



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

FILED

Jul 23, 2020, 12:16 pm

OFFICE OF FAIR HEARINGS

██████████

PETITIONER,

AHCA Case No.: 20-FH-██████████

Plan ID No.: ██████████

vs.

UNITEDHEALTHCARE OF FLORIDA, INC,

RESPONDENT.

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**FINAL ORDER**

Pursuant to notice, the undersigned convened a telephonic Fair Hearing on the instant case on June 23, 2020, at ██████████

**APPEARANCES**

For the Petitioner:

██████████  
Petitioner

For the Respondent:

David Jones  
Grievance and Hearing Coordinator  
UnitedHealthcare of Florida, Inc.

**STATEMENT OF ISSUE**

The issue is whether Petitioner has proved by a preponderance of the evidence that Respondent's decision to deny fourteen (14) hours per week of personal care services was incorrect.

**PRELIMINARY STATEMENT**

PRR0000083

All parties appeared telephonically. Petitioner appeared on her own behalf.

David Jones, Grievance and Hearing Coordinator for UnitedHealthcare of Florida, Inc. ("United"), appeared on behalf of Respondent. Dr. Sloan Karver, ("Dr. Karver") Long Term Care Director for United, attended as a witness for Respondent.

Juan from Language Line Solutions (translator identification number 351914) appeared for the Fair Hearing to offer translation services on behalf of Petitioner.

Linda Latson ("Ms. Latson"), Registered Nurse Specialist and Fair Hearing Liaison for the Agency for Health Care Administration ("Agency" or "AHCA"), appeared as an observer.

Petitioner did not introduce any exhibits at the hearing. Prior to the hearing, Respondent sent to the Office of Fair Hearings and Petitioner a 268-page Statement of Matters packet. The Statement of Matters packet included: a Notice of Adverse Benefit Decision ("NABD"), dated January 29, 2020; a CSP - General Request Form, dated March 10, 2020; a plan appeal acknowledgment letter, dated March 11, 2020; another CSP General Request Form, dated March 27, 2020; Print HSC History; Petitioner medical records, dated [REDACTED] 2020; a Florida Department of Elder Affairs 701B Comprehensive Assessment ("701B"), dated March 10, 2020; a Plan of Care Summary, signed November 6, 2019; Appeal Review; a Notice of Plan Appeal Resolution ("NPAR"), dated April 6, 2020; Florida Administrative Code Rule ("Fla. Admin. Code R.") 59G-1 in its entirety; the Florida Medicaid Statewide Medicaid Managed Long-term Care Program Coverage Policy (March 2017) ("LTC Policy"); the Florida Medicaid Authorization Requirements Policy (June 2016); the Florida Medicaid Personal Care Services Coverage Policy (November 2016); the Florida Medicaid Private Duty Nursing Services Coverage Policy (November 2016); the Home Health Visit Services Fee Schedule (January 1, 2017); the Personal Care Services

Fee Schedule (January 1, 2017); the Private Duty Nursing Services Fee Schedule (January 1, 2017); the Participant Direction Option Manual; the Florida Medicaid Hospice Services Coverage Policy (June 2016); 42 C.F.R. Part 418, Subpart C (Conditions of Participants: Patient Care); section 400.6105 of the Florida Statutes (2018); Fla. Stat. § 400.609; Fla. Stat. § 409.910; and Fla. Stat. § 400.462. Absent an objection from the Petitioner Authorized Representative, the undersigned admitted the 268-page Statement Matters packet into evidence as Respondent's Composite Exhibit 1.

### **FINDINGS OF FACT**

1. Petitioner is an enrolled member of United. United is a managed care organization contracted by the Agency to provide services to eligible Medicaid recipients in Florida.
2. Petitioner is an 89-year old adult that suffers from chronic pain caused by osteoarthritis and osteoporosis and is diagnosed with bladder incontinence. Petitioner has a history of myocardial infarction and suffers from renal disease. Respondent's Composite Exhibit 1 at page 58.
3. Petitioner lives independently without the assistance of any natural supports. Petitioner requires some assistance with light housekeeping, preparing meals, shopping, and using transportation. *Id.* at 57. Petitioner requires total assistance with heavy chores *Id.* Petitioner uses a walker to ambulate. Petitioner always has assistance with heavy chores, light housekeeping, preparing meals, shopping, and using transportation. *Id.* Petitioner requires no assistance with using the bathroom or eating. *Id.* at 56. Petitioner need some assistance with bathing and dressing and always has assistance. *Id.* Petitioner uses a walker and wheelchair for transferring and walking. *Id.*

4. Petitioner receives seven (7) hours of personal care services per week and seven (7) hours of homemaker services. Petitioner also receives five (5) home delivered meals per week. *Id.* at 5.

5. Petitioner requested an additional fourteen (14) hours per week of personal care services. Petitioner received an NABD denying Petitioner's request, dated January 29, 2020. The NABD explained the following rationale as to why the request was not medically necessary:

We determined that your requested services are not medically necessary because the services do not meet either of the reasons 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:

Your assessment tells us you need some help to bathe, dress, and go to the bathroom.

You get 7 hours a week of personal care.

You also get homemaker services 7 hours a week.

You get 5 home delivered meals a week so the aide does not have to make you a meal.

In my clinical opinion, you can split your current personal care 7 hours a week and homemaker services 7 hours a week to give you morning and night time care.

*Id.* at 4 through 5.

6. Petitioner requested a plan appeal and received an NPAR dated April 6, 2020, upholding the denial. The NPAR explained as follows:

We looked at your records. We have decided that what you asked for cannot be approved. This does not meet Florida Medicaid rules. You asked for more personal care. You would like 14 more hours a week. You need help with some daily activities. Based on my professional judgment, we are not approving these extra hours because they are in excess of your needs. You have 7 hours a week of personal care approved by the health plan. This should meet your personal care needs.

*Id.* at 85 through 86.

7. During the hearing, Petitioner testified that due to her incontinence she urinates on herself and has no assistance with cleaning herself in the afternoons. Petitioner also testified that she has no assistance with taking her medications in the afternoon.

8. Dr. Karver testified that Respondent's decision was based off the case manager's assessment in the 701B reflecting that Petitioner's needs for assistance are met as described in paragraph 5.

#### **CONCLUSIONS OF LAW**

9. 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).

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

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

12. The LTC Policy, incorporated by reference in Fla. Admin. Code R. 59G-4.192, governs Long-Term Care services available under Florida Medicaid. The LTC Policy provides the following with respect to personal care services:

**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.

...

**1.3.1 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

...

**1.3.6 Natural Supports**

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

...

**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
- Money Management
- Personal hygiene
- Transportation
- Using the telephone to take care of essential tasks (examples include paying bills and setting up medical appointments)

...

**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

...

#### **4.2.2.6 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.

13. The LTC Policy also addresses medical necessity:

#### **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.

14. 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 defines "Medically Necessary" or "Medical Necessity" as follows:

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.

15. The 701B admitted into the record as part of Respondent's Composite Exhibit 1 shows that Petitioner's needs for assistance with IADLs and ADLS are met through the services provided. *Supra* ¶ 3. Petitioner argued that the hours were not sufficient to meet Petitioner's needs with regards to receiving assistance with toileting and managing her medications in the afternoon. *Supra* ¶ 7. Petitioner's testimony conflicts with the case manager's assessment in the 701B and does not explain why Petitioner specifically need additional assistance to complete the tasks.

16. Dr. Karver provided testimony that the Petitioner's services match her needs based on Petitioner's current medical condition and the 701B showing that Petitioner's needs are met by the services provided. *Supra* ¶ 8.

17. As provided in section 4.1 of the LTC policy, personal care services must be medically necessary. A component of medical necessity is that services must be "individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment,

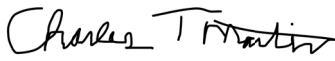
and not in excess of the patient's needs." As established by the record, Petitioner has medical needs and is advanced in age. The record also shows that Petitioner retains a level of independence even without assistance from any natural supports. The 701B in Respondent's Composite Exhibit 1 shows that Petitioner's needs are met with the services currently provided. Petitioner's argument that Petitioner's requires additional assistance in the amount of fourteen (14) hours are not supported by Petitioner's testimony explaining the hours requested. Petitioner's testimony, when weighed against the evidence and medical opinion testimony provided by Dr. Karver, has not demonstrated that Petitioner's request was medically necessary.

18. Therefore, upon consideration of the testimony provided, evidence submitted, and applicable policies, the undersigned concludes that Petitioner did not prove by a preponderance of the evidence that Respondent's denial of an additional fourteen (14) hours of personal care services was incorrect.

**DECISION**

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

**DONE and ORDERED** this 23rd day of July, 2020, in Tallahassee, Leon County, Florida.

 Charles Martin  
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**CHARLES MARTIN, Hearing Officer**  
**Agency for Health Care Administration**  
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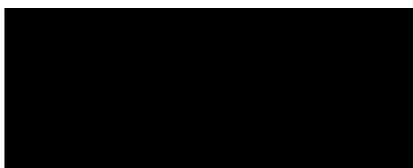
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**NOTICE OF A RIGHT TO JUDICIAL REVIEW**

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.

**Copies Furnished To:**



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