



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

FILED

Jan 04, 2024, 10:59 am  
OFFICE OF FAIR HEARINGS

[REDACTED]

PETITIONER,

vs.

AHCA Case No.: 23-FH2244

Plan ID No.: [REDACTED]

HUMANA MEDICAL PLAN, INC.,

RESPONDENT.

\_\_\_\_\_ /

[REDACTED]

PETITIONER,

vs.

AHCA Case No.: 23-FH2245

Plan ID No.: [REDACTED]

HUMANA MEDICAL PLAN, INC.,

RESPONDENT.

\_\_\_\_\_ /

**FINAL ORDER**

Pursuant to notice, the Office of Fair Hearings (“OFH”) convened a telephonic Medicaid Fair Hearing in the above styled consolidated case on December 19, 2023, at 10:17 a.m. Eastern Standard Time (“EST”).

**APPEARANCES**

For the Petitioner:

[REDACTED]

Authorized Representative

For the Respondent:

Markeshi Lee  
Appeals and Fair Hearing Specialist  
Humana Medical Plan, Inc.

### **STATEMENT OF ISSUES**

The first issue in this matter is whether the Petitioner proved by a preponderance of the evidence that the Respondent's denial of one hundred and ten (110) hours of personal care services per week (Case No. 23-FH2244) was incorrect.

The second issue in this matter is whether the Petitioner proved by a preponderance of the evidence that the Respondent's denial of fourteen (14) hours of adult companion care services per week (Case Number 23-FH2245) was incorrect.

### **PRELIMINARY STATEMENT**

All parties and witnesses appeared telephonically. [REDACTED] ("[REDACTED]"), the Petitioner's [REDACTED] and designated Authorized Representative appeared and testified on behalf of the Petitioner.

Markeshi Lee, Humana Medical Plan, Inc., ("Humana"), Appeals and Fair Hearing Specialist appeared at the hearing and represented Respondent. Dr. Manohar Chenchugalla, Humana Medical Director ("Dr. Chenchugalla"), provided testimony on behalf of the Respondent.

Linda Latson, Registered Nurse Specialist for the Agency for Health Care Administration ("Agency" or "AHCA"), appeared for observational purposes.

Prior to the hearing, the Respondent submitted a three hundred and twenty-nine (329)-page evidence package that was admitted into evidence without objection, is identified as "Respondent's Composite Exhibit 1", and is recorded in the OFH document management system as follows: "Evidence Packet\_Part 1.pdf"; "Evidence Packet\_Part 2.pdf"; "Evidence Packet\_Part 3.pdf"; "Evidence Packet\_Part 4.pdf"; "Evidence Packet\_Part 5.pdf"; and "Evidence Packet\_Part 6.pdf". The Petitioner did not submit any proposed exhibits into evidence.

**FINDINGS OF FACT**

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

2. As of the time of the hearing, Petitioner is a [REDACTED] ([REDACTED]) [REDACTED] [REDACTED] possessing a PhD in biochemistry that lives in a private home with [REDACTED] [REDACTED], who also serves at the Petitioner’s primary caregiver. See Respondent’s Composite Exhibit 1, pages 78 and 91, and *Testimony of* [REDACTED].

3. Petitioner has the following health conditions: traumatic brain injury with [REDACTED]  
[REDACTED]  
[REDACTED]  
[REDACTED]. See Respondent’s Composite Exhibit 1, pages 81, 83-84. During the past year, the Petitioner has been to the emergency room two (2) times and has been hospitalized three (3) times. See Respondent’s Composite Exhibit 1, page 80. In addition, Petitioner is bedbound eighty percent (80%) of the time and spends twenty percent (20%) of [REDACTED] time in an electric wheelchair. See Respondent’s Composite Exhibit 1, page 81. Finally, the Petitioner is transferred from [REDACTED] [REDACTED] [REDACTED] as [REDACTED] doctor has advised the Petitioner’s caregiver not to be advised not to [REDACTED]. See Respondent’s Composite Exhibit 1, page 93 and *testimony of* [REDACTED].

4. The 701B, reflects the following regarding Petitioner's Activities of Daily Living ("ADLs"). Petitioner needs total assistance (cannot do at all) with all of the activities of daily living, including [REDACTED], [REDACTED], [REDACTED], [REDACTED], [REDACTED], and [REDACTED]. See Respondent's Composite Exhibit 1, page 81. The 701B further reflects that the Petitioner uses assistive devices for [REDACTED], [REDACTED], [REDACTED], and [REDACTED]. See Respondent's Composite Exhibit 1, page 89.

5. Regarding Petitioner's Instrumental Activities of Daily Living ("IADLs"), the 701B reflects that Petitioner needs total assistance (cannot do at all) with [REDACTED], [REDACTED], [REDACTED], [REDACTED], [REDACTED], and [REDACTED]. See Respondent's Composite Exhibit 1, pages 82.

6. The Petitioner is currently authorized to receive the following home and community-based services from the Respondent: fifty-two (52) hours of personal care services per week, ten (10) hours per week of homemaker services per week, and a personal emergency response system ("PERS"). See Respondent's Composite Exhibit 1, pages 104 and 111-112.

7. On February 17, 2023, the Petitioner requested an additional one hundred and forty-three (143) hours of personal care services per week. See Respondent's Composite Exhibit 1, page 16. On February 24, 2023, the Respondent issued a Notice of Adverse Benefit Determination ("NABD") in Case Number 23-FH2244 approving an additional thirty-three (33) hours of the requested personal care services per week and denying the remaining one hundred and ten (110) hours of personal care services per week. See Respondent's Composite Exhibit 1, pages 16-23. The February 17, 2023, NABD stated the following reasons for denying an additional one hundred and ten (110) hours of personal care services hours per week as follows:

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



Meet all of the criteria as defined in Rule 59G-1.010(166), F.A.C., for all nursing facility services and mixed services; OR

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

- 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; and
- 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

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 have 3 hours of homemaker service each week; 19 hours of personal care service each week; and 3 hours of Adult Companion Care each week. You have requested an additional 143 hours of personal care service each week. You have [REDACTED]. You have [REDACTED]. You have [REDACTED]. You do not [REDACTED].

You have not had any recent changes in your health. You have not [REDACTED]. You live with [REDACTED]. [REDACTED] helps care for you. [REDACTED] works outside of the home. You use a [REDACTED]. You need total help [REDACTED]. You need total help [REDACTED];

[REDACTED]; and [REDACTED]. You need help with [REDACTED]; [REDACTED]; and [REDACTED]  
[REDACTED]. You always have [REDACTED]

You are being approved for an additional 33 hours of personal care service each week. This will give you a total of 58 hours of home health aide services daily to meet your needs

...

*Id.*

8. On May 15, 2023, the Petitioner timely requested a plan appeal of the Respondent's denial of one hundred and ten (110) hours of personal care services per week in Case Number 23-FH2244. See Respondent's Composite Exhibit 1, page 34. On June 2, 2023, the Respondent sent the Petitioner a Notice of Plan Appeal Resolution ("NPAR") letter in Case Number 23-FH2244 upholding the denial of one hundred and ten (110) hours of personal care services hours and stated as follows:

[The Petitioner] has [REDACTED]. [REDACTED] does not have [REDACTED]  
[REDACTED]. [REDACTED] sometimes has [REDACTED]  
[REDACTED]. [REDACTED] lives with [REDACTED] caregiver. [REDACTED] uses a [REDACTED]  
[REDACTED] [REDACTED] needs help [REDACTED] [REDACTED] needs help  
[REDACTED], [REDACTED], and [REDACTED]. [REDACTED] needs help with [REDACTED], [REDACTED], and  
[REDACTED].

The denial of 110 additional hours of 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.

See Respondent's Composite Exhibit 1, pages 34-42.

9. On June 13, 2023, the Petitioner requested an additional fourteen (14) hours of adult companion care hours per week. See Respondent's Composite Exhibit 1, page 24. On June 16,

2023, the Respondent issued a NABD in Case Number 23-FH2245 denying an additional fourteen (14) hours of adult companion care hours per week. See Respondent's Composite Exhibit 1, pages 24-31. The September 12, 2023, NABD stated the following reasons for denying an additional fourteen (14) hours of adult companion care hours per week as follows:

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



Meet all of the criteria as defined in Rule 59G-1.010(166), F.A.C., for all nursing facility services and mixed services; OR

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

- 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; and
- 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:

3. Enable the enrollee to maintain or regain functional capacity; or
4. 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**

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

You have requested 14 hours of Adult Companion (ACC) service weekly. You currently receive Adult Companion - 2 hours weekly and Personal Care - 52 hours

weekly, 24/7 PERS, and Homemaker - 7 hours weekly. You need total assistance with [REDACTED], [REDACTED], [REDACTED], [REDACTED], and [REDACTED]. You receive [REDACTED] from your caregiver. You wear [REDACTED] and have a [REDACTED]. As a result of [REDACTED]. You cannot [REDACTED]. You need total assistance with [REDACTED], [REDACTED], [REDACTED], [REDACTED], [REDACTED], [REDACTED], and [REDACTED]. You are on a [REDACTED]. You need assistance for [REDACTED]. You communicate with [REDACTED]. You live with your [REDACTED]/primary caregiver. Your representative is requesting ACC hours to avoid isolation as you have limited socialization. We are denying your request as you are currently receiving 61 hours of care weekly which also provides you with socialization and prevents isolation. Also, you live with [REDACTED] who can provide you with socialization.

...

*Id.*

10. On June 27, 2023, the Petitioner timely requested a plan appeal of the Respondent's denial of fourteen (14) hours of adult companion care services per week in Case Number 23-FH2245. See Respondent's Composite Exhibit 1, page 43. On September 12, 2023, the Respondent sent the Petitioner a Notice of Plan Appeal Resolution ("NPAR") letter in Case Number 23-FH2245 upholding the denial of fourteen (14) hours of adult companion care hours and stated as follows:

The reason for the decision is based on the information received. You have requested that the additional 14 hours of adult companion care each week that was denied in your initial request be reconsidered (appeal).

[REDACTED] has [REDACTED]. [REDACTED] sometimes has [REDACTED]. [REDACTED] has [REDACTED]. [REDACTED] lives with you. [REDACTED] uses a [REDACTED]. [REDACTED] needs help [REDACTED]; [REDACTED]; and [REDACTED]. [REDACTED] needs help with [REDACTED]; [REDACTED]; and [REDACTED]. The denial of the additional 14 hours of adult companion care each week is being upheld. The hours [REDACTED] is currently receiving should be enough to meet [REDACTED] companionship needs.

See Respondent's Composite Exhibit 1, pages 43-45.

11. The Petitioner requested a Fair Hearing due to the Respondent's denial of one hundred and ten (110) hours of personal care hours per week (Case Number 23-FH2244), and the denial of fourteen (14) hours per week of adult companion care (Case Number 23-FH2245). On November 27, 2023, the undersigned hearing officer scheduled a Fair Hearing for December 19, 2023, at 10:00 a.m. EST.

12. The Petitioner's [REDACTED] serves as the sole caregiver and the authorized representative in this matter. See Respondent's Composite Exhibit 1, page 78. The Petitioner's [REDACTED] is [REDACTED], works full time from home, is [REDACTED], and [REDACTED] resulting from [REDACTED]. See Respondent's Composite Exhibit 1, page 93.

13. The Petitioner's physician, Andrew Barkman, M.D. has provided a February 14, 2023, letter stating the Petitioner requires twenty-four (24) hour home healthcare. See Respondent's Composite Exhibit 1, page 54.

14. The Petitioner's Authorized Representative testified that the Petitioner [REDACTED] [REDACTED], which occurs seven (7) to eight (8) times per day. [REDACTED] further testified that when the Petitioner experiences [REDACTED] [REDACTED]. [REDACTED] testified that the currently approved home health hours cover approximately nine (9) hours per day, which is split into shifts for services between 9:00 am through 3:00 p.m., then an evening shift after 6:30 p.m., leaving a mid-day gap that interferes with the caregiver's ability to work. The Petitioner's

Authorized Representative, who also serves as the Petitioner's principal caregiver testified that [REDACTED] is seeking at least twelve (12) hours of help per day, is only asking for day-shift hours, and does not require help with the overnight hours. Finally, [REDACTED] testified the help [REDACTED] requires is assistance with respect to the Petitioner activities of daily living.

15. Dr. Chenchugalla testified on behalf of the Respondent and acknowledged that the Petitioner requires in-home skilled nursing but is awaiting confirmation from the Petitioner's primary insurer that the Petitioner is not eligible for home health care. The Petitioner's Authorized Representative testified that [REDACTED] [REDACTED]'s primary insurance does not include home health care and will not provide a confirmation that coverage has been "denied" for a benefit that is not included in [REDACTED] insurance coverage. Dr. Chenchugalla further testified that the home health care the Petitioner requires is focused on the performance of [REDACTED] activities of daily living, maintaining [REDACTED]

[REDACTED] Finally, Dr. Chenchugalla testified that the limited companionship and socialization associated with adult companion care is not medically necessary as it is not individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment in light of the fact that the Petitioner does [REDACTED]

#### **CONCLUSIONS OF LAW**

16. 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).

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

18. 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.

19. Because the Respondent has denied newly requested services, Fla. Admin. Code R. 59G-1.100(17)(g) assigns the burden of proof to the Petitioner to demonstrate that the Respondent’s decisions were incorrect. 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.).

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

**1.1 Description and Program Goal**

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

...

**1.3 Definitions**

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

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

ADLs include:

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

...

### **1.3.5 701-B Comprehensive Assessment**

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

...

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

When necessary for the recipient to function independently, including:

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

...

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

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

- (a) Nursing facility services and mixed services must meet the medical necessity criteria defined in Rule 59G-1.010, F.A.C.

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

And, one of the following:

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

...

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

...

## **2.2 Who Can Receive**

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

...

## **4.0 Coverage Information**

### **4.1 General Criteria**

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

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

### **4.2 Specific Criteria**

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

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

...

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

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

...

#### **4.2.1.1. 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.

...

#### **4.2.2 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.

21. 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.

22. 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   |
|--|---|
| <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 | 15–30 minutes day for all monitoring tasks performed   |

|                |  |
|----------------|--|
| intake/output. |  |
|----------------|--|

PC Policy, pages 3 – 8, and 10.

### **Personal Care Services**

23. As established on the record by the evidence and the testimony, the Respondent denied one hundred and ten (110) of the requested one hundred and forty-three (143) additional hours of personal care services (Case Number 23-FH2244). See *supra* ¶¶ 7 and 8. *Id.* Based upon Dr. Chenchugalla’s testimony and the NPAR, the Respondent denied the one hundred and ten hours per week of personal care services because they are not medically necessary, and are in excess of the patient’s needs. See *supra* ¶¶ 7, 8, 15 and 21.

24. 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* ¶ 20. The evidence presented in this case reflects it is in-fact medically necessary that the Petitioner receive additional hours of personal care services per week. See *supra* ¶¶ 4, 5, 12, 13, and 14. However, the Petitioner’s Authorized Representative testified that what is being sought in this case is twelve (12) hours of personal care services per day, which totals eighty-four (84) hours per week. The Petitioner’s currently receives fifty-two (52) hours of personal care services per week. See *supra* ¶ 206. The Petitioner’s Authorized Representative testified that personal care services are not required for the overnight hours and combined with the personal care services hours already provided to the Petitioner, the total number of hours of personal care services if the additional one hundred and ten (110) hours of personal care services were

approved, would equal one hundred and sixty-two (162) hours per week, or twenty-three and three quarters (23.75) hours per day, which are in excess of the Petitioner's needs.

25. Section 1.3.14 of the SMMC LTC Policy and section 2.83 of the Definitions Policy mandates that the requested 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 ¶ 20.

26. Considering the totality of Petitioner's circumstances, including [REDACTED] medical conditions, the level of required assistance for the ADLs and IADLs, and the amount of currently approved services, the Respondent has not proved beyond a preponderance of the evidence that the additional one hundred and ten (110) hours of personal care services are not in excess of Petitioner's needs. Therefore, the one hundred and ten (110) additional hours of personal care services per week do not meet medical necessity criteria. See supra ¶¶ 20, 21, and 22.

27. In light of the parties' testimony, Respondent's Composite Exhibit 1, the SMMC LTC Policy, the PC Policy, and the Definitions Policy, the undersigned Hearing Officer finds that Petitioner has not met the burden of proving that the Respondent's denial of an additional one hundred and ten (110) hours of personal care services was incorrect.

#### **Adult Companion Care Services**

28. In this case, the Respondent denied an additional fourteen (14) hours of adult companion services based on the 701B annual assessment. See supra ¶¶ 7 and 10. The Respondent's rationale for denying the fourteen (14) hours of adult companion services was that the additional hours adult companion care are in excess of the Petitioner's needs in that the Petitioner obtains sufficient companionship and socialization from living with [REDACTED] combined with the home

health hours and aides that visit the Petitioner, and additional hours of adult companion care are not medically necessary.

29. As provided in the LTC Policy, the purpose of adult companion care services is to provide “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.” See supra ¶ 20. Thus, adult companion care services are designed to prevent social isolation and to provide supervision to protect the enrollee’s safety. *Id.* The LTC Policy covers services that meet all of the following: are determined to be medically necessary, do not duplicate another service, and meet the criteria as specified in the LTP Policy. See supra ¶ 20. As Dr. Chenchugalla testified, the 701B states that the Petitioner needs constant supervision, but reflects ■ lives in the home with ■ ■ and combined with the socialization from the home health aides, the Petitioner requires no further socialization. See supra ¶ ¶ 6 and 15.

30. Based on the Petitioner’s living arrangements, ■ medical conditions, and ■ functional abilities, the record demonstrates by a preponderance of the evidence that the requested fourteen (14) hours of adult companion care are in excess of Petitioner’s supervision or socialization needs.

31. Upon consideration of the testimony provided, Respondent’s Composite Exhibit 1, and the applicable laws and policies, the undersigned finds that the Petitioner did meet ■ burden of proving by a preponderance of the evidence that the requested fourteen (14) hours per week of adult companion are medically necessary.


32. Accordingly, the undersigned Hearing Officer concludes that Petitioner did not prove by a preponderance of the evidence that the Respondent's decision to deny the Petitioner's requested fourteen (14) hours of adult companion care services was incorrect.

**DECISION**

Respondent's denial of an additional one hundred and ten (110) hours of personal care service hours per week (Case No. 23-FH2244) is **AFFIRMED**. Petitioner's appeal based on Respondent's reduction is **DENIED**.

Respondent's denial of an additional fourteen (14) hours per week of adult companion care services per week for the Petitioner (Case No. 23-FH2245) is **AFFIRMED**. Petitioner's appeal based on Respondent's termination is **DENIED**.

**DONE AND ORDERED** this 4th day of January, 2024, in Tallahassee, Leon County, Florida.

Alan J. Leifer  
  
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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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