



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

FILED

Dec 14, 2023, 11:11 am
OFFICE OF FAIR HEARINGS

████████████████████,

PETITIONER,

vs.

AHCA Case No.: 23-FH2345

Plan ID No.: ██████████

MOLINA HEALTH CARE OF FLORIDA, INC.,

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the Office of Fair Hearings (“OFH”) convened a telephonic Medicaid Fair Hearing in the above styled case on November 20, 2023, at 10:01 a.m. Eastern Standard Time (“EST”).

APPEARANCES

For the Petitioner: ██████████.
Petitioner’s Authorized Representative

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

STATEMENT OF ISSUE

The issue is whether the Petitioner proved by a preponderance of the evidence that the denial of an additional ten (10) hours of personal care services per week for the Petitioner was incorrect.

PRELIMINARY STATEMENT

All parties and witnesses appeared telephonically. ██████████ (“██████████”) the Petitioner’s designated Authorized Representative appeared on behalf of the Petitioner.

Melissa Hedrick, Esq., (“Ms. Hedrick”) appeared as a representative for Molina Health Care of Florida, Inc., (“Molina”). Katia Matos, Utilization Management Director (“Ms. Matos”) for Molina and Dr. Kathryn Madiwale, (“Dr. Madiwale”) Medical Director for Molina, both appeared and testified for the Respondent. Caridad Bello, Government Contracts Specialist and Mariana Nunez, Grievance and Appeals Lead, also appeared at the Fair Hearing on behalf of Molina but did not testify.

Linda Latson, Registered Nurse Specialist for the Agency for Health Care Administration (“Agency” or “AHCA”), appeared at the Fair Hearing for observational purposes.

Prior to the Hearing, the Petitioner sent to the Office of Fair Hearings and the Respondent a seven (7)-page proposed exhibit that was admitted into evidence without objection, is identified as “Petitioner’s Composite Exhibit 1” and is recorded in the Office of Fair Hearings document management system as “23-FH2345, 23-FH2349 Supporting Documents.pdf”.

Prior to the hearing, Respondent sent to the Office of Fair Hearings and Petitioner a one hundred and fifteen (115)-page proposed evidence packet that was admitted into evidence without objection, is identified herein as “Respondent’s Composite Exhibit 1” and is recorded in the Office of Fair Hearings document management system and designated as follows: “MFH [Petitioner]_1.pdf” and MFH [Petitioner]_2.pdf”.

FINDINGS OF FACT

1. The Petitioner is an enrolled member of Molina’s LTC plan. See Respondent’s Composite Exhibit 1, page 2. Molina is a managed care organization contracted by AHCA to provide services to eligible Medicaid recipients in Florida.

2. The Petitioner is an [REDACTED] who lives [REDACTED] with [REDACTED].
See Respondent's Composite Exhibit 1, page 17 and *Testimony of Authorized Representative*.

3. The Petitioner has the following health conditions: [REDACTED]
[REDACTED]
[REDACTED]. See Respondent's Composite Exhibit 1, pages 23-24. The
Petitioner has not been [REDACTED]
[REDACTED]. See Respondent's Composite Exhibit 1, pages 20.

4. The most recent Florida Department of Elder Affairs 701B Comprehensive Assessment ("701B"), admitted into evidence is dated June 6, 2023, reflects the following regarding Petitioner's Activities of Daily Living ("ADLs"). The Petitioner needs total assistance (cannot do at all) with [REDACTED], [REDACTED], [REDACTED], [REDACTED], [REDACTED], and requires some assistance (but not total help) with [REDACTED]. See Respondent's Composite Exhibit 1, page 21. The 701B further reflects the Petitioner always has assistance in performing [REDACTED] ADLs.

5. Regarding the Petitioner's Instrumental Activities of Daily Living ("IADLs"), the 701B reflects the Petitioner needs total assistance (cannot do at all) with all the instrumental activities of daily living, including [REDACTED], [REDACTED], [REDACTED], [REDACTED], [REDACTED], [REDACTED], [REDACTED], and [REDACTED]. See Respondent's Composite Exhibit 1, page 22. The 701B reflects Petitioner always has assistance in performing [REDACTED] IADLs. *Id.*

6. Petitioner is currently authorized to receive the following home and community-based services: thirty (30) hours per week of personal care services per week, seventeen (17) hours per

week of homemaker services, and seven (7) home delivered meals per week. See Respondent's Composite Exhibit 1, page 40.

7. On June 11, 2023, the Petitioner requested an additional ten (10) hours of personal care services per week. See Respondent's Composite Exhibit 1, pages 11 and 12. On June 15, 2023, the Respondent issued a Notice of Adverse Benefit Determination ("NABD") denying the Petitioner's request for an additional ten (10) hours of personal care services per week. See Respondent's Composite Exhibit 1, pages 11-17. In their NABD the Respondent stated the reason for their determination as follows:

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

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

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

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

1. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs;
2. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available statewide; and
3. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider; and one of the following:
 1. Enable the enrollee to maintain or regain functional capacity; or
 2. Enable an enrollee receiving long-term services and supports to have access to the benefits of community living, to achieve person-centered goals, and live and work in the setting of their choice.

The requested service is not a covered benefit.

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

The reason why the request was not approved is: The asked for additional Personal care 10 hours 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 47 hours of assistance based on the calculation tool we utilize to determine your needs. You will continue receiving 47 hours of home health assistance. This determination by the Medical Director has been made based on medical necessity (as defined by Florida law) and reflects the application of Molina Healthcare's approved review criteria and guidelines.

Id.

8. On June 23, 2023, the Petitioner requested an appeal of the decision to deny the requested ten (10) additional hours of personal care services per week. See Respondent's Composite Exhibit 1, page 104. In their Notice of Plan Appeal Resolution ("NPAR"), the Respondent provided the basis for denying the Petitioner's requested ten (10) additional hours of personal care services per week and stated as follows:

We made our decision based on the Florida Agency for Health Care Administration's Long-Term Care (LTC) Program Policy (Rule 59G-4.192) and the Molina Clinical Policy for Medically Necessary Services (332). It shows rules that you have to meet to show medical necessity (need). Part of the rules is having an evaluation (test) to find out what you need. These tests are done the first time a member needs a test. They are also done annually (every year), and when there is a significant (big) change in the member's care. A significant (big) change may involve a change in the member's state of health or the person taking care of them. Your recent test does not show a significant (big) change in your care. Your doctor has not told us of a significant (big) change in your care to show that you need a change to your plan of care. You are already receiving services that should meet your needs. For this reason, the request for the extra 10 hours a week of Personal Care Services is not approved. Please talk to your doctor and/or Case Manager about your options.

While we are denying the extra 10 hours a week of Personal Care Services, you are already receiving services that should meet your needs. You will still receive 30 hours a week of Personal Care Services and 17 hours a week of Homemaker Services.

Id.

9. On September 15, 2023, the Petitioner requested a Fair Hearing due to the denial of the requested ten (10) hours of personal care services per week. On October 30, 2023, this Hearing Officer issued a Scheduling Order, scheduling a Fair Hearing for November 20, 2023, at 10:00 a.m. EST.

10. The Molina Clinical Policy for Medically Necessary Services (332) (June 8, 2022) defines medically necessary or medical necessity for a requested service or technology, was cited by Respondent in both the NABD and the NPAR and states as follows:

Molina Healthcare defines the terms “Medically Necessary or Medical Necessity” as health care services provided to a patient for the purpose of evaluating, diagnosing, or treating an illness, injury, disease, or its symptoms and that are:

1. In accordance with generally accepted standards of medical practice; **AND**
2. Appropriate for the symptoms, diagnosis, or treatment of the Member’s condition, disease, illness or injury; **AND**
3. Not primarily for the convenience of the Member or health care provider; **AND**
4. Not more costly than an alternative service, or site of services, at least as likely to produce equivalent results.

See Respondent’s Composite Exhibit 1, pages 100 and 101.

11. The Petitioner submitted two letters from Alejandro Roca, MD, the Petitioner’s physician recommending additional home healthcare hours for the Petitioner. The April 13, 2023, letter from Dr. Roca stated that “[T]his request is medically necessary as [redacted] condition is deteriorating and requires more hours of help at home.” See Petitioner’s Composite Exhibit 1, page 6, and

Respondent's Composite Exhibit 1, page 8. The July 10, 2023, letter from Dr. Roca stated as follows:

I really don't know what else to write to get the point across that [the Petitioner] needs maximum allotted hours of care for [redacted] condition. [redacted] cannot be [redacted] It is medically necessary.

See Petitioner's Composite Exhibit 1, page 7.

12. During the Fair Hearing, the Petitioner's Authorized Representative testified that [redacted] [redacted] has progressed and is now advanced, and that the current thirty (30) hours of personal care services is not sufficient. The Authorized Representative testified that [redacted] lives over an hour away in Key Largo, that [redacted] spends between six (6) to seven (7) nights per week with [redacted] parents, and that [redacted] spends [redacted] own money out-of-pocket to supplement the forty-seven (47) hours of home health services when [redacted] is out-of-town or has to work late. Finally, the Authorized Representative testified that it is not unreasonable for [redacted] [redacted] to receive additional hours of personal care services in light of [redacted] advance [redacted] and declining health.

13. Ms. Matos testified for the Respondent and acknowledged that Petitioner is [redacted] and requires total assistance with performing [redacted] ADLs and IADLs. Ms. Matos testified that the Respondent's "Task Review" supports twenty-two (22) hours of personal care services per week, and Molina has approved thirty (30) hours per week, and that the Petitioner has sufficient personal care service hours per week. *See also* Respondent's Composite Exhibit 1, pages 49-63.

14. Dr. Madiwale testified for the Respondent that the Petitioner's current home health hours are individualized, specific, and consistent with the Petitioner's symptoms and confirmed diagnosis, and are not in excess of the patient's needs.

CONCLUSIONS OF LAW

15. The Agency's Office of Fair Hearings has jurisdiction over the subject matter of this proceeding and the parties pursuant to Fla. Stat. § 409.285(2). This order is the final administrative decision of AHCA under Fla. Stat. § 409.285(2)(a).

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

17. The burden of proof in this proceeding is governed by Fla. Admin. Code R. 59G-1.100(17)(g), which provides as follows:

The burden of proof is on the party asserting the affirmative of an issue, except as otherwise required by statute. The burden of proof is on the Agency or plan, whichever is applicable, when the issue presented is the suspension, reduction, or termination of a previously authorized service. The burden of proof is on the recipient or enrollee when the issue presented is the denial or a limited authorization of a service. The party with the burden of proof shall establish its position to the satisfaction of the Hearing Officer by a preponderance of the evidence.

18. Because the Respondent has denied the newly requested personal care services, Fla. Admin. Code R. 59G-1.100(17)(g) assigns the burden of proof to the Petitioner to demonstrate the Respondent's decision to deny the requested ten (10) additional hours of personal care services per week was 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.).

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

1.1 Description and Program Goal

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

...

1.3 Definitions

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

1.3.1 Activities of Daily Living (ADLs)

ADLs include:

- 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:

...

4.2.2 Mixed Services

Mixed services may exceed State Plan limits on those services in accordance with this policy. The Long-term Care benefit includes coverage of the following mixed services:

...

4.2.2.6 Personal Care

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

...

6.0 Documentation

...

6.2 Specific Criteria

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

SMMC LTC Policy, pages 1-8.

20. The Florida Medicaid Definitions Policy (August 2017) (“Definitions Policy”), which is incorporated by reference in Fla. Admin. Code R. 59G-1.010, defines “medical necessity” as follows:

2.83 Medically Necessary or Medical Necessity

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

- Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain
- Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient’s needs

- Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational
- Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available statewide
- Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider

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

21. The Agency's Florida Medicaid Personal Care Services Coverage Policy, November 2016 ("PC Policy") has been incorporated, by reference, into Fla. Admin. Code R. 59G-4.215. The PC Policy provides as follows:

1.1 Description

Florida Medicaid personal care services provide medically necessary assistance, in the home or in the community, with activities of daily living (ADL) and age appropriate instrumental activities of daily living (IADL) to enable recipients to accomplish tasks they would normally be able to do for themselves if they did not have a medical condition or disability.

...

1.1.2 Statewide Medicaid Managed Care Plans

Florida Medicaid managed care plans must comply with the coverage requirements outlined in this policy, unless otherwise specified in the AHCA contract with the Florida Medicaid managed care plan. The provision of services to recipients enrolled in a Florida Medicaid managed care plan must not be subject to more stringent coverage limits than specified in Florida Medicaid policies.

...

4.0 Coverage Information

4.1 General Criteria

Florida Medicaid reimburses for services that meet all of the following:

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

4.2 Specific Criteria

Florida Medicaid reimburses for up to 24 hours of personal care services per day, per recipient, in order to provide assistance with ADLs and age appropriate IADLs when the recipient meets the following criteria:

- Has a medical condition or disability that substantially limits their ability to perform ADLs or IADLs and do not have a parent or legal guardian able to provide the required care
- Is under the care of a physician and has a physician's order for personal care services
- Requires more extensive and continual care than can be provided through a home health visit
- Requires services that can be safely provided in their home or the community

...

5.1 General Non-Covered Criteria

Services related to this policy are not reimbursed when any of the following apply:

- The service does not meet the medical necessity criteria listed in section 1.0.
- The recipient does not meet the eligibility requirements listed in section 2.0.
- The service unnecessarily duplicates another provider's service.

5.2 Specific Non-Covered Criteria

Florida Medicaid does not reimburse for the following:

- A skill level other than what is prescribed in the physician order and approved plan of care (POC)
- Assistance with homework
- Babysitting
- Care, grooming, or feeding of pets and animals
- Certification of the POC by a physician
- Companion sitting or leisure activities
- Escort services
- Housekeeping (except light housekeeping to make the environment safe), homemaker, and chore services
- Nursing assessments related to the POC
- Professional development training or supervision of home health staff or other home health personnel
- Respite care to facilitate the parent or legal guardian attending to personal matters
- Services funded under section 110 of the Rehabilitation Act of 1973 or under the provisions of the Individuals with Disabilities Educational Act
- Services furnished by relatives as defined in section 429.02(18), F.S., household members, or any person with custodial or legal responsibility for the recipient. (Except when a recipient is enrolled in the Consumer-Directed Care Plus program)
- Services provided in any of the following locations:

- Hospitals
- Intermediate care facility for individuals with intellectual disabilities – Nursing facilities
- Prescribed pediatric extended care centers
- Residential facilities or assisted living facilities when the services duplicate those provided by the facility
- Services rendered prior to the development and approval of the POC
- Travel time to or from the recipient’s place of residence
- Yard work, gardening, or home maintenance work

Florida Medicaid may reimburse for some services listed in this section through a different service benefit.

...

7.0 Authorization

7.1 General Criteria

The authorization information described below is applicable to the fee-for-service delivery system. For more information on general authorization requirements, please refer to Florida Medicaid’s General Policies on authorization requirements.

...

Personal Care Task	General Time Allowances
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 intake/output.	15–30 minutes day for all monitoring tasks performed

PC Policy, pages 3 – 8, and 10.

22. In the instant case, Respondent denied the Petitioner’s request for an additional ten (10) hours of personal care services hours per week stating the requested services were not medically necessary and were in excess of the Petitioner’s needs. *See supra* ¶ 7, 8, 13 and 14.

23. Section 4.1 of the SMMC LTC Policy provides that Florida Medicaid LTC plans cover services that: (a) are determined medically necessary, as defined in the SMMC LTC Policy; (b) do not duplicate another service; and (c) meet the criteria as specified in the SMMC LTC Policy. See supra ¶ 19.

24. The evidence presented in this case does not reflect that the Respondent's decision to deny the Petitioner's requested additional ten (10) hours per week was incorrect. Specifically, the Petitioner did not identify any unmet needs of the Petitioner in the performance of the ADLs and IADLs and the 701B in this matter reflects the Petitioner always has assistance in performing the ADLs and IADLs. See supra ¶ ¶ 4 and 5. While the Authorized Representative testified that ■ is paying for additional home health services out-of-pocket, both the LTC Policy and the Medicaid Definitions policy specifically states that medically necessary does not include services that are primarily intended for the convenience of the recipient's caretaker. See supra ¶ ¶ 19 and 20.

25. Section 1.3.14 of the SMMC LTC Policy mandates that the requested services must "[b]e individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs", and not for the convenience of the recipient. See supra ¶ 19. Here, the Petitioner is currently authorized to receive thirty (30) hours of personal care services per week. See supra ¶ 6. Petitioner's currently authorized personal care services are "[t]o provide assistance with ADLs which are incidental to the care furnished or are essential to the health and welfare of the enrollee." See supra ¶ 21. The Authorized Representative has not established any unmet needs of the Petitioner in performing ADLs or IADLs, and that the Petitioner's requires a greater level of assistance in performing ■

ADLs than that reflected in the 701B Assessment. *See supra* ¶¶ 4, 12. Given the fact that the Petitioner's health has not significantly declined since the 701B Assessment admitted into evidence, the Petitioner has not established by a preponderance of the evidence that an additional ten (10) hours of personal care services per week are medically necessary to meet the Petitioner's needs, that the current approved thirty (30) hours of personal care service hours per week is not individualized, specific, or inconsistent with symptoms or confirmed diagnosis of the illness or injury under treatment, are not in excess of the patient's needs, and are not intended for the convenience of the recipient's caregiver. *See supra* ¶¶ 19, 20 and 21.

26. Considering the totality of Petitioner's circumstances, including [REDACTED] medical condition and diagnoses, level of need for ADLs and IADLs, and the amount of currently approved services, the Petitioner failed to prove by a preponderance of the evidence that the additional ten (10) hours of personal care services was incorrect." *See supra* ¶¶ 19, 20 and 21.

27. In light of the testimony and evidence in this matter, the SMMC LTC Policy, the PC Policy, and the Definitions Policy, the undersigned Hearing Officer finds that the Petitioner failed to meet the burden of proving that a denial of ten (10) additional hours of personal care services per week were medically necessary, not in excess of the Petitioner's needs, and not for the convenience of the Petitioner's primary caregiver. Accordingly, the undersigned Hearing Officer concludes that Petitioner failed to prove by a preponderance of the evidence that the denial of an additional ten (10) hours of personal care services per week was incorrect.

DECISION

Respondent’s denial of an additional ten (10) hours per week of personal care services is hereby **AFFIRMED**. Petitioner’s appeal based on Respondent’s denial of an additional ten (10) hours per week of personal care services per week is **DENIED**.

DONE AND ORDERED this 14th day of December, 2023, in Tallahassee, Leon County, Florida.

Alan J. Leifer
Alan J. Leifer
23-FH2345
2023.12.14
07:58:52 -05'00'

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:

[Redacted]

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