

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



FILED

Aug 28, 2020, 4:14 pm
OFFICE OF FAIR HEARINGS

[REDACTED]
PETITIONER,

AHCA Case No.: 20-FH [REDACTED]
Plan ID No.: [REDACTED]

vs.

HUMANA MEDICAL PLAN, INC.,
RESPONDENT.

FINAL ORDER

Pursuant to notice, the undersigned Hearing Officer convened a telephonic Fair Hearing in the above-styled case on July 30, 2020, at [REDACTED]

APPEARANCES

For the Petitioner: [REDACTED]
Authorized Representative

For the Respondent: Michael Moens
Grievance and Appeals Specialist
Humana Medical Plan, Inc.

STATEMENT OF ISSUE

The issue is whether Petitioner proved by a preponderance of the evidence that Respondent's denial of additional Personal Care services was incorrect.

PRELIMINARY STATEMENT

All parties and witnesses appeared for the Fair Hearing telephonically. [REDACTED] (" [REDACTED]" or "Petitioner's Authorized Representative"), appeared for the Fair Hearing

to provide testimony on behalf of Petitioner. [REDACTED] (“[REDACTED]”), [REDACTED]’s relative, appeared as a witness for the Petitioner.

Michael Moens, Grievance and Appeals Specialist for Humana Medical Plan, Inc. (“Humana”), appeared as a representative for Respondent. Dr. Heather Cappello (“Dr. Cappello”), LTC Medical Director for Humana, appeared as a witness for the Respondent.

Doris Rivera, Medical Health Care Program Analyst and Fair Hearing Liaison for the Agency for Health Care Administration (“Agency” or “AHCA”), appeared as an observer.

Petitioner’s Authorized Representative introduced an evidence packet containing one hundred and forty-four (144) pages, which was admitted into evidence as Petitioner’s Composite Exhibit 1. Petitioner’s Composite Exhibit 1 included the following: [REDACTED]’s letter (dated July 24, 2020); Complaint for Damages and Demand for Jury Trial (undated); Certificate of Occupancy (dated March 4, 2019); Wages statement (dated December 5, 2018); [REDACTED]’s Google email thread (dated March 6, 2019, March 7, 2019, July 15, 2019, February 26, 2019, and August 9, 2019); Credit Karma credit report (printed on July 25, 2020); AHCA My Choices Participant Direction Option (PDO) Guidelines for Florida Community Care; Humana American Elder Care PDO Guidelines (printed on December 14, 2019); [REDACTED]’s letter (dated May 13, 2020); Transaction statement (dated May 18, 2020); Designation of Authorized Representative for Medicaid Fair Hearing Participation (DAR); Transaction statement (dated May 18, 2020); Transaction statement (dated May 14, 2020); Humana Grievance Acknowledgement letter (dated January 23, 2020); Handwritten document (undated); AHCA My Choices Participant Direction Option (PDO) Guidelines for Humana; [REDACTED] screenshot; [REDACTED] Live-In Form (dated [REDACTED], 2020); Handwritten document (undated); Direct deposit form;

Notice of Adverse Benefit Determination (“NABD”) (dated March 23, 2020); Notice of Plan Appeal Resolution (“NPAR”) (dated April 22, 2020); a copy of the NABD; Letter from [REDACTED] [REDACTED] (dated [REDACTED] 2020); Tissue Biopsy for Petitioner (dated [REDACTED] 2019); [REDACTED] [REDACTED] for Petitioner (dated [REDACTED] 2019); [REDACTED] Neurology Reports and Diagnosis document (undated); Patient Request to Access Records (dated April 27, 2020); Handwritten document (undated); Transaction statements (dated April 27, 2020); Medical records from [REDACTED] (dated [REDACTED] 2020, [REDACTED] 2019, [REDACTED] 2019, [REDACTED] 2019, [REDACTED] 2019, [REDACTED] 2019, [REDACTED] 2019, [REDACTED] 2019, [REDACTED] 2019, and [REDACTED] 2019); Physician Discharge Orders and Instructions (dated [REDACTED] 2019); [REDACTED] records (authored on [REDACTED] 2020); Physician Order: Medication Reconciliation Discharge Form (undated); [REDACTED] Delivery Ticket (dated [REDACTED] 2020); [REDACTED] [REDACTED] prescription (dated [REDACTED] 2020); and an United States Postal Services time-stamped envelope.

Respondent introduced an evidence packet containing two hundred and seventy (270) pages, which was admitted into evidence as Respondent’s Composite Exhibit 1. Respondent’s Composite Exhibit 1 included the following: Table of Contents (dated July 30, 2020); NABD (dated March 23, 2020); NPAR (dated April 22, 2020); Humana authorization screenshots (dated March 16, 2020); AHCA Complaint Allegation [REDACTED] (dated March 31, 2020); Power of Attorney form (dated October 20, 2017); NABD (dated March 23, 2020); Florida Department of Elder Affairs: 701B Comprehensive Assessment (“701-B Comprehensive Assessment”) (dated June 11, 2020); Humana’s Summary of Services (dated August 21, 2019); Humana’s Plan of Care (dated May 6, 2020); Florida Medicaid Statewide Medicaid Managed Care Long-Term Care

Program Coverage Policy (“LTC Policy”) (March 2017); Humana’s Florida Medicaid Member Handbook (English version); and Humana’s Florida Medicaid Member Handbook (Spanish version).

FINDINGS OF FACT

1. Petitioner is an enrolled member of Humana’s Long-Term Care (“LTC”) Program. Humana is a Medicaid Managed Care organization contracted by the Agency to provide services to eligible Medicaid recipients in the State of Florida.

2. Petitioner is a fifty-six (56) year old female residing in the community with her husband and daughter. *See* Respondent’s Composite Exhibit 1, pages 43-61. Petitioner is bedbound twenty-four (24) hours per day. *Id.* at 45. Petitioner ambulates with the use of a wheelchair. *Id.* Petitioner is not a fall risk. *Id.* at 47. Petitioner is diagnosed with the following health conditions: Allergies; bed sores; constant bladder incontinence; constant bowel incontinence; Multiple Sclerosis (MS); Seizure disorder; Depression; legal blindness; and chronic body pain. *Id.* at 50-51. Petitioner’s husband provides supervision. *Id.* at 53. Petitioner’s husband prepares the Petitioner’s meals. *Id.* at 55. Petitioner is prescribed ten (10) medications. *Id.* at 56.

3. The Petitioner needs total assistance (cannot do at all) with Activities of Daily Living (“ADLs”) such as bathing, dressing, using the bathroom, transferring, and walking/mobility. *Id.* at 48. Petitioner needs assistance (but not total help) with eating. *Id.* Petitioner needs total assistance (cannot do at all) with Instrumental Activities of Daily Living (“IADLs”) such as heavy chores, light housekeeping, using the telephone, managing money, preparing meals, shopping, and using transportation. *Id.* at 49. Petitioner needs assistance (but not total help) with managing medication. *Id.*

4. Petitioner currently receives forty (40) hours per week of Personal Care services. *Id.* at 80. Petitioner's Personal Care services are administered through the Participant Direction Option ("PDO") program. [REDACTED] is the Petitioner's Direct Service Worker ("DSW") in the PDO program. *Id.* Petitioner also receives consumable medical supplies, including adult briefs, disposable wipes, disposable gloves, and chux underpads. *Id.* at 74-82.

5. [REDACTED] is a fifty-seven (57) year old male residing with the Petitioner. *Id.* at 58. [REDACTED] does not work outside of the home. *Id.*

6. On March 16, 2020, Humana received Petitioner's request for an additional eighty (80) hours per week of Personal Care services. *Id.* at 3-4.

7. On March 23, 2020, Humana issued an NABD denying Petitioner's request for an additional eighty (80) hours per week of Personal Care services based on medical necessity. *Id.* at 3-4. The NABD stated 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 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 determination of the Medical Director has been made based on medical necessity (as defined by Florida law – specifically see checked box above) and reflects the application of the Plan’s approved review criteria and guidelines.

You are requesting Personal Care PDO services, an additional 80 hours weekly. You are 56 years old and live with your husband who is your caregiver for 25 years. He is also your Direct Service Worker. He does not have any other job. Your daughter also helps with moral support. You are alert and oriented x 3. You have multiple sclerosis, legally blind, bedbound, incontinent of bladder and bowels, and use a foley catheter. You require total care for all activities of daily living except some assistance with eating and using the phone. We are denying the additional Personal Care PDO for 80 hours weekly. There has been no changes in your condition reported. No admissions reported. only 1 DSW approved (husband).

Id. at 4-5.

8. On April 22, 2020, Humana issued an NPAR upholding the denial of an additional eighty (80) hours per week of Personal Care services. *Id.* at 13-14. The NPAR explained as follows:

On 04/21/2020, after consideration of the information you provided to Humana Long- Term Care Plan in support of your plan appeal, was reviewed by a medical director who is a MD and board certified in Family Medicine & Geriatric Medicine.

The reason for the decision is as follows. You appealed a denial for 80 hours of personal care participant directed option hours. You have 40 hours now in the home participant directed option hours. You have not had an acute change in condition, hospitalization or emergency room visit. The hours are not approved as you have one direct social worker your husband who does not work outside the home. The additional hours are not medically necessary. We reviewed all the information provided to us and we have upheld the denial because the requested services are not medically necessary.

We determined that your 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 life, prevent significant illness or disability, or alleviate severe pain.

- Must be individualized, specific, consistent with symptoms or diagnosis of illness or injury, and not be in excess of the patient'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.

Id. at 13-14.

9. [REDACTED] recommended a full-time caregiver to assist the Petitioner with ADLs due to her "severe comorbidities." See Petitioner's Composite Exhibit 1, page 81. Dr. [REDACTED] cited Multiple Sclerosis, chronic pain syndrome, and seizures as the Petitioner's "severe comorbidities." *Id.*

10. Petitioner has constant pain in her cervical spine, thoracic spine, and lumbar spine. *Id.* at 100. Petitioner's medication prevents her from sleeping. *Id.* Petitioner experiences extensive fatigue. *Id.* Petitioner has an indwelling catheter installed. *Id.* at 101. Petitioner experiences "almost complete paralysis." *Id.* at 102. Petitioner has bone infections in her pelvis, urinary tract infection, and an infection in her blood stream. *Id.* at 127. Petitioner requires assistance with ADLs and IADLs. *Id.* at 131.

11. On April 30, 2020, [REDACTED] timely requested a Fair Hearing on behalf of the Petitioner to contest the Respondent's denial of additional Personal Care services.

12. [REDACTED] is the Petitioner's husband and DSW. [REDACTED] has cared for the Petitioner for the past 26 years. [REDACTED] changes the Petitioner's catheter and provides wound care for the Petitioner. [REDACTED] provides assistance for all of the Petitioner's ADLs and IADLs. Petitioner receives Speech Therapy services because she beginning to deteriorate in

her speech due to her MS diagnosis. [REDACTED] testified that the Petitioner requires full assistance with all ADLs and IADLs. [REDACTED] testified that it is tiring and frustrating coordinating the care for the Petitioner with Florida Medicaid. [REDACTED] testified that he barely sleeps because the Petitioner barely sleeps. [REDACTED] testified that he is not fatigued from caring for the Petitioner; he is fatigued from the process of obtaining more services for his wife through Humana.

13. [REDACTED] prefers to render care to the Petitioner. [REDACTED] has a Registered Nurse come to the home one day per week for twenty (20) minutes to monitor the [REDACTED]'s care for the Petitioner. [REDACTED] testified that the Petitioner was incorrectly assessed by Humana. [REDACTED] asserted that the Petitioner's medical records support the Petitioner's claim that the Petitioner needs additional Personal Care services. Petitioner has received outpatient services three weeks prior to the hearing for a "flap." Petitioner stated that this procedure is for the Petitioner's wound care due to the Petitioner's bone infection. [REDACTED] argued that he is the person best suited to care for the Petitioner.

14. Petitioner's daughter helped Petitioner for a temporary period of time, but she resides in the [REDACTED] and returned back to [REDACTED]. Petitioner has a disabled friend to assist with paperwork and monitoring the Petitioner. Petitioner sleeps from three (3) to four (4) hours per day with only three (3) of those hours being consecutive. [REDACTED] does not want to hire a home health aide because the previous home health aide dropped the Petitioner when she attempted to transfer the Petitioner. [REDACTED] tried two (2) Home Health Agencies through Florida Medicaid and reported bad experiences with both agencies. [REDACTED] does not want to accept additional Personal Care services, Homemaker services, and Adult

Companion Care services through a Home Healthy Agency. [REDACTED] requested to be the only person providing care to the Petitioner, not a Home Health Agency with whom he has had bad experiences with.

15. Dr. Cappello is a LTC Medical Director for Humana. Humana's concern is that [REDACTED] is working a forty (40) hour work week through the PDO program, and providing additional PDO Personal Care services is not healthy for [REDACTED]. Dr. Cappello stated that it is a lot of work to care for the Petitioner and [REDACTED] may have experienced fatigue. Dr. Cappello agrees that the Petitioner needs more Personal Care services. Dr. Cappello testified that the Petitioner needs more Personal Care services, but in a traditional sense, through a Home Health Agency, not one hundred and twenty (120) hours per week of work paid directly to the Petitioner. Dr. Cappello testified that Humana would approve additional Personal Care services, Homemaker services, and Adult Companion Care services through a Home Healthy Agency. Dr. Cappello testified that a 17-hour work day on a daily basis for any person is excessive, and would cause fatigue.

CONCLUSIONS OF LAW

16. The Agency's Office of Fair Hearings has jurisdiction over the subject matter of this proceeding and the parties pursuant to Florida Statutes ("Fla. Stat.") § 409.285(2) (2019). This order is the final administrative decision of AHCA under Fla. Stat. § 409.285(2)(a).

17. Pursuant to Fla. Admin. Code R. 59G-1.100(17)(b), this hearing was held as a *de novo* proceeding.

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

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

(Emphasis added).

19. Because Petitioner requested a new service, the burden of proof is on the Petitioner. See Fla. Admin. Code R. 59G-1.100(17)(g). The standard of proof in an administrative hearing is a preponderance of the evidence. *Id.* The preponderance of the evidence standard requires proof by “the greater weight of the evidence” (Black’s Law Dictionary at 1201, 7th Ed.).

20. The LTC Policy, incorporated by reference in Fla. Admin. Code R. 59G-4.192, governs LTC services available to eligible Medicaid recipients in the State of Florida. See Respondent’s Composite Exhibit 1, pages 92-113.

21. The LTC Policy provides the following applicable definitions:

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

1.3.2 Authorized Representative

An individual who has the legal authority to make decisions on behalf of an enrollee or potential enrollee.

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)

...

1.3.16 Natural Supports

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

Respondent's Composite Exhibit 1, pages 92-113.

22. The LTC Policy states the following coverage criteria:

4.1 General Criteria

Florida Medicaid covers services that meet all of the following:

- Are determined medically necessary;
- Do not duplicate another service; and
- Meet the criteria as specified in the 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 restrictive setting

...

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.

Respondent's Composite Exhibit 1, pages 92-113.

23. The LTC Policy defines "Medically Necessary" or "Medical Necessity" as follows:

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.

Respondent's Composite Exhibit 1, pages 92-113.

24. The Florida Medicaid Definitions Policy (August 2017) ("Definitions Policy"), which is incorporated by reference in Fla. Admin. Code R. 59G-1.010, provides definitions of commonly used terms that are applicable to all sections of Fla. Admin. Code R. 59G, unless specifically stated

otherwise in a service-specific coverage policy or rule. The Definitions Policy defines Medically Necessary or Medical Necessity as:

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.

(Emphasis added).

25. Humana's Member Handbook for Florida Medicaid enrollees state as follows:

Long-Term Care Participant Direction Option

You may be offered the Participant Direction Option (PDO). You can use PDO if you use any of these services and live in your home:

- Attendant care services
- Homemaker services
- **Personal Care services**
- Adult companion care services
- Intermittent and skilled nursing care services

PDO lets you **self-direct** your services. This means you get to choose your service provider and how and when you get your service. You have to hire, train, and supervise the people who work for you (your direct service workers).

You can hire family members, neighbors, or friends. You will work with a case manager who can help you with PDO.

If you are interested in PDO, ask your case manager for more details. You can also ask for a copy of the PDO Guidelines to read and help you decide if this option is the right choice for you.

(Emphasis added).

Respondent's Composite Exhibit 1, page 169.

26. Attachment II– Exhibit II-B – LTC Managed Care Program (February 1, 2018) (“Florida Medicaid Core Contract”) provides contract provisions that are applicable to all LTC managed care plans unless specifically noted otherwise. The Florida Medicaid Core Contract states:

3. Participant Direction Option (PDO)

a. General Provisions

- 1) The Managed Care Plan is responsible for implementing and managing the Participant Direction Option (PDO) as defined in Attachment II, Section I, Definitions and Acronyms. **The Managed Care Plan shall ensure the PDO is available to all Long-term Care enrollees who have any PDO-qualifying service on their authorized care plan and who live in their own home or family home.**
- 2) **An enrollee’s plan of care shall include one or more of the following services in order for the enrollee to be eligible to participate in the PDO: adult companion care, attendant nursing care, homemaker services, intermittent and skilled nursing, or personal care. The enrollee may choose to participate in the PDO for one or more of the eligible PDO services, as outlined in their authorized care plan.**
- 3) Enrollees who receive PDO services shall be called “participants” in any PDO specific published materials. The enrollee shall have employer authority. An enrollee may delegate their employer authority to a representative. The representative can neither be paid for services as a representative, nor be a direct service worker. For the purposes of this section, “enrollee” means the enrollee or their representative.
- 4) The Managed Care Plan shall develop PDO-specific policies and procedures that shall be updated at least annually and shall obtain Agency approval prior to distributing PDO materials to enrollees, representatives, direct service workers, and case managers.
- 5) **The Managed Care Plan shall operate the PDO service delivery option in a manner consistent with the PDO Manual and the PDO Participant Guidelines provided by the Agency.**

- 6) The Agency will provide templates for the following to the Managed Care Plan: PDO Consent Form, PDO Representative Agreement, PDO Participant Guidelines, and PDO Pre-Screening Tool.
- 7) The Managed Care Plan shall maintain books, records, documents, and other evidence of PDO-related expenditures using generally accepted accounting principles (GAAP).
- 8) The Managed Care Plan shall submit a PDO report monthly as specified in Section XIV, Reporting Requirements and the Managed Care Plan Report Guide. The Managed Care Plan shall provide ad-hoc PDO related information, records, and statistics, at the request of the Agency within the specified timeframe.
- 9) The Agency will conduct PDO satisfaction surveys on at least an annual basis and shall provide results to the Managed Care Plan for use in quality improvement plans.
- 10) The Managed Care Plan shall cooperate with, and participate in, ongoing evaluations and focus groups conducted by the Agency to evaluate the quality of the PDO.

...

d. Enrollee Employer Authority/Direct Service Workers

- 1) **Enrollees may hire any individual who satisfies the minimum qualifications set forth in Section VI, Provider Network, including but not limited to neighbors, family members, or friends. The Managed Care Plan shall not restrict an enrollees' choice of direct service worker(s) or require them to choose providers in the Managed Care Plan's provider network.**

(Emphasis added).

27. Petitioner is a fifty-six (56) year old female residing in the community with her husband, Petitioner's Authorized Representative. *See supra* ¶ 2. Petitioner requires total assistance with all ADLs and IADLs, except eating and medication management. *See supra* ¶ 3. Petitioner's Authorized Representative currently renders forty (40) hours per week of Personal Care services through the PDO program. *See supra* ¶ 4. Petitioner's Authorized Representative argued that the request should be approved because Petitioner requires full assistance with all ADLs and IADLs. *See supra* ¶ 12-14. In addition, Petitioner's Authorized Representative asserted Petitioner sleeps from three (3) to four (4) hours per day with only three of those hours being consecutive;

Petitioner's Authorized Representative did not assert that the Petitioner requires assistance while sleeping. *See supra* ¶ 12-14. [REDACTED] [REDACTED] also recommended a full-time caregiver to assist the Petitioner with ADLs due to Petitioner's "severe comorbidities." *See supra* ¶ 8. Respondent testified that Petitioner does need more Personal Care services, and Respondent would approve more Personal Care services along with other LTC services, but only through a Home Healthy Agency. Respondent did not identify how many additional hours of personal care services it would approve through a Home Health Agency. *See supra* ¶ 15. Respondent speculated that one person, Petitioner's Authorized Representative, rendering care to the Petitioner would lead to fatigue. *See supra* ¶ 15. Petitioner's Authorized Representative denied any such fatigue. *See supra* ¶ 12-14.

28. The LTC Policy covers Personal Care services, if they are deemed medically necessary. *See supra* ¶ 24. To be medically necessary, a service must meet the five criteria set forth in section 2.83 of the Definitions Policy. *See supra* ¶ 24. In the alternative, Dr. Cappello testified that Petitioner's request should be approved through a Home Health Agency, not the PDO program. Petitioner's Authorized Representative established through his testimony, *supra* ¶ 12-14, [REDACTED] [REDACTED]' recommendation, *supra* ¶ 9, and Petitioner's medical records, *supra* ¶ 10, that the Petitioner requires full assistance with ADLs and IADLs, and the Petitioner does not require care while she is sleeping. However, the fact that Petitioner's provider recommended and prescribed services does not, in itself, establish medical necessity. *See supra* ¶ 24. The undersigned considered such recommendation in conjunction with the documentary evidence and testimony elicited at the hearing. The record also indicates that the Petitioner has extensive medical conditions that require extensive care and attention. *See supra* ¶ 2, 9-10, and 12-14.

Further, Petitioner has only Petitioner's Authorized Representative as a natural support. See supra ¶ 12-14.

29. The requested additional Personal Care services must 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." See supra ¶ 23. Respondent's NABD and NPAR determined that the requested additional Personal Care services did not meet this criterion. See supra ¶ 7-8. The record indicates that the Petitioner requires full assistance with ADLs and IADLs and the Petitioner is near complete paralysis. Petitioner cannot assist with any ADLs or IADLs outside of eating and medication management. See supra ¶ 3. Petitioner also requires daily open wound care. See supra ¶ 12. Petitioner only sleeps three (3) to four (4) hours per night. See supra ¶ 14. No testimony was presented that Petitioner requires assistances while sleeping. The record indicates that Petitioner requires an additional eighty (80) hours per week of "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." However, the Petitioner also has natural support from their primary caregiver and husband, Petitioner's Authorized Representative. Based on the record, Petitioner's Authorized Representative lives with the Petitioner, Petitioner's Authorized Representative does not maintain employment outside of the home, and Petitioner's Authorized Representative provides for all of the Petitioner's needs regarding ADLs and IADLs. Further, along with the level of natural support available, Petitioner also already receives forty (40) hours per week of Long-term care. In light of Petitioner's natural support being provided and the current LTC services being provided, Petitioner did not establish that there is a need for an additional eighty (80) hours per

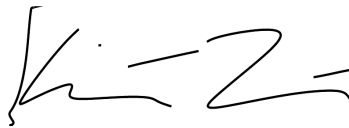
week of Personal Care services. Petitioner has not shown that an additional eighty (80) hours per week of Personal Care services are not in excess of their needs. Thus, Petitioner did not demonstrate that the requested service is medically necessary.

30. Accordingly, upon consideration of both parties' sworn testimony, Respondent's Composite Exhibit 1, and applicable policies, the undersigned Hearing Officer concludes that Petitioner did not prove by a preponderance of the evidence that Respondent's denial of an additional eighty (80) hours per week of Personal Care services was incorrect.

DECISION

Respondent's denial of Petitioner's request for an additional eighty (80) hours per week of Personal Care services is **AFFIRMED**. Petitioner's request for relief is hereby is **DENIED**.

DONE and ORDERED this 28th day of August, 2020, in Tallahassee, Leon County, Florida.



Digitally signed by Kristopher
León
Reason: 20-FH [REDACTED]
Date: 2020.08.28 16:03:01
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KRISTOPHER LEÓN, Hearing Officer
Agency for Health Care Administration
Office of Fair Hearings
2727 Mahan Drive, Mail Stop # 11
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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.

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