



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

**FILED**

Jun 11, 2024, 11:49 am

OFFICE OF FAIR HEARINGS

[REDACTED]

PETITIONER,

vs.

AHCA Case No.: 24-FH0601

Plan ID No.: [REDACTED]

CHILDREN'S MEDICAL SERVICES,

RESPONDENT.

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**FINAL ORDER**

Pursuant to notice, the undersigned convened a telephonic Fair Hearing on the instant case on April 10, 2024, at 10:00 a.m. Eastern Standard Time ("EST").

**APPEARANCES**

For the Petitioner:

[REDACTED]

Petitioner's Authorized Representative

For the Respondent:

Nichole Vega,  
Regulatory Research Coordinator  
Childrens Medical Services Health Plan

**STATEMENT OF ISSUE**

The issue is whether the Petitioner proved by a preponderance of the evidence that Respondent's decision to deny seventy (70) hours per week of home health aide services was incorrect.

**PRELIMINARY STATEMENT**

All parties appeared telephonically. Petitioner's Authorized Representative, [REDACTED], of [REDACTED], in [REDACTED], Florida ("[REDACTED]"), appeared on behalf of the Petitioner.

Nichole Vega, Regulatory Research Coordinator (“Ms. Vega”) appeared on behalf of the Respondent Childrens Medical Services Health Plan (“Respondent” or “CMS”). Maria Samerson, M.D. (“Dr. Samerson”), a Medical Director for the Respondent also testified on behalf of the Respondent. Anita Melton, CMS Ombudsman, Josephine Sanchez, Case Manager, and Julia Moya, Case Management Supervisor appeared on behalf of the Respondent but did not testify. Lori Huskisson, Esq., with the Florida Department of Health appeared at the Fair Hearing for observation purposes.

Prior to the hearing, the Petitioner sent the Office of Fair Hearing and the Respondent a sixteen (16) page proposed composite exhibit and a seven (7) page proposed composite exhibit that were admitted into evidence without objection. The Petitioner’s seven (7) page exhibit is identified as “Petitioner’s Composite Exhibit 1” and is maintained in the Office of Fair Hearing document management system as “2024 0221-0148-02 Urgent status and follow up.pdf”. The Petitioner’s sixteen (16) page composite exhibit is identified as the “Petitioner’s Composite Exhibit 2” and is maintained in the Office of Fair Hearings document management system as “24-FH0601 DAR and Supporting Documents.pdf”.

Prior to the hearing, Respondent sent to the Office of Fair Hearings and Petitioner a three hundred and forty-four (344)-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 since September 1, 2022. See Respondent’s Composite Exhibit 1, page 3. 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] that has been diagnosed with [REDACTED]



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: Request for home health aide services (S9122) has been reviewed and is partially approved. This is a trained worker who provides personal care in the home. For the hours requested, 10 hours a day, 7 days a week, but only for 30 days. More notes will be required to approve further home health aide services beyond 30 days. All prior approvals for home health aide services were approved by an executive director Not reviewed for medical need. This is the first review by a Medical Director since the services started. The notes sent with this request do not support the medical need for the home health aide service hours requested. It is unclear if your child attends school. If so, a school schedule must be provided. Please provide this. Note that it is a Medicaid requirement that parents, or legal guardians must give guidance and help with activities of daily living ( [REDACTED] ) as much as they can. [REDACTED]'s Work Schedule has not been signed by supervisor at place of employment. Also, the hours listed cannot be confirmed. Information is needed addressing whether there is a second care giver in the home. If so, the caregivers' work hours. Please address this. If the parent is unable to care for the child there needs to be a signed Parent Medical Limitation. Services noted to be a not be a covered benefit include custodial care (non-medical care), daycare, afterschool care, guidance, or similar childcare not related to the services that are medically needed for the child. Another review of this request can be done. When the above issues have been addressed.

...

*Id.*

5. The Petitioner requested a plan appeal on January 19, 2024, and received a Notice of Plan Appeal Resolution (“NPAR”), dated February 14, 2024, that affirmed the previous denial. *See*

Respondent's Composite Exhibit 1, pages 26-29. 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. Adult supervision does not require a home health aide. All young children need constant supervision and assistance with activities of daily living. The reasons for this decision are based on a set of standards. This included 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 February 21, 2024, the Petitioner requested a Fair Hearing to challenge the denial of a home health aide for seventy (70) hours per week over five (5) months. On March 5, 2024, the undersigned issued an Order Scheduling Fair Hearing by Telephone and Prehearing Instructions, setting the hearing for April 10, 2024, at 10:00 a.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 58-69.

8. The Petitioner's Authorized Representative testified that the Petitioner has been diagnosed with [REDACTED]

[REDACTED] testified the Petitioner has been [REDACTED] and receives both applied behavior analysis therapy, speech therapy, and occupational therapy services. In addition, [REDACTED] testified the Petitioner is in school Monday through Friday between 8:20 a.m. and 1:50 p.m., receives occupational therapy services on Thursday's between 3:00 and 5:00 p.m., and speech therapy services on Wednesday's between 2:00 p.m. and 3:00 p.m. Finally, [REDACTED] testified the home health aide hours are needed before and after school hours and also requires transportation services from the home health aide.

9. Dr. Samerson testified for the Respondent and stated that all [REDACTED] children require supervision, and the records in this matter reflect that the [REDACTED] and other family members live in the home that can assist with the Petitioner. Dr. Samerson stated that no special needs required by the Petitioner are demonstrated in this file and that it appears the Petitioner requires "babysitting" services which is not a Medicaid covered benefit. Finally, Dr. Samerson testified that the home health aide services for the Petitioner were denied as not being medically necessary.

10. [REDACTED], DO, a pediatric neurologist with [REDACTED] provided a [REDACTED], Letter stating that home health services are medically necessary for the Petitioner. See Petitioner's Composite Exhibit 1, page 3.

### **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 the Petitioner requested new services from the Respondent that were denied, namely the five (5) months of home health aide services, Fla. Admin. Code R. 59G- 1.100(17)(g) assigns the burden of proof to Petitioner to demonstrate that the decision to deny the services by the Respondent 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.)

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 January 10, 2024, the respondent approved thirty (30) days of home health aide services and denied five (5) months (150 days) of home health aide services. See ¶ 4. The Respondent explained in the NABD that medical necessity for seventy (70) hours per week for six (6) months was not reflected in the file. *Id.*

20. The February 14, 2024, NPAR upheld the denial of seventy (70) hours of home health aide services for five (5) months. See ¶ 5. In the NPAR Respondent stated that

“[Y]our child appears to need adult supervision.” Adult supervision does not require a home health aide. All young children need constant supervision and assistance with activities of daily living.”

*Id.*

21. As the Petitioner bears the burden of proof, the Petitioner must show that the requested services are medically necessary. As provided in the Personal Care 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 ¶ 15. As shown by the record, the Petitioner is diagnosed with [REDACTED]. See ¶ 2. Further, the record shows that Petitioner's [REDACTED] works full-time outside the home on Mondays through Saturdays between 7:00 a.m. and 7:00

p.m. and between 7:00 a.m. and 5:00 p.m. on Saturdays. See ¶ 3. The Petitioner's Authorized Representative did not provide credible and persuasive testimony that the services of a home health aide for the Petitioner are medically necessary. See ¶ 8. Moreover, there is no evidence in the record that demonstrates the Petitioner does in-fact requires 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. As for the requested transportation services mentioned by the Petitioner's Authorized Representative in [REDACTED] testimony, the approval of transportation services under Florida Medicaid is based on a case-by-case of medical necessity, was not part of the requested services in this matter, and there is no jurisdiction in this case to decide an issue that was not presented in the Petitioner's request for services. Lastly, even if medical necessity was demonstrated in this matter, which it is not, the requested ten (10) hours of home health aide services for ten (10) hours per day for seven (7) days per week are clearly excessive of the Petitioner's needs in that the Petitioner's [REDACTED] does not work seven (7) days per week.

22. [REDACTED], DO provided a [REDACTED], prescription for the home health services were medically necessary. See ¶ 10. However, 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, and the Petitioner has not provided credible evidence or testimony otherwise.

23. Upon consideration of the testimony provided, evidence submitted, and applicable polices, the undersigned concludes that Petitioner has not proved by a preponderance of the evidence that the decision for the denial of home health aide services in this matter was incorrect. Looking at all the evidence relevant to the particular needs of Petitioner, the Petitioner has not demonstrated that an additional seventy (70) hours per week per week of home health aide services for

the denied five (5) months are necessary to correct or ameliorate a defect or a physical and mental illness or condition. Accordingly, the Petitioner has not proved by a preponderance of the evidence that the denial of home health aide services week was incorrect.

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

Respondent's denial of seventy (70) hours per week for five (5) months is **AFFIRMED**.

Petitioner's appeal based on Respondent's denial is **DENIED**.

**DONE and ORDERED** this 11th day of June, 2024, in Tallahassee, Leon County, Florida.

Alan J. Leifer

24-FH0601

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**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:**



**Children's Medical Services**  
**[CMSPlanContract@flhealth.gov](mailto:CMSPlanContract@flhealth.gov)**

**AHCA Medicaid Hearing Unit**  
**[MedicaidHearingUnit@ahca.myflorida.com](mailto:MedicaidHearingUnit@ahca.myflorida.com)**