



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

FILED

Oct 23, 2020, 8:36 am

OFFICE OF FAIR HEARINGS

[REDACTED]

PETITIONER,

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

vs.

WELLCARE OF FLORIDA, INC. D/B/A
STAYWELL HEALTH PLAN OF FLORIDA,

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned Hearing Officer convened a telephonic Medicaid Fair Hearing on September 22, 2020, at [REDACTED]

APPEARANCES

For the Petitioner: [REDACTED]
Petitioner's Authorized Representative

For the Respondent: Nicole Vega
Regulatory Research Coordinator
UnitedHealthcare of Florida, Inc.

STATEMENT OF ISSUE

The issue is whether Respondent proved by a preponderance of the evidence that Respondent's reduction of personal care services from 96 hours per week to 40 hours per week was correct.

PRELIMINARY STATEMENT

All parties and witnesses appeared telephonically. [REDACTED] (“[REDACTED]”), Petitioner’s Authorized Representative and mother, appeared for the hearing and provided testimony on Petitioner’s behalf.

Nicole Vega, Regulatory Research Coordinator for UnitedHealthcare of Florida, Inc. (“United”), represented Respondent at the hearing. The following individuals appeared at the hearing on Respondent’s behalf: Dr. Sheryce Andrews (“Dr. Andrews”), Medical Director for Staywell; Michelle Burgos, Regulatory Research Coordinator for Staywell; Carol Farranc, Operations Resolution Supervisor for Staywell; Dondrue Okwuasaba, Manager for Long Term Care (“LTC”) for Staywell; Donna Louis, Care Manager for Staywell; and Claudia Williams, LTC Supervisor for Staywell.

Lisa Sanchez, Medical Healthcare Program Analyst for the Agency for Health Care Administration (“Agency” or “AHCA”), appeared for observational purposes.

Prior to the hearing, Petitioner did not send to the Office of Fair Hearings and Respondent an evidence packet. Prior to the hearing, Respondent sent to the Office of Fair Hearings and Petitioner a 151-page evidence packet. The packet included the following documents: an email from Nicole Vega to the Office of Fair Hearings, sent on June 18, 2020; the Summary; the Supporting Documents; the Eligibility Verification documents; the Prior Authorization screen; a Notice of Adverse Benefit Determination (“NABD”), dated March 26, 2020; the Appeal Request; the letter from Respondent to Petitioner, dated March 27, 2020; Respondent’s Case Notes; Respondent’s Clinical Notes; a 5-page facsimile transmission (“fax”) from [REDACTED] to Respondent, sent December 10, 2019; the letter from Respondent to Petitioner, dated March 23, 2020; the Care Plan, last revised March 23, 2020; Petitioner’s medical records printed on

November 8, 2019; the Service Plan, revised on March 23, 2020; the Long Term Services and Supports (“LTSS”) Comprehensive Assessment with an assessment date of December 19, 2019; Notice of Plan Appeal Resolution (“NPAR”), dated April 17, 2020; Florida Administrative Code Rule (“Fla. Admin. Code R.”) 59G-1.010; Respondent’s Policy Number HS-500; the Medicaid Managed Medical Assistance (“MMA”) Contract, section V.D.3.a.(1).(2).(3).(4).(5); and excerpts from the Staywell Member Handbook. Absent an objection from Petitioner, the undersigned admitted Respondent’s 151-page evidence packet into evidence as Respondent’s Composite Exhibit 1.

FINDINGS OF FACT

1. Petitioner is an enrolled member of Staywell’s Long-term Care (“LTC”) plan. *See* Respondent’s Composite Exhibit 1, page 126. Staywell is a managed care organization contracted by AHCA to provide services to eligible Medicaid recipients in Florida.
2. As of the date of the Fair Hearing, Petitioner is a 26-year-old male who resides in a private residence with his parents. *See* Respondent’s Composite Exhibit 1, pages 60 and 75. Petitioner’s primary diagnosis is identified as persistent vegetative state. *Id.* at 65. Petitioner has the following diagnoses: epilepsy; traumatic brain injury; difficult intubation; and hemiplegia. *Id.* at 54 and 99. Petitioner “has cognitive and physical impairments that require 24 hour care/assistance.” *Id.* at 52.
3. The LTSS Comprehensive Assessment reflects the following regarding Petitioner’s Instrumental Activities of Daily Living (“IADLs”). Petitioner’s status is total dependence – full performance by others during entire period for meal preparation; ordinary housework; managing

finances; managing medications; managing full flight of stairs; shopping; and transportation. See Respondent's Composite Exhibit 1, pages 86 – 90.

4. The LTSS Comprehensive Assessment reflects the following regarding Petitioner's Activities of Daily Living ("ADLs"). Petitioner's status is total dependence – full performance by others during all episodes for the following: bathing; personal hygiene; dressing upper body; dressing lower body; walking; locomotion; toilet transfer; toilet use; bed mobility; and eating. See Respondent's Composite Exhibit 1, pages 91 – 94. Petitioner' primary mode of locomotion is a wheelchair or scooter. *Id.* at 96. Petitioner is incontinent of bowel and bladder, and has a condom catheter. *Id.* at 98.

5. On March 26, 2020, Respondent issued an NABD reducing Petitioner's personal care services. See Respondent's Composite Exhibit 1, page 10. The NABD stated the reason for Respondent's determination as follows:

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

...

Meet all of the 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:

WellCare received your request for 92 hours of personal care services in the home, which is an increase of 51.5 hours. This request is denied because the information provided does not show that this is required to manage your medical condition(s). Your currently authorized services are: 76 hours of Nursing, 40.5 hours of Personal Care (provided by your family member as a paid caregiver), and 10 hours of Homemaking (provided by your family member as a paid caregiver). With your request, the new total of in-home hours requested would be 168/week, which is 24 hours/day, 7 days/week. There has not been a change in your ability to walk, transfer, or complete basic daily activities; you continue to need total assistance for all aspects of your care. The Medical Director has reviewed office visit notes from your doctor who writes that your medical conditions are stable at this time. Your medications have not been changed and you have not recently been hospitalized. The Medical Director recognizes that you do benefit from nursing assistance for managing the feeding tube for food and medications; however these are not considered high-level nursing needs and your family is trained and able to perform these tasks. The Medical Director has approved to continue 40 hours of personal care services. With this, your total paid caregiving hours remain a total of 126 hours/week= 18 hours/day. This policy does not cover 24/7 paid care; it is expected that your live-in family members will assist you, unpaid, for the remaining 6 hours/day. Criteria: WellCare Clinical Coverage Guideline. Lona Term Services and Supports /LTSS) - Florida

Respondent's Composite Exhibit 1, pages 10 – 11.

6. Petitioner requested a plan appeal for the reduction of personal care services. On April 17, 2020, Respondent sent Petitioner an NPAR, denying Petitioner's plan appeal. See

Respondent's Composite Exhibit 1, page 126. The NPAR stated as follows:

On 3/27/2020 we received your timely plan appeal request regarding Staywell's Notice of Adverse Benefit Determination dated 3/26/2020, NABD Number [REDACTED]: denying the service to be provided to you.

The request has been reviewed. The review was completed by a licensed doctor. The doctor was not a part of the first review or the findings from that review.

The Medical Director involved is Board Certified MD with a specialty in Internal Medicine.

On 4/17/2020, after consideration of the information you provided to Staywell in support of your plan appeal, Staywell hereby Denies your plan appeal. As a result, you will not receive the personal care services, effective 4/17/2020.

The facts that we used to make our decision are: We looked at your case again. The request for additional home care hours at [REDACTED] from 03/23/2020 - 03/30/2020 has been denied. The notes did not show that you need more hours. You can be treated with the 126 hours of personal care a week or 18 hours per day. The reasons for this decision are based on a set of standards. This included WellCare Clinical Coverage Guideline, Long Term Services and Supports (LTSS) -Florida HS-500 to make our decision.

Respondent's Composite Exhibit 1, pages 126 – 127.

7. On May 14, 2020, Petitioner requested a Fair Hearing due to the reduction of personal care services from 96 hours per week to 40 hours per week. On June 3, 2020, the undersigned Hearing Officer scheduled the Fair Hearing for June 25, 2020, at [REDACTED], and all parties were duly notified. During the Fair Hearing on June 25, 2020, Respondent requested a continuance, Petitioner did not object, and the continuance was granted. On August 17, 2020, the undersigned Hearing Officer scheduled the Fair Hearing for September 8, 2020, at [REDACTED], and all parties were duly notified. The parties agreed on the record at the Fair Hearing that the issue in this case is whether Respondent proved by a preponderance of the evidence that Respondent's reduction of personal care services from 96 hours per week to 40 hours per week was correct.

8. Dr. Andrews is a Medical Director for Staywell. Dr. Andrews testified that she reviewed all documentation submitted to Respondent for this case, and it is her professional opinion that Respondent's reduction of personal care services was correct. Dr. Andrews explained that

Petitioner joined Respondent's LTC program in [REDACTED] 2019 when it was a new program, and as part of onboarding process under continuity of care, Petitioner was allowed to keep his 96 hours per week of personal care services, because that is what he was receiving at his previous plan. In September 2019, Dr. Andrews determined that the 96 hours per week should be reduced. Dr. Andrews testified that [REDACTED] can provide the 56 hours per week of personal care services that have been taken away, as she is paid to do it and logging them at night, and she is available to provide the services. Dr. Andrews explained that if [REDACTED] is providing the services and being paid for them, then she can provide them and be unpaid for them. Dr. Andrews testified that Staywell is a supplemental program and it augments what the family is able to provide. Dr. Andrews agreed that Petitioner needs someone with him at all times, and she explained that Respondent has an expectation that the family will provide some of the care. Dr. Andrews explained that it is not Respondent's position that all 24/7 care needs to be paid. Dr. Andrews explained that Respondent knows that [REDACTED] is available and trained to provide Petitioner's care.

9. Dr. Andrews explained that Petitioner is currently authorized to receive the following services: 76 hours per week of skilled nursing services; 10 hours per week of homemaker services; and 40 hours per week of personal care services. Dr. Andrews testified that once services are authorized, Petitioner can adjust times the services are provided to meet his needs.

10. [REDACTED] is Petitioner's mother. Petitioner needs 24/7 care and resides in the home with [REDACTED] and [REDACTED]'s husband. [REDACTED] provides Petitioner's personal care services and homemaker services through the Patient Directed Option ("PDO") service delivery model. [REDACTED] does not work outside the home. The time period during which the nurse is

not present, and [REDACTED] is alone with Petitioner and provides his personal care services, are: 5:30 p.m. to 8:30 a.m. on Monday, Tuesday, Thursday, and Friday; and 8:00 p.m. to 8:30 a.m. on Wednesday, Saturday and Sunday. [REDACTED] does not sleep until the nurse arrives at 8:30 a.m. each morning. [REDACTED] testified that it impossible for her to care for Petitioner and work, and she needs the income from the personal care services at night to survive. [REDACTED]'s husband is self-employed, works Monday through Saturday and sometimes Sunday, and does not assist with Petitioner's care or appointments.

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 Fla. Stat. § 409.285(2)(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 is reducing an existing service, Fla. Admin. Code R. 59G-1.100(17)(g) assigns the burden of proof to the 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 Florida Medicaid policy that applies to the requested services is the Florida Medicaid Statewide Medicaid Managed Care Long-term Care Program Coverage Policy (March 2017) (“SMMC LTC Policy”). The Agency for Health Care Administration’s SMMC LTC Policy has been incorporated, by reference, into Florida Administrative Code Rule 59G-4.192. The SMMC LTC Policy provides as follows:

1.1 Description and Program Goal

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

...

1.3 Definitions

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

1.3.1 Activities of Daily Living (ADLs)

ADLs include:

- Bathing
- Dressing
- Eating (oral feedings and fluid intake)
- Maintaining continence (examples include taking care of a catheter or colostomy bag or changing a disposable incontinence product when the recipient is unable to control bowel or bladder functions)
- Toileting
- Transferring

...

1.3.5 701-B Comprehensive Assessment

An individualized, complete assessment of an individual’s medical, developmental, behavioral, social, financial, and environmental status. The assessment is conducted by a trained individual employed by the Department of Elder Affairs Comprehensive Assessment and Review for Long-Term Care Services (CARES) program or the LTC plan, to determine

eligibility for the LTC program based on the need for a nursing facility level of care.

...

1.3.9 Instrumental Activities of Daily Living (IADLs)

When necessary for the recipient to function independently, including:

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

...

1.3.14 Medically Necessary or Medical Necessity

For the purposes of this policy, the service must meet either of the following criteria:

- (a) Nursing facility services and mixed services must meet the medical necessity criteria defined in Rule 59G-1.010, F.A.C.
- (b) All other LTC supportive services must meet all of the following:
 - Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs
 - Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available statewide
 - Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider

And, one of the following:

- Enable the enrollee to maintain or regain functional capacity; or
- Enable the enrollee to have access to the benefits of community living, to achieve person-centered goals, and to live and work in the setting of his or her choice.

...

1.3.16 Natural Supports

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

...

2.2 Who Can Receive

Florida Medicaid recipients requiring medically necessary LTC services who are enrolled in a LTC plan and have a nursing facility level of care determined by the CARES program. Some services may be subject to additional coverage criteria as specified in section 4.0.

...

4.0 Coverage Information

4.1 General Criteria

Florida Medicaid LTC plans cover services that meet all of the following:

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

4.2 Specific Criteria

Florida Medicaid LTC plans cover services that meet all of the following:

- Consistent with the type, amount, duration, frequency, and scope of services specified in an enrollee's authorized plan of care
- Provided in accordance with a goal in the enrollee's plan of care
- Intended to enable the enrollee to reside in the most appropriate and least.

...

4.2.1.9 Homemaker Services

The provision of general household activities (such as meal preparation) and routine household care (including laundry and pest control) by a trained homemaker, when the individual regularly responsible for these activities is temporarily absent or unable to manage these activities.

...

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:

...

4.2.2.2 Attendant Nursing Care

In accordance with 59G-4.261, F.A.C., for enrollees under the age of 21 years. To provide nursing care of both a supportive and health-related nature, specific to the needs of a medically stable, physically handicapped enrollee age 21 and older who requires more individual and continuous care than an intermittent nursing visit. The scope and nature of these services do not otherwise differ from private duty services furnished to persons under the age of 21 years.

...

Intermittent Skilled Nursing

In accordance with Rule 59G4.130, F.A.C. This service includes the provision of skilled nursing services at intervals of more than one hour apart, and for the length of time necessary to complete the service, for enrollees who do not require continuous nursing care (see attendant nursing care services).

...

4.2.2.6 Personal Care

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

...

6.0 Documentation

...

6.2 Specific Criteria

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

SMMC LTC Policy, pages 1-8.

16. The PC Policy, which is incorporated by reference in Fla. Admin. Code R. 59G-4.215, states as follows:

1.1 Description

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

...

1.1.2 Statewide Medicaid Managed Care Plans

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

...

1.3 Definitions

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

...

1.3.6 Home Health Services

Medically necessary services that can be safely provided to the recipient in their home or in the community that include home health visits (skilled nursing and home health aide services), private duty nursing, and personal care services.

...

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

PC Policy, pages 3 - 5.

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

2.83 Medically Necessary or Medical Necessity

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

- Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain
- Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs
- Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational

- Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available statewide
- Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient’s caretaker, or the provider

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

Medically necessary or medical necessity for inpatient hospital services requires that those services furnished in a hospital on an inpatient basis could not, consistent with the provisions of appropriate medical care, be effectively furnished more economically on an outpatient basis or in an inpatient facility of a different type.

18. The Florida Medicaid Authorization Requirements Policy, June 2016, (“Authorizations Policy”) states in pertinent part, as follows:

1.1 Description

This policy contains general requirements for providers to obtain authorization to render Florida Medicaid services, when applicable.

1.1.1 Florida Medicaid Policies

This policy is intended for use by all providers that render services to eligible Florida Medicaid recipients through the fee-for-service delivery system, unless otherwise specified. It must be used in conjunction with Florida Medicaid’s general policies (as defined in section 1.3) and any applicable service-specific and claim reimbursement policies with which providers must comply.

...

1.2 Definitions

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

1.3.1 Authorization

The process of obtaining approval for reimbursement of a service based on medical necessity.

1.3.2 Claim Reimbursement Policy

A policy document that provides instructions on how to bill for services.

1.3.3 Coverage and Limitations Handbook or Coverage Policy

A policy document that contains coverage information about a Florida Medicaid service.

1.3.4 General Policies

A collective term for Florida Medicaid policy documents found in Rule Chapter 59G-1 containing information that applies to all providers (unless otherwise specified) rendering services to recipients.

1.3.5 Medically Necessary/Medical Necessity

As defined in Rule 59G-1.010, F.A.C.

1.3.6 Provider

The term used to describe any entity, facility, person, or group that has been approved for enrollment or registered with Florida Medicaid.

1.3.7 Quality Improvement Organization

Entity designated to perform utilization review, quality assurance, and quality improvement activities for Florida Medicaid-covered services rendered by fee-for service providers (also known as the QIO).

2.4.3 Modifications

Providers must submit a modification request to the QIO to update the authorization when the recipient requires a different level of service (amount, frequency, duration, or scope) than is currently authorized. Providers must submit additional information documenting the need for the change, including an updated physician's order and plan of care (as applicable) with the request.

Authorizations Policy, pages 1 and 3.

19. In the instant case, Respondent reduced Petitioner's personal care services from 96 hours per week to 40 hours per week. *See supra* ¶ 7. As established on the record by the evidence and testimony, Respondent reduced Petitioner's personal care services, because the documentation submitted in support of Petitioner's request failed to establish that the requested services were medically necessary. *See supra* ¶ 5 and 6.

20. Section 4.1 of the LTC Policy provides that Florida Medicaid LTC plans cover services that: are medically necessary, as defined in the SMMC LTC Policy; do not duplicate another service; and meet the criteria as specified in the SMMC LTC Policy. *See supra* ¶ 15. Section 4.2.2.6 of the SMMC LTC Policy reflects that personal care services are "[t]o 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.” See supra ¶ 15.

21. The evidence presented in this case reflects that Respondent’s reduction of personal care services is warranted under the circumstances of this case. Specifically, Regarding IADLs, Petitioner’s status is total dependence – full performance by others during entire period for meal preparation; ordinary housework; managing finances; managing medications; managing full flight of stairs; shopping; and transportation. See supra ¶ 3. Regarding ADLs, Petitioner’s status is total dependence – full performance by others during all episodes for the following: bathing; personal hygiene; dressing upper body; dressing lower body; walking; locomotion; toilet transfer; toilet use; bed mobility; and eating. See supra ¶ 4. Petitioner uses a wheelchair or scooter, and is incontinent of bowel and bladder. See supra ¶ 4. Petitioner has a primary diagnosis of persistent vegetative state, and he has traumatic brain injury, hemiplegia, and other medical conditions. See supra ¶ 2. It is undisputed that Petitioner requires 24-hour care and assistance. See supra ¶ 2, 8 and 10. However, Petitioner resides in the home with his parents. See supra ¶ 2. Currently, [REDACTED] provides Petitioner’s personal care services at night during the following times: 5:30 p.m. to 8:30 a.m. on Monday, Tuesday, Thursday, and Friday; and 8:00 p.m. to 8:30 a.m. on Wednesday, Saturday and Sunday. See supra ¶ 10. Additionally, Petitioner receives 76 hours per week of skilled nursing services. See supra ¶ 9. The record reflects that [REDACTED] is trained to provide care to Petitioner and available Provide Petitioner’s care. See supra ¶ 8 and 10. [REDACTED] did not dispute that she is trained and available to provide Petitioner’s care. At hearing, [REDACTED] argued that if she does not provide the services to Petitioner, then she will have to go outside the home and work. However, pursuant to section 2.4.3 of the Authorizations Policy, [REDACTED]

██████ can submit a “modification request” to Respondent “to update the authorization when the recipient requires a different level of service (amount, frequency, duration, or scope) than is currently authorized.” See supra ¶ 18. In light of that fact that ██████ currently lives in the home with Petitioner and is trained and available to provide Petitioner’s care, Respondent’s position that ██████ is providing natural support appears to be reasonable under the circumstances of this case. Based upon the evidence presented by both parties, Respondent established that a reduction of personal care services was warranted in this matter.

22. Additionally, section 1.3.14 of the LTC Policy requires that “LTC supportive services must . . . [b]e individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient’s needs.” See supra ¶ 15. In addition to personal care services, Petitioner is currently authorized to receive the following services: 76 hours per week of skilled nursing services; 10 hours per week of homemaker services; and 40 hours per week of personal care services. See supra ¶ 9. Once services are authorized, Petitioner can adjust times the services are provided to meet his needs. See supra ¶ 9. Considering the LTC Policy’s definitions for homemaker services and personal care services, *supra* ¶ 15, Respondent demonstrated that Petitioner’s aforementioned needs, *supra* ¶ 2 – 4, 10, and 20, are sufficiently met by his currently authorized services. Given that Respondent established that the reduction of personal care services is warranted in this matter, *supra* ¶ 21, the requested 96 hours per week of personal care services is “in excess of [Petitioner’s] needs.” See supra ¶ 15.

23. Appurtenant to this matter, section 1.3.14 of the LTC Policy provides that natural supports are “[u]npaid supports that are provided voluntarily to the individual in lieu of home and community-based services and supports.” See supra ¶ 15. Petitioner resides in the home with

██████████ and her husband. See supra ¶ 2 and 10. The record reflects that ██████████'s husband is self-employed, works Monday through Saturday and sometimes Sunday, and does not assist with Petitioner's care or appointments. See supra ¶ 10. However, the record does not reflect that ██████████'s husband is physically incapable of providing assistance to Petitioner. Further, ██████████ is trained to provide care to Petitioner and available Provide Petitioner's care. See supra ¶ 8 and 10. Therefore, Petitioner has natural supports available to assist with his care and needs.

24. In light of the both parties' testimony, Respondent's Composite Exhibit 1, the SMMC LTC Policy, the Authorization Requirements Policy, and the Definitions Policy, the undersigned Hearing Officer finds that Respondent met its burden of proving that the reduction of personal care services from 96 hours per week to 40 hours per week is medically necessary.

25. Accordingly, the undersigned Hearing Officer finds that Respondent proved by a preponderance of the evidence that Respondent's reduction of personal care services was correct.

DECISION

Respondent's reduction of personal care services from 96 hours per week to 40 hours per week is **AFFIRMED**. Petitioner's appeal based on Respondent's reduction in this matter is **DENIED**.

DONE AND ORDERED this 23rd day of October, 2020, in Tallahassee, Leon County, Florida.

Tracie Hardin
20-FH ██████████
2020.10.23 07:49:11
-04'00'

TRACIE HARDIN, Hearing Officer
Agency for Health Care Administration

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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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