



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

FILED

Dec 20, 2023, 12:32 pm

OFFICE OF FAIR HEARINGS

[REDACTED]

PETITIONER,

AHCA Case No.: 23-FH2313

Plan ID No.: [REDACTED]

vs.

MOLINA HEALTH CARE OF FLORIDA, INC.,

RESPONDENT.

_____ /

[REDACTED]

PETITIONER,

AHCA Case No.: 23-FH2314

Plan ID No.: [REDACTED]

vs.

MOLINA HEALTH CARE OF FLORIDA, INC.,

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the Office of Fair Hearings convened a telephonic Medicaid Fair Hearing in the above styled case on November 6, 2023, at 9:35 a.m. Eastern Standard Time ("EST").

APPEARANCES

For the Petitioner:

[REDACTED]

Petitioner's Authorized Representative

For the Respondent:

Mariana Nunez
Lead Appeals & Grievances
Molina Healthcare of Florida

STATEMENT OF ISSUE

The first issue is whether Petitioner proved by a preponderance of the evidence that Respondent's denial of eleven (11) hours per week of personal care services was incorrect.

The second issue is whether Petitioner proved by a preponderance of the evidence that Respondent's denial of five (5) hours per week of homemaker services was incorrect.

PRELIMINARY STATEMENT

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

Marina Nunez, Lead Appeals & Grievances, represented the Respondent, Molina Healthcare of Florida ("Molina Healthcare"), at the Fair Hearing and provided testimony. Dr. Nadia Lopez, Medical Director for Respondent, appeared at the Fair Hearing to offer testimony. Katia Matos, Utilization Director, also provided testimony on behalf of Respondent at the Fair Hearing. The following employees of Molina Healthcare attended the Fair Hearing as witnesses but did not testify: Yuneisy Cruz, Director of Healthcare Services with the Long Term Care Team; and Caridad Bello, Government Contract Specialist.

Sandra Durden, Medical Health Care Program Analyst for Health Care Administration ("Agency" or "AHCA"), appeared for observational purposes.

The following Spanish translators appeared at the Fair Hearing to provide translation services for Petitioner: Myrna, ID Number JW369; Myriam, ID Number, BI075; Cesar, ID Number GB086; and Christian, ID Number IT737.

Prior to the hearing, Petitioner sent to the Office of Fair Hearings and Respondent a three (3) page evidence packet. The evidence packet appears in the Office of Fair Hearings' Case Management system as "23-FH2313 and 23-FH2314 Email Correspondence.pdf". Absent an objection from Respondent, the undersigned admitted Petitioner's evidence packet into evidence as Petitioner's Composite Exhibit 1 ("PCE 1").

Prior to the hearing, Respondent sent to the Office of Fair Hearings and Petitioner a one hundred and thirty-seven (137)-page evidence packet. The evidence packet appears in the Office of Fair Hearings' Case Management system as "MFH Office Packet_[Petitioner's Name]_1.pdf," "MFH Office Packet_[Petitioner's Name]_2.pdf," "MFH Office Packet_[Petitioner's Name]_3.pdf," "MFH Office Packet_[Petitioner's Name]_4.pdf," and "MFH Office Packet_[Petitioner's Name]_5.pdf". Absent an objection from Petitioner, the undersigned admitted Respondent's evidence packet into evidence as Respondent's Composite Exhibit 1 ("RCE 1").

FINDINGS OF FACT

1. Petitioner is an enrolled member of Molina Healthcare's LTC plan. *See* RCE 1, page 1. Molina Healthcare 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 is [REDACTED]. *Id.* at 37. Petitioner lives with [REDACTED] [REDACTED] in a private residence. *Id.* at 70, 71.
3. Petitioner answered the questions on Petitioner's Florida Department of Elder Affairs: 701B Comprehensive Assessment, dated May 4, 2023 ("701B Assessment"). *Id.* at 70 – 88.

Question 33 states that no one else besides Petitioner provided answers to the 701B Assessment.

Id. at 71.

4. According to the 701B, Petitioner has the following health conditions: [REDACTED]
[REDACTED]
[REDACTED]. *Id.* at 76 – 77. Petitioner is [REDACTED]. *Id.* at 77. Petitioner is satisfied with [REDACTED] overall quality of life and feels things are about the same as they were a year prior to May of 2023. *Id.* at 78. Petitioner does not have the problem behaviors of [REDACTED]. *Id.* at 79. Petitioner needs supervision due to [REDACTED] *Id.* at 79.

5. According to the 701B Assessment, regarding Petitioner’s Activities of Daily Living (“ADLs”), Petitioner needs total assistance (cannot do at all) with [REDACTED] and [REDACTED]; needs assistance (but not total help) with [REDACTED], [REDACTED], [REDACTED], and [REDACTED]; and needs supervision or prompting with [REDACTED], [REDACTED], and [REDACTED]. *Id.* at 74. Petitioner always has assistance with all of [REDACTED] ADLs. *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 [REDACTED], [REDACTED], [REDACTED], [REDACTED], [REDACTED], and [REDACTED]; needs assistance (but not total help) with [REDACTED]; and needs supervision or prompting with [REDACTED]. *Id.* at 75. Petitioner always has assistance with all of [REDACTED] IADLs. *Id.*

7. [REDACTED] [REDACTED] is listed as Petitioner’s caregiver. Petitioner testified that [REDACTED] answered the questions on the 701B regarding the caregiver section without [REDACTED] [REDACTED]. *Id.* at 84. [REDACTED] [REDACTED] provides twenty (20) hours per week of care to Petitioner. *Id.* at 85. [REDACTED] [REDACTED] is very confident in [REDACTED] ability to continue to provide care to Petitioner and does not have any mental or emotional strain in providing the care. *Id.*

8. The notes and summary of the 701B Assessment observe, in pertinent part:

Case Manager conducted significant change Assessment (face to face) with member [Petitioner] (HHA present) at [REDACTED] home residence to follow up on member’s health status and to provide any additional support that may be needed. CM spoke directly with member and caregiver.

...
Member presents [REDACTED] and [REDACTED].

...
Member is still [REDACTED].

...
Member requires [REDACTED].

...
Although member is [REDACTED] member is able to [REDACTED].
[REDACTED] Member is also able to [REDACTED].
[REDACTED]. Member needs total assistance with all ADLs and IADLs.

RCE 1 at 71 – 72, 75.

9. Petitioner requested fifteen (15) additional hours of personal care services. *Id.* at 22. On June 22, 2023, Respondent issued a Notice of Adverse Benefit Determinations (“NABD”) approving four (4) additional hours of personal care service hours and denying eleven (11) hours of personal care services. *Id.* at 21 – 27. The NABD explained the basis of the denials 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 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 decision was based on medical necessity (as defined by Agency for Health Care Administration's Medical Necessity as defined in Rule 59-G, 192 and reflects the application of Molina Clinical Policy (332)

The reason why the request was not approved is: The [Petitioner] asked for additional Personal care 15 hours weekly are partially approved for 4 hours per week, while 11 hours per week are denied by the Medical Director because service is not medically necessary. You are already receiving other services that should meet your needs. You should be receiving 24 hours of assistance based on the calculation tool we utilize to determine your needs. You will receive 24 hours of medical necessity (as defined by Florida law) and reflects the application of Molina Healthcare's approved review criteria guidelines.

...

Id. at 21 – 22.

10. Petitioner requested five (5) additional hours of homemaker services. *Id.* at 31. On June 22, 2023, Respondent issued a Notice of Adverse Benefit Determinations ("NABD") denying the homemaker services. *Id.* at 30 – 36. The NABD explained the basis of the denials 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 following criteria for all extended state plan services used for the purposes of maintenance therapy and all other home and community-based services:

4. 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;
5. 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
6. 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.

...

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 59-G, 192 and reflects the application of Molina Clinical Policy (332)

The reason why the request was not approved is: The [Petitioner] asked for additional Homemaker 5hours weekly are denied by the Medical Director because service is not medically necessary. You are already receiving other services that should meet your needs. You should be receiving 24 hours of assistance based on the calculation tool we utilize to determine your needs. You will receive 24 hours of medical necessity (as defined by Florida law) and reflects the application of Molina Healthcare's approved review criteria guidelines.

...

Id. at 30 – 31.

11. Petitioner requested a plan appeal and received a Notice of Plan Appeal Resolution ("NPAR"), dated October 10, 2023, upholding the denial of homemaker services and upholding the denial of personal care services. *Id.* at 133 – 137. The NPAR states in pertinent part:

On September 18, 2023, we received your timely plan appeal request regarding Molina Healthcare of Florida's Notice of Adverse Benefit Determination (NABD) dated June 22,

2023, NABD Number [REDACTED], denying the extra 11 hours of Personal Care Services and the extra 5 hours of Homemaker Services to [Petitioner].

On October 6, 2023, after consideration of the information you provided to Molina Healthcare of Florida in support of your plan appeal, Molina Healthcare of Florida denies your plan appeal. As a result, [Petitioner] will not receive extra 11 hours of Personal Care Services and the extra 5 hours of Homemaker Services effective October 6, 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. You are already receiving services that should meet your needs. For this reason, the 11 hours of Personal Care Services, and the 5 hours of Homemaker Services is not approved. Please talk to your doctor and/or Case Manager about your options.

While we are denying the 11 hours of Personal Care Services and the 5 hours of Homemaker Services, you will still receive 14 hours of Personal Care Services and the 10 hours of Homemaker Services.

...

RCE 1 at 133.

12. On September 15, 2023, Petitioner requested a Fair Hearing to challenge the denial of personal care services and the denial of homemaker services. On October 18, 2023, the Hearing Officer issued an Order Scheduling Fair Hearing by Telephone and Prehearing Instructions, setting the hearing for November 6, 2023, at 9:00 a.m. EST.

13. Petitioner testified as follows:

- a. Petitioner lives with [REDACTED] and adult [REDACTED]. Petitioner needs help because [REDACTED] is [REDACTED] and cannot [REDACTED].
- b. Petitioner has been [REDACTED].

- c. Petitioner receives services Monday to Friday from 9:30 a.m. until 1:30 p.m. to 2:00 p.m. Petitioner is alone until [REDACTED] adult [REDACTED] returns home at 7:00 p.m. Petitioner's adult [REDACTED] assists [REDACTED] on Saturday and Sunday.
- d. Petitioner never had a walker.

14. Ms. Matos testified as follows:

- a. Petitioner completed the appeal process with Molina.
- b. Petitioner has been a Long Term Care recipient since November 2015.
- c. Petitioner's care plan includes ten (10) hours per week of personal care services, ten (10) hours per week of homemaker services, consumable medical supplies, and five (5) home delivered meals per week.
- d. After the 701B Assessment was completed, Respondent approved an additional four (4) hours per week of personal care services.
- e. Ms. Matos reviewed Petitioner's medical conditions.
- f. Ms. Matos reviewed Petitioner's ADL and IADL needs.
- g. Respondent provides consumable products for Petitioner to use during the time between the aide leaving and Petitioner's adult [REDACTED] returning home.

15. Dr. Lopez testified as follows:

- a. Respondent denied Petitioner's request for additional services based on Petitioner's functional levels and needs.
- b. Based on the 701B Assessment, Respondent established that Petitioner's ADL and IADL needs were properly assessed.

- c. Dr. Lopez opined that the services for Petitioner were properly allocated based on medical necessity.
- d. Dr. Lopez read the medically necessary criteria into the record.
- e. Petitioner’s requested services are not for treating medical conditions; these are nonskilled services to complete ADLs and IADLs.

16. Petitioner submitted a letter from Petitioner’s doctor, Rodriguez Mayili, MD, dated October 23, 2023. The letter states, in pertinent part:

The above referenced individual is currently a patient in my care. The patient suffers from the following medical diagnoses:

[REDACTED]

Patient with a [REDACTED] would benefit with an increase in the hours for assistance with [REDACTED] activities of daily living.

...

PCE 1 at 3.

17. As of the date of the hearing, November 6, 2023, Petitioner is authorized to receive ten (10) hours per week of homemaker services and fourteen (14) hours of personal care services.

CONCLUSIONS OF LAW

18. 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).

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

20. 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.

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

22. 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"). See RCE 1 at 98 – 119. 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.

...

4.2.2 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.

...

6.2 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, at 100 – 107.

23. 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.

24. 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
Bathing	
Full-body Bath: Tub, shower or sponge/bed bath.	Up to 30 minutes. May rotate with partial bath based on recipient’s needs
Partial Bath: A sponge bath includes, at a minimum, bathing of the face, hands, and perineum.	15–20 minutes per partial bath
Dressing	

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

intake/output.	
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PCS Coverage Policy at page 1, 3 – 5.

A. Denial of Homemaker Services

25. In the instant case, Respondent denied five (5) hours weekly of homemaker service hours. See supra ¶ 10, 11. As established on the record by the evidence and testimony, Respondent denied Petitioner’s request because the documentation submitted in support of Petitioner’s request failed to establish that the requested services were medically necessary. See supra ¶ 9 – 11.

26. 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 ¶ 22. 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 ¶ 22.

27. The evidence presented in this case does not reflect that five (5) additional hours weekly of homemaker services are warranted. Specifically, regarding ADLs, Petitioner needs total assistance (cannot do at all) with [REDACTED] and [REDACTED]; needs assistance (but not total help) with [REDACTED], [REDACTED], [REDACTED], and [REDACTED]; and needs supervision or prompting with [REDACTED], [REDACTED], and [REDACTED]. See supra ¶ 5. According to the 710B Assessment, Petitioner always has assistance with all of [REDACTED] ADLs. See supra ¶ 5. Petitioner testified that [REDACTED] is home alone between 2:00 p.m. when [REDACTED] aide leaves and 7:30 p.m.

when [redacted] adult [redacted] returns home. See supra ¶ 13. However, Petitioner also testified that [redacted] lives with [redacted]. See supra ¶ 13. Neither Petitioner nor [redacted] testified that Petitioner's [redacted] is unable to assist Petitioner.

28. Petitioner has multiple medical conditions, including [redacted]
[redacted]
[redacted]. See supra ¶ 4. Petitioner is [redacted]. See supra ¶ 4.

29. The SMMC LTC Policy require 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 ¶ 22. Here, Petitioner is currently authorized to receive fourteen (14) hours of personal care services and ten (10) hours of homemaker services. See supra ¶ 11.

30. Here, Petitioner bears the burden of proof regarding the denial of five (5) hours weekly of homemaker services. See supra ¶ 21. Petitioner provided no time estimates to explain the amount of time Petitioner requires for each of [redacted] 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 five (5) hours weekly of homemaker services per week. The definition of homemaker services most closely aligns with IALD tasks. Petitioner’s 701B Assessment, which Petitioner answered on [redacted] own, indicates that Petitioner needs total assistance (cannot do at all) with [redacted], [redacted], [redacted], [redacted], [redacted], [redacted], and [redacted]; needs assistance (but not total help) with [redacted]; and needs supervision or prompting with [redacted],

and that Petitioner always has assistance with all of [REDACTED] IADLs. *See supra* ¶ 6. However, Petitioner did not explain which ADLs or IADLs would no longer be covered if the requested homemaker 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] in-home family members, Petitioner failed to prove by a preponderance of the evidence that five (5) additional hours weekly of homemaker services are not "in excess of [Petitioner's] needs." *See supra* ¶ 22.

32. In light of both parties' testimony, Petitioner's Composite Exhibit 1, 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 five (5) additional hours weekly 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

33. In the instant case, Petitioner requested fifteen (15) additional hours weekly of personal care hours. *See supra* ¶ 9. Respondent approved four (4) additional hours of personal care service hours and denying eleven (11) hours of personal care services. *See supra* ¶ 9. As established on the record by the evidence and testimony, Respondent denied Petitioner's request because the documentation submitted in support of Petitioner's request failed to establish that the requested services were medically necessary. *See supra* ¶ 9, 10.

34. 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 ¶ 22. 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 ¶ 22.

35. The evidence presented in this case does not reflect that an additional thirty-five (35) hours weekly of personal care services are warranted. Specifically, regarding ADLs, Petitioner needs total assistance (cannot do at all) with [REDACTED] and [REDACTED]; needs assistance (but not total help) with [REDACTED], [REDACTED], [REDACTED], and [REDACTED]; and needs supervision or prompting with [REDACTED], [REDACTED], and [REDACTED]. See supra ¶ 5. According to the 710B Assessment, Petitioner always has assistance with all of [REDACTED] ADLs. See supra ¶ 5.

36. Petitioner has multiple medical conditions, including [REDACTED]
[REDACTED]
[REDACTED]. See supra ¶ 4. Petitioner is [REDACTED]. See supra ¶ 4.

37. 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 ¶ 22. Here, Petitioner is currently authorized to receive fourteen (14) hours of personal care services and ten (10) hours of homemaker services. See supra ¶ 11.

38. Here, Petitioner bears the burden of proof regarding the denial of eleven (11) hours per week of personal care services. *See supra* ¶ 21. 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 eleven (11) additional hours of personal care services per week. The definition of personal care services most closely aligns with ADL tasks. Petitioner's 701B Assessment, which Petitioner completed on [redacted] own with the case manager, indicates that Petitioner always has assistance with all of [redacted] ADLs. *See supra* ¶ 6. Petitioner did not explain which ADLs or IADLs would no longer be covered if the requested hours personal care services were not approved in this matter.

39. 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] family, Petitioner failed to prove by a preponderance of the evidence that eleven (11) additional hours of personal care services are not "in excess of [Petitioner's] needs." *See supra* ¶ 22.

40. In light of both parties' testimony, Petitioner's Composite Exhibit 1, 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 eleven (11) additional hours 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.

IT IS THEREFORE ORDERED AND ADJUDGED THAT:

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

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

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



Kameisha Presley
23-FH2313 & 23-
FH2314
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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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