.pdf," "Evidence Packet 223-FH2227 23-FH2228 \_Part4.pdf," "Evidence Packet 223-FH2227 23-FH2228 \_Part5.pdf," "Evidence Packet 223-FH2227 23-FH2228 \_Part6.pdf." Absent an objection from Petitioner, the undersigned admitted Respondent's six hundred and eighty-three (683)-page packet into evidence as Respondent's Composite Exhibit 1 ("RCE 1").

### **FINDINGS OF FACT**

1. Petitioner is an enrolled member of Humana's LTC plan. See RCE 1, page 1. Humana is a managed care organization contracted by AHCA to provide services to eligible Medicaid recipients in the State of Florida.
2. As of the time of the hearing, Petitioner was [REDACTED] ([REDACTED]) [REDACTED]. *Id.* at 1. Petitioner lives in a private residence with [REDACTED], [REDACTED], [REDACTED]. *Id.* at 440.

3. Petitioner has the following health conditions: [REDACTED]

[REDACTED]. *Id.* at 445 –

446. Petitioner is [REDACTED]. *Id.*

at 448. Petitioner needs supervision. *Id.*

4. [REDACTED] provided the responses to the questions on Petitioner’s Florida Department of Elder Affairs: 701B Comprehensive Assessment, dated September 6, 2023 (“701B Assessment”). *Id.* at 440, question 33. According to the 701B Assessment, [REDACTED] provides twenty (20) hours per week of care. *See* RCE 1 at 454. However, at the Fair Hearing, [REDACTED] testified that [REDACTED] provides a lot more than twenty (20) hours per week of care.

5. According to the 701B Assessment, regarding Petitioner’s Activities of Daily Living (“ADLs”), Petitioner needs total assistance (cannot do at all) with each ADL: [REDACTED], [REDACTED], [REDACTED], [REDACTED], [REDACTED], and [REDACTED]. *Id.* at 443. Petitioner also uses an assistive device with [REDACTED], [REDACTED], and [REDACTED]. *Id.* Petitioner rarely has assistance with [REDACTED], [REDACTED], and [REDACTED]; and has assistance most of the time with [REDACTED], [REDACTED], and [REDACTED]. *Id.*

6. According to the 701B Assessment, regarding Petitioner’s Instrumental Activities of Daily Living (“IADLs”), Petitioner needs total assistance (cannot do at all) with each IADL: [REDACTED], [REDACTED], [REDACTED], [REDACTED], [REDACTED], [REDACTED], [REDACTED], and [REDACTED]. *Id.* at 444. Petitioner rarely has assistance with [REDACTED] and [REDACTED]; has assistance most of the time with [REDACTED], [REDACTED]

and [REDACTED]; and always has assistance with [REDACTED], [REDACTED],  
and [REDACTED]. *Id.*

7. On July 24, 2023, Respondent issued two (2) Notice of Adverse Benefit Determinations (“NABDs”), one denying forty (40) hours per week of homemaker services and the other denying [REDACTED]-three (93) hours per week of personal care services. *Id.* at 14 – 21 and 22 – 29. The NABDs stated identical reasons for Respondent’s determinations as follows, in pertinent part:

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

...

Meet all of the following criteria for all extended state plan services used for the purposes of maintenance therapy and all other home and community-based services:

1. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient’s needs;
2. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available statewide; and
3. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient’s caretaker, or the provider;

And one of the following:

1. Enable the enrollee to maintain or regain functional capacity; or
2. Enable an enrollee receiving long-term services and supports to have access to the benefits of community living, to achieve person-centered goals, and live and work in the setting of their choice.

...

The facts that we used to make our decision are:

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 are requesting an additional 40 hours of homemaker service each week, and an additional 93 hours of personal care service each week. You have [REDACTED]

[REDACTED]. You do not have [REDACTED]. You often have [REDACTED]. You receive 7 home delivered [REDACTED] each week. You have not had [REDACTED]. You have not [REDACTED]. You live with your [REDACTED] who helps care for you and shares in household responsibilities. You use a [REDACTED]. You need help [REDACTED] ([REDACTED]). You need help [REDACTED], [REDACTED], and [REDACTED]. You need help with [REDACTED], [REDACTED] and [REDACTED]. Your request for an additional 40 hours of homemaker services each week and an additional 93 hours of personal care services each week is being denied as not medically necessary. 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.* at 15, 23.

8. Petitioner requested plan appeals for both of Respondent’s denials. On August 15, 2023, Respondent issued two (2) Notice of Plan Appeal Resolutions (“NPARs”), upholding the denial of forty (40) additional hours per week of homemaker services and ninety-three (93) additional hours per week of personal care services. *Id.* at 36 – 41. The NPARs stated similar reasons for Respondent’s denials as follows, in pertinent part:

On August 14, 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 MD and board certified in Family Medicine hereby denies your plan appeal.

We have reviewed [Petitioner’s] documents and reassessed [REDACTED] needs. [REDACTED] does not have any documented change in [REDACTED] clinical condition. [REDACTED] did not have any [REDACTED]. [REDACTED] uses a [REDACTED]. [REDACTED] is [REDACTED]. [Petitioner] receives 7 home delivered [REDACTED] each week. [REDACTED] lives with [REDACTED] [REDACTED] where [REDACTED] and [REDACTED] are completed for the benefit of the household and not as an additional task for [REDACTED]. [Petitioner] also currently receives 7 home delivered [REDACTED] weekly and [REDACTED] HMK aide can help prepare additional [REDACTED] for [REDACTED] along with [REDACTED] of [REDACTED] room and doing laundry for [REDACTED].

The hours [Petitioner] is receiving should be enough to meet [REDACTED] medical needs and can be divided into shifts to better meet [REDACTED] medical needs. We are therefore, upholding the decision of the medical director and denying your appeals for [Petitioner].

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.

...

9. On September 8, 2023, Petitioner requested a Fair Hearing due to the denial of additional homemaker services and denial of additional personal care services. On October 10, 2023, the undersigned scheduled the Fair Hearing for October 31, 2021, at 1:00 p.m., and all parties were duly notified.

10. [REDACTED] testified as follows:

- a. Petitioner [REDACTED].
- b. Petitioner has [REDACTED].
- c. Petitioner has [REDACTED].
- d. Petitioner disturbs [REDACTED]'s sleep when [REDACTED] calls out.
- e. [REDACTED] has cared for Petitioner for nearly fifteen (15) years.
- f. [REDACTED]'s own needs have taken a back seat.
- g. Petitioner is not [REDACTED]'s dependent.
- h. Petitioner receives fourteen (14) [REDACTED] every two (2) weeks.
- i. [REDACTED] believes Petitioner requires [REDACTED].
- j. [REDACTED] referred to letters of recommendation written by Petitioner's doctors.

*See PCE 2 at 2 – 3.*

- k. Petitioner's personal care needs are not being met overnight. There are gaps in time when Petitioner does not have a home health aide during the day.
- l. Hospice provides Petitioner with two (2) bed baths per week.
- m. Petitioner's other [REDACTED] lives in New York and visits three (3) or four (4) times a year when [REDACTED] gets time off work.

- n. Petitioner receives ten (10) hours per day of care, from 9:00 a.m. to 12:00 p.m. or 1:00 p.m., and then 4:00 p.m. to 11:00 p.m. [REDACTED] cares from Petitioner between 12:00 p.m. and 4:00 p.m.
- o. [REDACTED] does not work outside the home because [REDACTED] takes care of Petitioner. [REDACTED] does not think it is fair.

11. Dr. Sherman testified as follows:

- a. Dr. Sherman reviewed Petitioner's assistance needs with [REDACTED] ADLs and IADLs.
- b. On September 18, 2023, Petitioner was approved for an additional five (5) hours of homemaker care services each week, an additional fourteen (14) hours of personal care services each week, and an additional sixteen (16) hours of adult companion care each week. In total, Petitioner is receiving fourteen (14) hours of homemaker care services each week, thirty-five (35) hours of personal care services each week, and twenty-one (21) hours of adult companion care services each week, for a total of seventy (70) hours per week.
- c. Petitioner's approved hours should be sufficient to meet [REDACTED] needs.
- d. Respondent does not routinely provide service over night when a member should be sleeping.
- e. Petitioner can use [REDACTED] approved hours in shifts to cover [REDACTED] needs.
- f. Respondent gives hours based on a member's necessity and can be put into shifts.
- g. There is a certain expectation that the people a member lives with will take on some of the responsibility of care.

- h. Respondent does not believe there is medically necessity for additional hours of care.

**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 section 409.285(2), Florida Statutes. This order is the final administrative decision of AHCA under section 409.285(2)(a).

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

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 Petitioner is requesting new services, Rule 59G-1.100(17)(g), F.A.C., assigns the burden of proof to the Petitioner regarding homemaker services and personal care services. The standard of proof in an administrative hearing is a preponderance of the evidence. The preponderance of the evidence standard requires proof by "the greater weight of the evidence" (Black's Law Dictionary at 1201, 7th Ed.).

16. The Florida Medicaid policy that applies to the requested services is the Florida Medicaid Statewide Medicaid Managed Care Long-term Care Program Coverage Policy ("March 2017")

("SMMC LTC Policy"). The Agency's SMMC LTC Policy has been incorporated, by reference, into Rule 59G-4.192, F.A.C. The SMMC LTC Policy provides as follows:

**1.1 Description and Program Goal**

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

...

**1.3 Definitions**

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

**1.3.1 Activities of Daily Living (ADLs)**

ADLs include:

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

...

**1.3.5 701-B Comprehensive Assessment**

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

...

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

When necessary for the recipient to function independently, including:

- Grocery shopping
- Laundry
- Light housework
- Meal preparation
- Medication management
- Money management

- Personal hygiene
- Transportation
- Using the telephone to take care of essential tasks (examples include paying bills and setting up medical appointments)

...

#### **1.3.14 Medically Necessary or Medical Necessity**

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

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

And, one of the following:

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

...

#### **2.2 Who Can Receive**

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

...

#### **4.0 Coverage Information**

##### **4.1 General Criteria**

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

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

## **4.2 Specific Criteria**

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

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

...

### **4.2.1 Home and Community-Based Supportive Services**

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

#### **4.2.1.1 Adult Companion Care**

The provision of non-medical care, supervision when necessary to protect the health, safety, and well-being of the enrollee, or social enrichment of a functionally impaired enrollee. This includes assistance or supervision with meal preparation, laundry, and light housekeeping tasks incidental to the care and supervision of the enrollee.

...

#### **4.2.1.9 Homemaker Services**

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

...

#### **4.2.1.14 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.

### **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:

...

#### **4.2.2.2 Attendant Nursing Care**

In accordance with Rule 59G-4.261, F.A.C., for enrollees under the age of 21 years. To provide nursing care of both a supportive and health-related nature, specific to the needs of a medically stable, physically handicapped enrollee age 21 and older who requires more individual and continuous care than an intermittent nursing

visit. The scope and nature of these services do not otherwise differ from private duty nursing services furnished to persons under the age of 21 years.

#### **4.2.2.6 Personal Care**

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

...

#### **6.0 Documentation**

...

#### **6.2 Specific Criteria**

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

RCE 1, SMMC LTC Policy, pages 494 – 501.

17. The Florida Medicaid Definitions Policy (August 2017) (“Definitions Policy”), which is incorporated by reference in Rule 59G-1.010, F.A.C, defines “medical necessity” as follows:

#### **2.83 Medically Necessary or Medical Necessity**

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

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

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

...

Definitions Policy at 7.

18. The Agency's Florida Medicaid Personal Care Services Coverage Policy (November 2016) ("PC Policy") has been incorporated, by reference, into Rule 59G-4.215, F.A.C. 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
<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 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 at page 1, 3 – 5.

#### **A. Denial of Homemaker Services**

19. In the instant case, Petitioner requested an additional forty (40) hours per week of homemaker services. *See supra* ¶ 7. As established on the record by the evidence and testimony, Respondent denied Petitioner’s request because the requested services were not medically necessary. *See supra* ¶ 7 – 8, 11. On September 18, 2023, Respondent approved an additional five (5) hours of homemaker services. *See* ¶ 11. As such, the issue involves the denial of thirty-five (35) hours of homemaker services, weekly.

20. 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 ¶ 16. Section 4.2.1.9 of the SMMC LTC Policy defines homemaker services as the “provision of general household activities (such as meal preparation) and routine household care (including laundry and pest control) by a trained homemaker, when the individual regularly responsible for these activities is temporarily absent or unable to manage these activities.” See supra ¶ 16.

21. The evidence presented in this case does not reflect that an additional thirty-five (35) hours per week of homemaker services is warranted. Specifically, regarding the related IADLs, Petitioner needs total assistance (cannot do at all) with each IADL: [REDACTED], [REDACTED], [REDACTED], [REDACTED], [REDACTED], [REDACTED], and [REDACTED]. See supra ¶ 6. According to the 701B Assessment, Petitioner rarely has assistance with [REDACTED] and [REDACTED]; has assistance most of the time with [REDACTED], [REDACTED] and [REDACTED]; and always has assistance with [REDACTED], [REDACTED], and [REDACTED]. See supra ¶ 6.

22. The SMMC LTC Policy requires that the additional homemaker services must “[b]e individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient’s needs.” See supra ¶ 20. Here, Petitioner is currently authorized to receive fourteen (14) hours of homemaker care services each week, thirty-five (35) hours of personal care services each week, and twenty-one (21) hours of adult companion care services each week, for a total of seventy (70) hours per week. See supra ¶ 11. Petitioner has [REDACTED], including

[REDACTED] [REDACTED]  
[REDACTED] [REDACTED]  
[REDACTED]. See supra ¶ 3. However, both the NABD and NPAR state that Petitioner has not had any recent changes in [REDACTED] health. See supra ¶ 7, 8. Neither Petitioner nor [REDACTED] provided any testimony or evidence that Petitioner has had a change in [REDACTED] health that would make the requested homemaker services not in excess of Petitioner's current needs.

23. Here, Petitioner bears the burden of proof regarding the denial of the requested additional thirty-five (35) hours per week of homemaker services. See supra ¶ 19. Neither Petitioner nor [REDACTED] provided time estimates to explain the amount of time Petitioner requires for each of the ADLs. Further, Petitioner provided no evidence (e.g., a daily schedule, a schedule of ADLs and IADLs, the amount of time needed for each ADL and IADL) to support the approval of the additionally requested homemaker services. The definition of homemaker services most closely aligns with IALD tasks. Petitioner's 701B Assessment, which was completed with input from [REDACTED], indicates that Petitioner needs total assistance (cannot do at all) with each IADL: [REDACTED], [REDACTED], [REDACTED], [REDACTED], [REDACTED], [REDACTED], [REDACTED], [REDACTED], and [REDACTED]; and that Petitioner rarely has assistance with [REDACTED] and [REDACTED]; has assistance most of the time with [REDACTED], [REDACTED] and [REDACTED]; and always has assistance with [REDACTED], [REDACTED], and [REDACTED]. See supra ¶ 6. However, Petitioner did not explain which ADLs or IADLs would not be covered if the requested homemaker care services were not approved in this matter.

24. Considering the totality of Petitioner's circumstances, including [REDACTED] diagnoses, level of

functional need for assistance with ADLs and IADLs, amount of currently approved services, and the natural support provided by [REDACTED] caregiver, [REDACTED], Petitioner failed to prove by a preponderance of the evidence that an additional thirty-five (35) hours per week of homemaker services are not “in excess of [Petitioner’s] needs.” See supra ¶ 16, 17.

25. In light of both parties’ testimony, Petitioner’s Composite Exhibit 1, Petitioner’s Composite Exhibit 2, Petitioner’s Composite Exhibit 3, Respondent’s Composite Exhibit 1, and the applicable laws and policies, the undersigned Hearing Officer finds that Petitioner failed to meet his burden of proving that an additional thirty-five (35) hours per week of homemaker services are medically necessary. Accordingly, the undersigned Hearing Officer concludes that Petitioner failed to prove by a preponderance of the evidence that Respondent’s denial of homemaker services was incorrect.

#### **B. Denial of Personal Care Services**

26. In the instant case, Petitioner requested an additional ninety-three (93) hours per week of personal care services. See supra ¶ 7. As established on the record by the evidence and testimony, Respondent denied Petitioner’s request because the requested services were not medically necessary. See supra ¶ 7 – 8, 11.

27. 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 ¶ 16. The LTC Policy states that personal care services are intended to “provide assistance with ADLs and IADLs, including assistance with preparation of meals, and housekeeping chores

which are incidental to the care furnished or are essential to the health and welfare of the enrollee.” See supra ¶ 16.

28. The evidence presented in this case does not reflect that an additional ninety-three (93) hours weekly of personal care services is warranted. Specifically, regarding ADLs, Petitioner needs total assistance (cannot do at all) with each ADL: [REDACTED], [REDACTED], [REDACTED], [REDACTED], [REDACTED], [REDACTED], and [REDACTED]. See supra ¶ 5. According to the 710B Assessment, Petitioner rarely has assistance with [REDACTED], [REDACTED], and [REDACTED]; and has assistance most of the time with [REDACTED], [REDACTED], and [REDACTED]. See supra ¶ 5. Petitioner has [REDACTED], including [REDACTED] [REDACTED] [REDACTED] [REDACTED] [REDACTED] [REDACTED] [REDACTED] [REDACTED]. See supra ¶ 3. However, as discussed *supra* ¶ 22 both the NABD and NPAR state that Petitioner has not had any recent changes in [REDACTED] health. See supra ¶ 7, 8. Neither Petitioner nor [REDACTED] provided any testimony or evidence that Petitioner has had a change in [REDACTED] health that would make the requested personal care services not in excess of Petitioner’s current needs.

29. The SMMC LTC Policy and the Definitions Policy require that the additional personal care services must “[b]e individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient’s needs.” See supra ¶ 17, 18. Here, Petitioner is currently authorized to receive fourteen (14) hours of homemaker care services each week, thirty-five (35) hours of personal care services each week, and twenty-one

(21) hours of adult companion care services each week, for a total of seventy (70) hours per week.

See supra ¶ 11.

30. Here, Petitioner bears the burden of proof regarding the denial of an additional ninety-three (93) hours weekly of personal care services. See supra ¶ 14. Petitioner provided no time estimates to explain the amount of time Petitioner requires for each of the ADLs. Further, Petitioner provided no evidence (e.g., a daily schedule, a schedule of ADLs and IADLs, the amount of time needed for each ADL and IADL) to support the approval of the requested personal care services per week. The definition of personal care services most closely aligns with ADL tasks. Petitioner's 701B Assessment, which was completed with input from [REDACTED], indicates that Petitioner rarely has assistance with [REDACTED], [REDACTED], and [REDACTED]; and has assistance most of the time with [REDACTED], [REDACTED], and [REDACTED]. See supra ¶ 6. However, the testimony and documentation show that Petitioner is received seventy (70) hours of care. Neither Petitioner nor [REDACTED] explained which ADLs or IADLs would no longer be covered if the requested hours personal care services were not approved in this matter.

31. Considering the totality of Petitioner's circumstances, including [REDACTED] diagnoses, level of functional need for assistance with ADLs and IADLs, amount of currently approved services, and the natural support provided by [REDACTED] caregiver, [REDACTED], Petitioner failed to prove by a preponderance of the evidence that an additional [REDACTED]-three (93) hours per week of personal care services are not "in excess of [Petitioner's] needs." See supra ¶ 16, 17.

32. In light of both parties' testimony, Petitioner's Composite Exhibit 1, Petitioner's Composite Exhibit 2, Petitioner's Composite Exhibit 3, Respondent's Composite Exhibit 1, and the applicable laws and policies, the undersigned Hearing Officer finds that Petitioner failed to meet

the burden of proving that an additional ninety-three (93) hours per week of personal care services are medically necessary. Accordingly, the undersigned Hearing Officer concludes that Petitioner failed to prove by a preponderance of the evidence that Respondent's denial of personal care services was incorrect.

**DECISION**

**IT IS THEREFORE ORDERED AND ADJUDGED THAT:**

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

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

**DONE AND ORDERED** this 20th day of December, 2023 in Tallahassee, Leon County, Florida.



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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:**



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**GAMedicaidRightFax@humana.com**

**AHCA Medicaid Hearing Unit**  
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