

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



FILED

May 22, 2024, 11:24 am

OFFICE OF FAIR HEARINGS

[REDACTED]

PETITIONER,

vs.

AHCA Case No.: 24-FH0256

Plan ID No.: [REDACTED]

CHILDREN'S MEDICAL SERVICES,

RESPONDENT.

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic Fair Hearing on the instant case on March 13, 2024, at 2:04 p.m. Eastern Standard Time ("EST").

APPEARANCES

For the Petitioner:

[REDACTED]

Petitioner's Authorized Representative

For the Respondent:

Kimberly Bouchette,
Clinical Appeals Coordinator
Childrens Medical Services Health Plan

STATEMENT OF ISSUE

The issue is whether the Respondent proved by a preponderance of the evidence that Respondent's decision to deny sixty (60) hours per week of home health aide services for five (5) months was correct.

PRELIMINARY STATEMENT

All parties appeared telephonically. Petitioner's Authorized Representative and [REDACTED],

[REDACTED] (" [REDACTED] "), appeared on behalf of the Petitioner.

Kimberly Bouchette, Clinical Appeals Coordinator (“Ms. Bouchette”) appeared on behalf of the Respondent Childrens Medical Services Health Plan (“Respondent” or “CMS”). Andrew Metinko, M.D. (“Dr. Metinko”), a Medical Director for the Respondent also testified on behalf of the Respondent. Joanne White, CMS Client Management Services and Anna Velarco, CMS Case Manager both appeared at the Fair Hearing for observational purposes. Daryl Hunter, CMS Supervisor and Theresa Sawyer, Esquire, with Florida Department of Health also appeared at the Fair Hearing for observation purposes. Finally, Linda Latson, Registered Nurse Specialist with the Agency for Healthcare Administration appeared at the Fair Hearing for observational purposes.

Prior to the hearing, the Petitioner sent the Office of Fair Hearing and the Respondent an eleven (11) page proposed composite exhibit and a seven (7) page proposed composite exhibit that were admitted into evidence without objection. The eleven (11) page composite is identified as the “Petitioner’s Composite Exhibit 1” and is maintained in the Office of Fair Hearings document management system as “MFH Request [Petitioner].pdf”. The Petitioner’s seven (7) page exhibit is identified as “Petitioner’s Composite Exhibit 2” and is maintained in the Office of Fair Hearing document management system as “24-FH0256 DAR and Supporting Documents.pdf”.

Prior to the hearing, Respondent sent to the Office of Fair Hearings and Petitioner a seventy-four (74)-page proposed evidence packet that was admitted into evidence without objection, is identified herein as “Respondent’s Composite Exhibit 1” and appears in the Office of Fair Hearings document management system as file title “MFH Packet [Petitioner].pdf”.

FINDINGS OF FACT

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

2. The Petitioner is a [REDACTED]. *Id.* at 11. Petitioner is diagnosed with [REDACTED]

[REDACTED] See Respondent's Composite Exhibit 1, page 12. The Petitioner has difficulties completing all of [REDACTED] Activities of Daily Living ("ADLs"), and is currently receiving applied behavioral analysis services, occupational therapy services, physical therapy services, and physical therapy services. See Respondent's Composite Exhibit 1, page 12. Petitioner needs assistance with the following ADLs: [REDACTED]

[REDACTED]. *Id.* at 15.

3. [REDACTED] works full-time outside the home on Mondays through Fridays between 7:00 a.m. and 8:00 p.m. and between 7:00 a.m. and 5:00 p.m. on Saturdays. See Respondent's Composite Exhibit 1, page 18. [REDACTED] testified [REDACTED] is the primary wage earner in [REDACTED] household, [REDACTED]. See also Respondent's Composite Exhibit 1, page 18.

4. On December 12, 2023, the Petitioner requested a continuation of home healthcare benefits for sixty (60) hours per week for six (6) months. See Respondent's Composite Exhibit 1, page 4. The Petitioner's [REDACTED] testified [REDACTED] has been receiving sixty (60) hours per week of home health care for [REDACTED] [REDACTED] since [REDACTED] from the provider Wellcare before Wellcare was acquired by the Respondent. In a Notice of Adverse Benefit Determination ("NABD"), dated December 19, 2023, the Respondent approved sixty (60) hours per week of home healthcare for one (1) month and denied the additional five (5) months of home healthcare services. See Respondent's Composite Exhibit 1, pages 4-9. The NABD explained the basis of the denial as follows:

- We determined that the requested services are not medically necessary because the services do not meet the reason(s) checked below: (See Rule 59G-1.010).

- Must be needed to protect your child’s life, prevent significant illness or disability to your child, or to alleviate your child’s severe pain.
- Must be individualized, specific, consistent with symptoms or diagnosis of illness or injury and not be in excess of your child’s needs.
- Must meet accepted medical standards and not be experimental or investigational.
- Must be able to be 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.
- Must be furnished in a manner not primarily intended for convenience of the recipient, caretaker, or provider.
(The convenience factor is not applied to the determination of the medically necessary level of private duty nursing (PDN) for children under the age of 21.)
- The requested service is not a covered benefit.
- Other authority:

The facts that we used to make our decision are:

Sunshine Health Policy on Review for Personal Care Services Requests, FL.UM.25.00. Florida Medicaid Personal Care Services Coverage Policy, Agency for Health Care Administration, November 2016. These services have also been reviewed under EPSDT (Early and Periodic Screening, Diagnostic and Treatment).

Rationale: The request to approve a home health aide for your child is partially approved. This is a trained health care worker who helps people with daily care needs. Approval is granted for one month. After this approved period, ongoing home health aide is denied. It is denied for lack of medical need. This authorization was sent to the medical director (doctor) for review. Please note that previous authorizations for home health aide services were approved without medical need review. It is unknown if your child attends school or homebound. Updated parent/guardian work/school form and/or medical limitations form is needed.

...

Id.

5. The Petitioner requested a plan appeal on December 28, 2023, and received a Notice of Plan Appeal Resolution (“NPAR”), dated January 18, 2024, that affirmed the previous denial. *See* Respondent’s Composite Exhibit 1, pages 23-25. The NPAR explained as follows:

The facts that we used to make our decision are: The previous denial to authorize

a home health aide for your child is upheld. Your child appears to need adult supervision/childcare/babysitting services. Adult supervision does not require a home health aide. All young children need adult supervision and assistance with activities of daily living. The reasons for this decision are based on a set of standards. This included Criteria: SUNSHINE POLICY AND PROCEDURE Review for Personal Care Services Requests FL.UM.25; Personal Care Services Coverage Policy, Agency for Health Care Administration, November 2016. This decision was made with regards to EPSDT.

...

Id.

6. On January 22, 2024, the Petitioner requested a Fair Hearing to challenge the denial of a home health aide for sixty (60) hours per week over five (5) months. On February 9, 2024, the undersigned issued an Order Scheduling Fair Hearing by Telephone and Prehearing Instructions, setting the hearing for March 13, 2024, at 2:00 p.m. EST.

7. The Sunshine Policy *Id.* FL.UM.25.00, entitled Review for Personal Care Service Requests, June 2015 is applicable for members under the age of 21 and states in-part as follows:

POLICY STATEMENT:

Personal care services are covered for members who are under the age of 21. To be considered for approval, the member's treating physician must order the service.

PURPOSE:

To establish clinical criteria on which to review requests for Personal Care Services to provide medically necessary assistance with activities of daily living (ADL) and age-appropriate instrumental activities of daily living (IADL) that enable a member to accomplish tasks that they would normally be able to do for themselves if they did not have a medical condition or disability. This service will assist in maintaining the member in their home and community environment, in a safe manner.

DEFINITIONS:

Personal Care Services are services that assist a member with ADLs or IADLs. These services can be provided to members up to the age of 21. Personal care service assistance can be in the form of hands-on assistance (actually performing the task for the member) or cuing along, with supervision, to ensure the member performs the personal care task properly. The personal care services must be prescribed by a treating physician, provided by a home health aide or independent personal care provider, and supervised by a registered nurse if provided through a home health

agency, or supervised by the parent or legal guardian if provided by a non-home health agency, or supervised by the member, if the services are provided by a non-home health agency and the member is a legal adult between the ages of 18 up to 21 with no legal guardian.

...

Limitations and Exclusions

Personal care services can be authorized to supplement care provided by parents and legal guardians. Parents and legal guardians must participate in providing care to the fullest extent possible....

See Respondent's Composite Exhibit 1, pages 46 and 47.

8. The Petitioner's Authorized Representative and [REDACTED] testified at the Fair Hearing and stated that [REDACTED] has the ability to care for [REDACTED] but needs to work as [REDACTED] is the principal wage earner for the household. [REDACTED] further testified that [REDACTED] has had sixty (60) hours per week of home healthcare since [REDACTED] and has [REDACTED]

[REDACTED]
[REDACTED]

[REDACTED] See Respondent's Composite Exhibit 2, pages 4-7.

9. Dr. Metinko testified for the Respondent and stated the records in this matter on their face do not support the medical necessity of a home health aide or specialized care. Dr. Metinko further testified he thought [REDACTED]

[REDACTED]

10. [REDACTED] is the Petitioner's treating physician and has provided a prescription for a home health aide for the Petitioner to assist in the performance of [REDACTED] ADLs for sixty (60) hours per week for six (6) months. See Respondent's Composite Exhibit 1, page 12. [REDACTED]

states a home health aide for the Petitioner is medically necessary, that the Petitioner has difficulties in performing all [REDACTED] ADLs, and that the Petitioner has maladaptive behaviors, including

See

Respondent's Composite Exhibit 1, pages 12 and 17.

CONCLUSIONS OF LAW

11. 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) of the Florida Statutes (2019). This order is the final administrative decision of AHCA under Fla. Stat. § 409.285(2)(a).

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

13. 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.

14. Because Respondent approved one (1) month of services and denied five (5) subsequent months of services, Fla. Admin. Code R. 59G- 1.100(17)(g) assigns the burden of proof to Respondent. 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.)

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

Personal Care services available under Florida Medicaid. The Policy provides the following with respect to personal care services:

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.

...

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

...

4.2.1 Parental Responsibility

Florida Medicaid reimburses for personal care services rendered to a recipient whose parent or legal guardian is not able to provide ADL or IADL care, and to supplement care provided by parents and legal guardians. Parents and legal guardians must participate in providing care to the fullest extent possible. Providers must offer training to enable parents and legal guardians to provide care they can safely render without jeopardizing the health or safety of the recipient when needed.

...

4.2.2 Services Provided by Independent Personal Care Providers

Personal care services provided by independent personal care providers must be:

- Supervised by the parent or legal guardian if provided by a non-home health agency when the recipient is under the age of 18 years.

- Supervised by the recipient, or their authorized representative, if the services are provided by a non-home health agency when the recipient is between the age of 18 and 21 years with no legal guardian.

...

4.3 Early and Period Screening, Diagnosis, and Treatment

As required by federal law, Florida Medicaid provides services to eligible recipients under the age of 21 years, if such services are medically necessary to correct or ameliorate a defect, a condition, or a physical or mental illness. Included are diagnostic services, treatment, equipment, supplies, and other measures described in section 1095(a) of the SSA, codified in Title 42 of the United States Code 1396d(a). As such, services for recipients under the age of 21 years exceeding the coverage described within this policy or the associated fee schedule may be approved, if medically necessary.

The Policy further addresses excluded services as follows:

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 recipients place of residence
- Yard work, gardening, or home maintenance work.

See Respondent's Composite Exhibit 1, pages 62-65

16. States must provide Early and Periodic Screening, Diagnostic, and Treatment ("EPSDT") services to Medicaid-eligible children under age 21 when requested under the Medicaid state plan.

See 42 U.S.C. § 1396a(a)(43); 42 U.S.C. § 1396d(a)(4). According to 42 U.S.C. § 1396d(r)(5), EPSDT services mean, in relevant part, the following items and services:

Such other necessary health care, diagnostic services, treatment, and other measures described in subsection (a) of this section to correct or ameliorate defects and physical and mental illness and conditions discovered by the screen services, whether or not such services are covered under the state plan.

17. Petitioner is under age 21, and therefore EPSDT applies to [REDACTED] request for services.

However, a state may place medical necessity limitations on EPSDT services. See 42 C.F.R. §§ 440.230(a), (b), (d). Fla. Stat. § 409.905(2) limits EPSDT services with a medical necessity standard:

The [Agency] shall pay for early and periodic screening and diagnosis of a recipient under age 21 to ascertain physical and mental problems and conditions and all services determined by the agency to be medically necessary for the treatment, correction, or amelioration of these problems and conditions, including personal care, private duty nursing, durable medical equipment, physical therapy, occupational therapy, speech therapy, respiratory therapy, and immunizations.

18. The Florida Medicaid Definitions Policy (August 2017) ("Definitions Policy"), incorporated

by reference in Fla. Admin. Code R. 59G-1.010, provides the applicable definitions for Florida Statewide Medicaid Managed Care policy. The Definitions Policy provides the following definitions applicable to the instant case:

2.2 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

2.64 Instrumental Activities of Daily Living (IADLs)

When necessary for the recipient to function independently, including:

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

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 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.

See Definition Policy, pages 1-7.

19. In the NABD, dated December 7, 2023, Respondent approved sixty (60) hours of home health aides per week for one month and denied sixty (60) hours per week for five (5) months.

See ¶ 4. The Respondent explained in the NABD that medical need for sixty (60) hours per week for six (6) months was not reflected in the file, and that further records were required. *Id.*

20. The January 18, 2024, NPAR upheld the denial of sixty (60) hours of home health aide services for five (5) months. See ¶ 5. In the NPAR Respondent stated that “[A]ll young children need adult supervision and assistance with the activities of daily living.” *Id.*

21. As Respondent bears the burden of proof, Respondent must show that the previously authorized services are not medically necessary for Petitioner. As provided in the Policy, personal care services are to “provide medically necessary assistance . . . with activities of daily living (ADL) and age appropriate instrumental activities of daily living (IADL).” See ¶ 14. As shown by the record, the Petitioner is diagnosed with autistic disorder, attention deficit hyperactivity disorder and a development disorder for speech and language, has difficulties completing ■ ADLs, and is currently receiving applied behavioral analysis services, occupational therapy services, physical therapy services, and physical therapy services. See ¶ 2. In addition, the Petitioner has maladaptive behaviors, including ■
■

See ¶ 10. Further, the record shows that Petitioner's works full-time outside the home on Mondays through Fridays between 7:00 a.m. and 8:00 p.m. and between 7:00 a.m. and 5:00 p.m. on Saturdays. See ¶ 3.

. See ¶¶ 3 and

8. Dr. Metinko did not provide credible and persuasive testimony that the services of a home health aide for the Petitioner are not medically necessary. See ¶ 9. Moreover, there is compelling evidence in the record that demonstrates the Petitioner does in-fact requires any assistance to perform the activities of daily living and that the five (5) months of home health aide services are required to satisfy an unmet need by the Petitioner.

22. There is no evidence in this matter that the request home health aide services are merely for the convenience of the Recipient's caregiver parent, are in excess of Petitioner's needs, are not medically necessary.

23. the Petitioner's physicians provided a prescription for the precise services and exact number of hours that were requested by the Petitioner and specifically concluded the services were in-fact "medically necessary". See ¶ 10. While 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, the Respondent has not provided credible evidence or testimony otherwise.

24. Upon consideration of the testimony provided, evidence submitted, and applicable polices, the undersigned concludes that Respondent has not proved by a preponderance of the

evidence that the decision for the cessation of home health aide services that had historically been reflected as the services requested in this matter was not correct. Looking at all the evidence relevant to the particular needs of Petitioner, Respondent demonstrated that an additional sixty (60) hours per week of home health aide services for the denied five (5) months is necessary to correct or ameliorate a defect or a physical and mental illness or condition. Accordingly, Respondent has not proved by a preponderance of the evidence that the cessation of home health aide services week was correct.

IT IS HEREBY ORDERED AND ADJUDGED THAT:

Respondent's reduction of sixty (60) hours per week for five (5) months is **REVERSED**.
Petitioner's appeal based on Respondent's denial is **GRANTED**.

DONE and ORDERED this 22nd day of May, 2024, in Tallahassee, Leon County, Florida.



Alan J. Leifer
24-FH0256
2024.05.22 09:10:30 -04'00'

**ALAN LEIFER, Hearing Officer Agency
for Health Care Administration Office
of Fair Hearings
2727 Mahan Drive, Mail Stop # 11
Tallahassee, FL 32308**

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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