



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

**FILED**

Aug 10, 2020, 2:21 pm  
OFFICE OF FAIR HEARINGS

[REDACTED]

PETITIONER,

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

vs.

UNITEDHEALTHCARE OF FLORIDA, INC.,

RESPONDENT.

\_\_\_\_\_ /

[REDACTED]

PETITIONER,

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

vs.

UNITEDHEALTHCARE OF FLORIDA, INC.,

RESPONDENT.

\_\_\_\_\_ /

**FINAL ORDER**

Pursuant to notice, the undersigned Hearing Officer convened a telephonic Fair Hearing in the above-styled case on August 5, 2020, at [REDACTED]

**APPEARANCES**

For the Petitioner:

[REDACTED]  
Authorized Representative

For the Respondent:

Deborah Havey-Levy  
Program Integrity Manager  
UnitedHealthcare of Florida, Inc.

**STATEMENT OF ISSUE**

The first issue is whether Petitioner proved by a preponderance of the evidence that Respondent's denial of thirty-five (35) hours per week of Adult Companion Care services was incorrect.

The second issue is whether Petitioner proved by a preponderance of the evidence that Respondent's denial of thirty-one (31) Home-Delivered Meals per month was incorrect.

**PRELIMINARY STATEMENT**

All parties and witnesses appeared telephonically. [REDACTED] ("Petitioner's Authorized Representative" or "[REDACTED]"), appeared for the Fair Hearing on behalf of Petitioner to offer testimony and did not call any witnesses.

Deborah Havey-Levy, Program Integrity Manager for UnitedHealthcare of Florida, Inc. ("United"), appeared as a representative for Respondent. Dr. Sloan Karver ("Dr. Karver"), Medical Director for United, appeared as a witness for Respondent.

Lisa Sanchez, 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 did not introduce any exhibits at the Fair Hearing. Prior to the hearing, Respondent sent to the Office of Fair Hearings and Petitioner a two hundred and sixty (260)-page evidence packet. The evidence packet, which was admitted into evidence as Respondent's Composite Exhibit 1, includes the following documents: a Statement of Matters; a Notice of Adverse Benefit Determination ("NABD") (dated June 16, 2020); CSP – General Request Form – [REDACTED]; a Plan Appeal Acknowledgement letter (dated June 17, 2020); a letter from Respondent (dated June 17, 2020); a time-stamped envelope; Sharecare blank documents; a letter from Respondent (dated June 17, 2020); [REDACTED] medical

records (dated [REDACTED] 2020, [REDACTED] 2018, and [REDACTED] 2018); Print HSC History - HSR Production Environment; Florida Department of Elder Affairs 701B Comprehensive Assessment (701-B Comprehensive Assessment) (dated [REDACTED] 2020); Appeal Review notes (undated); a Notice of Plan Appeal Resolution (“NPAR”) (dated July 17, 2020); Exhibit 2 (References) Cover Page – Long Term Care; Florida Administrative Code Rule (“Fla. Admin. Code R.”) 59G-1; Florida Medicaid Definitions Policy (“Definitions Policy”) (August 2017); Florida Medicaid Statewide Medicaid Managed Care Long-term Care Program Coverage Policy (“LTC Policy”) (March 2017); Florida Medicaid Authorization Requirements Policy (June 2016); Florida Medicaid Personal Care Services Coverage Policy (November 2016); Florida Medicaid Private Duty Nursing Services Coverage Policy (November 2016); Home Health Visit Services Fee Schedule (January 2017); Personal Care Services Fee Schedule (January 2017); Private Duty Nursing Services Fee Schedule (January 2017); AHCA’s Participant Direction Option (PDO) Manual; 42 C.F.R. § 441.480; Florida Medicaid Hospice Services Coverage Policy (“Hospice Policy”) (June 2016); 42 C.F.R. 418 Subpart C – Conditions of Participation: Patient Care; Florida Statute (“Fla. Stat.”) § 400.6105 (2018); Fla. Stat. § 400.609 (2018); Fla. Stat. § 409.910 (2018); Fla. Stat. § 400.462 (2018); and an additional copy of Fla. Admin. Code R. 59G-1.

### **FINDINGS OF FACT**

1. Petitioner receives Medicaid services through United’s Long-term Care (LTC) program. United is a Medicaid Managed Care organization contracted by AHCA to provide services to eligible Medicaid recipients in the State of Florida.
2. Petitioner is a sixty-one (61) year old man residing in the community with a primary caregiver. See Respondent’s Composite Exhibit 1, pages 53-70. As of [REDACTED] 2020, Petitioner has

been enrolled into Hospice services. *Id.* at 55. Petitioner resides with his wife. *Id.* at 57. Petitioner is on oxygen 24 hours per day and has PIC line that must be flushed daily. *Id.* at 60. Hospice services are coming into the home to treat the member weekly. *Id.* at 61. According to Respondent's Case Manager [REDACTED] who conducted the the 701-B Comprehensive Assessment (dated May 15, 2020), Petitioner needs supervision relating to physical health. *Id.* at 62.

3. According to the 701-B Comprehensive Assessment, Petitioner needs assistance (but not total help) with Activities of Daily Living ("ADLs") such as bathing. *Id.* at 57. Petitioner needs no assistance with ADLs such as dressing, using the bathroom, and transferring. *Id.* Petitioner uses an assistive device for walking and mobility. *Id.* Petitioner needs supervision or prompt with eating. *Id.* According to the 701-B Comprehensive Assessment, Petitioner needs assistance (but not total help) with Instrumental Activities of Daily Living ("IADLs") such as using the telephone. *Id.* at 58. Petitioner needs total assistance (cannot do at all) with IADLs such as heavy chores, light housekeeping, managing money, preparing meals, shopping, managing medication, and using transportation.

*Id.*

4. On June 16, 2020, United issued an NABD denying Petitioner's request for thirty-five (35) hours per week of Adult Companion Care services and thirty-one (31) Home-Delivered Meals per month. *Id.* at 5-6. The NABD stated:

UnitedHealthcare Community Plan has reviewed your request for 35 hours a week of Adult Companion Care and 31 Home Delivered Meals a month, which we received on 06/11/2020. After our review, this service has been:

DENIED as of 06/16/2020.

We made our decision because:  
(Check all boxes that apply)

- **Other authority:** F.A.C. 59G-4.192 - Statewide Medicaid Managed Care Long-Term Care Program Coverage Policy. A service cannot duplicate another service.

The facts that we used to make our decision are: A Long Term Care doctor reviewed your request for Adult Companion Care and Home Delivered Meals. You are getting Hospice. The service you asked for should be provided by hospice.

*Id.*

5. Respondent's Appeal Review notes state the following:

Services requested: Companion Care New Request from 0 hours per week to 35 hours per week. (+35)

Services requested: Home Delivered Meals New Request 31 meals per month

Current services:

- Hospice
- Personal Care 15 hr per week

Age/diagnosis: 61 year old male with diagnosis of CHF, Polycythemia Vera, Anxiety, Depression, Chronic Pain, HTN, Pulmonary Heart Disease, Hx Cocaine use, Smoker .

- Living situation/supports: Member lives with wife/primary CG and stepson. Reported they are able to assist the member with all ADL's and IADL's when home.

\*\*Per 6/17 CM note: \* Wife reported during call she is no longer working. Stated she lost her job yesterday.

- Appeal information received from member or provider: Member wife stated that UHC is incorrect she has spoke with Hospice and she has two different case workers there and she was advised that they do not offer meal services and they do not offer any companion care only a skilled nurse comes out she is currently employed fulltime and she needs someone to be there with her husband 40 hrs a week

Functional Assessment Tool: UHC Assessment Tool: 701B Comprehensive Assessment

Assessment Date: 5/15/2020

Summary of tool results:

- Bathing: Needs assistance (but not total help)
- Dressing: No assistance needed
- Eating: Needs supervision or prompt
- Toileting: No assistance needed
- Transfers: No assistance needed
- Ambulation: Uses assistive device
- Heavy chores: Needs total assistance (cannot do at all)
- Light housekeeping: Needs total assistance (cannot do at all)
- Using telephone: Needs assistance (but not total help)
- Managing money: Needs total assistance (cannot do at all)
- Preparing meals: Needs total assistance (cannot do at all)
- Shopping: Needs total assistance (cannot do at all)
- Medication Management: Needs total assistance (cannot do at all)
- Using Transportation: Needs total assistance (cannot do at all)

Nutritional Status:

- Height: 5'9"
- Weight: 162
- BMI: not noted
- Albumin: not noted

At time of assessment, number of:

- o Falls in the last [REDACTED]: 1
- o ED visits in the last year: 2
- o Hospitalizations in the last year: 3

Pertinent Case Manager Notes:

Member with Increased confusion, decline in condition and unable to be left alone—per wife No changes in ADL/IADL's since last assessment. Remains on Hospice and has supports in the homewife/ primary CG and step-son.

701-B: Needs assistance with bathing and using the telephone. Needs total assistance with heavy chores, housekeeping, managing money, preparing meals, shopping, managing medications and using transportation. Uses assistive device with walking/mobility. Needs supervision with eating. Is independent with dressing, using the bathroom and transferring.

Summary and Comments: Case information reviewed in nurse's note and agree. The member is a 61 year old male with diagnosis of CHF, Polycythemia Vera, Anxiety, Depression, Chronic Pain, HTN, Pulmonary Heart Disease, Hx Cocaine use, Smoker who is appealing the denial of home delivered meals.

Member lives with wife/primary CG and stepson. Reported they are able to assist the member with all ADL's and IADL's when home. Wife reported during call she is no longer working. Stated she lost her job yesterday.

*Id.* at 73-78.

6. On July 17, 2020, United issued an NPAR denying Petitioner's plan appeal. *Id.* at 81-82.

The NPAR stated as follows:

As part of our review we look at information you or your provider gave us. We also look at your benefits. Based on our review of your appeal, we have determined that the service you requested will not be approved.

Lisa Herbet, MD, United Medical Director, who specialized in Family Medicine, reviewed the appeal. This doctor did not make the original decision. The decision was based on Florida Administrative Code 59G-1.1010(166).

Part 1 of 2: You asked for home delivered meals. You asked for help preparing your meals. We cannot approved this because it is not medically necessary. Based on my professional judgment, this is in excess of your need. You also get help with your meals from family. You also have approved personal care services 15 hours a week. This is why we cannot approve what you asked for.

Part 2 of 2: You asked for companion care. We cannot approve this because it is not medically necessary. Based on my professional judgment, this is in excess of your need. You can also get help from family and paid caregivers. You also have approved personal care services 15 hours a week. This is why we cannot approve what you asked for.

I, Samuel T. Wilmit, MD, am a licensed Florida physician (License # ME 95845). I am Board Certified in Pediatrics. I have reviewed this case. I concur with the decision that was made by Lisa Herbert, M.D. I also concur with the rational used to arrive at that decision.

*Id.*

7. On July 17, 2020, Petitioner timely requested a Fair Hearing to contest the denial of Adult Companion Care services and the denial of Home-Delivered Meals.

8. Under oath, Petitioner's Authorized Representative testified that she is withdrawing the request of a Fair Hearing regarding Respondent's denial of thirty-one (31) meals per month of Home-Delivered Meals. [REDACTED] stated that the issue regarding Home-Delivered Meals has been resolved outside of the hearing, and did not need to be discussed at the hearing. Petitioner's Authorized Representative stated that United is now providing the Petitioner with Home-Delivered Meals.

9. [REDACTED] is the Petitioner's wife. In [REDACTED] 2020, Petitioner experienced hospitalization due to pneumonia, blood clot in left lung, congestive heart failure, renal failure, respiratory failure, and kidney failure. Petitioner was released from the hospital in [REDACTED] 2020. Petitioner requires the use of an oxygen tank "24/7." United's documentation does not indicate that the Petitioner accidentally set himself on fire at home after release from the home. Petitioner occurred second-degree burns later from scolding hot water. Petitioner is a safety risk to himself and is a frequent fall risk resulting in injuries. Petitioner's oxygen tank was not working while Petitioner was sleeping and he could not breath. [REDACTED] works sixty (60) hours per week and the Petitioner needs supervision when [REDACTED] is not present in the home. [REDACTED] lost her job on June 16, 2020, but begins work again August 6, 2020. [REDACTED] provides for the Petitioner's care when she is not working. Petitioner has no natural support outside of [REDACTED]. [REDACTED] argues that the Petitioner requires constant supervision. [REDACTED] alleged that the 701B Assessment is inaccurate because it has not been updated in the past ninety (90) days, and it does not reflect Petitioner's injuries from being set on fire, burns, and falls. [REDACTED] stated that United never asked questions about herself as a caregiver in the 701B Assessment. [REDACTED] argued that the Hospice agency does not provide home care services.

██████████ stated that the Hospice agency sends a nurse to the home once biweekly to evaluate the Petitioner. ██████████ claims that the services being requested are not offered by the Hospice agency. Petitioner is not at the stage in his life where he is expected to die within the next week. In closing, ██████████ speculated future injuries from a home accident if he does not have someone to ensure his safety when ██████████ is not present in the home.

10. Dr. Karver is a Medical Director for United. Respondent denied Petitioner's request for Adult Companion Care services because the Petitioner is enrolled into Hospice services, and United determined that the such services are duplicative. United's position is that the Hospice agency should provide the Petitioner with Adult Companion Care services, not United. Dr. Karver cited Florida Statute 400.6095 as legal authority that Hospice includes Adult Companion Care services. Petitioner continues to receive fifteen (15) hours per week of Personal Care services through Respondent to meet his needs.

#### **CONCLUSIONS OF LAW**

11. Pursuant to Fla. Stat. § 409.285(2) (2019), the Agency's Office of Fair Hearings has jurisdiction over the subject matter of this proceeding and the parties. This order is the final administrative decision of AHCA. See Fla. Stat. § 409.285(2)(a).

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

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.

(Emphasis added).

14. 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.).

#### **Respondent’s Denial of Home-Delivered Meals**

15. A Hearing Officer may deny or dismiss a Fair Hearing request if the Recipient files a written withdrawal of the request. A Hearing Officer may also deny or dismiss a Fair Hearing request if the Recipient testifies on the record that he or she wishes to withdraw the request. See Fla. Admin. Code. R. 59G-1.100(9)(b)(5)(a).

16. Petitioner’s Authorized Representative testified on the record that she is withdrawing the Petitioner’s request of a Fair Hearing regarding Respondent’s denial of thirty-one (31) meals per month of Home-Delivered Meals because the issue has been resolved outside of the hearing. See *supra* ¶ 8.

#### 17. **Respondent’s Denial of Adult Companion Care services**

18. 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.

19. The 701B Comprehensive Assessment is, “an individualized, complete assessment of an individual’s medical, developmental, behavioral, social, financial, and environmental status. . . .

to determine eligibility for the LTC program based on the need for a nursing facility level of care.”  
§ 1.3.5 of the LTC Policy.

20. Natural Supports are, “[u]npaid supports that are provided voluntarily to the individual in lieu of home and community-based services and supports.” § 1.3.16 of the LTC Policy.

21. The LTC Coverage Policy defines ADLs and IADLs as follows:

**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

...

**1.3.9 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)

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

#### **4.2.1 Home and Community-Based Supportive Services**

The LTC program benefit includes coverage of the following home and community-based supportive services:

##### **4.2.1.1 Adult Companion Care**

The provision of non-medical care, supervision when necessary to protect the health, safety, and well-being of the enrollee, or social enrichment of a functionally impaired enrollee. This includes assistance or supervision with meal preparation, laundry, and light housekeeping tasks incidental to the care and supervision of the enrollee.

##### **4.2.1.8 Home Delivered Meals**

The provision of nutritionally sound meals delivered to an enrollee's home when an enrollee has difficulty shopping for, or preparing food, without assistance. All meals must provide a minimum of 33 1/3% of the current Dietary Reference Intake. The meals must meet the current Dietary Guidelines for Americans, the United States Department of Agriculture My Pyramid Food Intake Pattern and reflect the predominant statewide demographic.

...

#### **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:

...

##### **4.2.2.3 Hospice**

In accordance with Rule 59G-4.140, F.A.C.

##### **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.

23. The Hospice Policy, which is incorporated by reference in Fla. Admin. Code R. 59G-4.140, governs Hospice services available to Medicaid recipients in the State of Florida.

24. Hospice services provide palliative care to terminally ill recipients. See § 1.1 of the Hospice Policy. The Hospice Policy states as follows:

## **2.2 Who Can Receive**

Florida Medicaid recipients requiring medically necessary hospice services who meet the following:

- Certified as terminally ill in accordance with 42 CFR 418.22
- Elected hospice in accordance with 42 CFR 418.24
  - Recipients under the age of 21 years are not required to forego curative treatment as a result of their hospice election, and may continue to receive medically necessary covered services under the Florida Medicaid program.

....

## **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 365/6 days of hospice services per year, per recipient, when the following criteria are met:

- The provider conducts an initial assessment in accordance with 42 CFR 418.54
- The provider develops and maintains a plan of care in accordance with section 400.6095, F.S.
- Services are rendered in accordance with 42 CFR 418.202 and 42 CFR 418.302

Providers must provide or arrange for the provision of necessary care and services to manage a recipient's terminal illness or related condition including:

### **4.2.1 Core Services**

The following services, included in the per diem payment, must be provided in accordance with 42 CFR 418.64:

- Counseling services
- Dietitian services
- Medical social services

- Nursing services
- Physician services

#### 4.2.2 Non-Core Services

The following services, included in the per diem payment, must be provided when specified in the recipient’s plan of care and in accordance with 42 CFR 418.70-78 and 42 CFR 418.106-108:

- Hospice aide services
- Medical supplies and durable medical equipment
- Pharmacy services
- Therapy services
- Volunteer services
- Any other item or service specified in the plan of care as reasonable and necessary for the palliation and management of the recipient’s terminal illness or related condition in accordance with 42 CFR 418.202

...

#### 4.2.4 Physician Services

Florida Medicaid reimburses for the following separately, in addition to the per diem payment, in accordance with the applicable Florida Medicaid fee schedule(s) when rendered by a practitioner licensed within the scope of their practice:

- Consultations provided by a physician whose opinion or advice regarding the evaluation or management of a specific problem is requested by another physician or the hospice
- Hospital services for the evaluation and management of initial hospital admission, subsequent care, and discharge services
- Nurse practitioner services in accordance with 42 CFR 418.304(2)
- Office and home visits

25. Fla. Stat. § 400.609(1) – (2) states the following:

**400.609 Hospice services.**—Each hospice shall provide a continuum of hospice services which afford the patient and the family of the patient a range of service delivery which can be tailored to specific needs and preferences of the patient and family at any point in time throughout the length of care for the terminally ill patient and during the bereavement period. These services must be available 24 hours a day, 7 days a week, and must include:

- 1) SERVICES.—
  - a. The hospice care team shall directly provide the following core services: nursing services, social work services, pastoral or counseling services, dietary counseling, and bereavement counseling services. Physician services may be provided by the hospice directly or through contract. A hospice may also use contracted staff if necessary to supplement hospice employees in

order to meet the needs of patients during periods of peak patient loads or under extraordinary circumstances.

- b. Each hospice must also provide or arrange for such additional services as are needed to meet the palliative and support needs of the patient and family. These services may include, but are not limited to, physical therapy, occupational therapy, speech therapy, massage therapy, home health aide services, infusion therapy, provision of medical supplies and durable medical equipment, day care, homemaker and chore services, and funeral services.
- 2) HOSPICE HOME CARE.—Hospice care and services provided in a private home shall be the primary form of care. The goal of hospice home care shall be to provide adequate training and support to encourage self-sufficiency and allow patients and families to maintain the patient comfortably at home for as long as possible. The services of the hospice home care program shall be of the highest quality and shall be provided by the hospice care team.
- 3)

26. Fla. Stat. § 400.6095 (2018) states the following:

**400.6095 Patient admission; assessment; plan of care; discharge; death.—**

- 1) Each hospice shall make its services available to all terminally ill persons and their families without regard to age, gender, national origin, sexual orientation, disability, diagnosis, cost of therapy, ability to pay, or life circumstances. A hospice shall not impose any value or belief system on its patients or their families and shall respect the values and belief systems of its patients and their families.
- 2) Admission to a hospice program shall be made upon a diagnosis and prognosis of terminal illness by a physician licensed pursuant to chapter 458 or chapter 459 and shall be dependent on the expressed request and informed consent of the patient.
- 3) At the time of admission, the hospice shall inquire whether advance directives have been executed pursuant to chapter 765, and if not, provide information to the patient concerning the provisions of that chapter. The hospice shall also provide the patient with information concerning patient rights and responsibilities pursuant to s. 381.026.
- 4) The admission process shall include a professional assessment of the physical, social, psychological, spiritual, and financial needs of the patient. This assessment shall serve as the basis for the development of a plan of care.
- 5) Each hospice, in collaboration with the patient and the patient's primary or attending physician, shall prepare and maintain a plan of care for each patient, and the care provided to a patient must be in accordance with the plan of care. The plan of care shall be made a part of the patient's medical record and shall include, at a minimum:

- a. Identification of the primary caregiver, or an alternative plan of care in the absence of a primary caregiver, to ensure that the patient's needs will be met.
  - b. The patient's diagnosis, prognosis, and preferences for care.
  - c. Assessment of patient and family needs, identification of the services required to meet those needs, and plans for providing those services through the Hospice team, volunteers, contractual providers, and community resources.
  - d. Plans for instructing the patient and family in patient care.
  - e. Identification of the nurse designated to coordinate the overall plan of care for each patient and family.
  - f. A description of how needed care and services will be provided in the event of an emergency.
- 6) The hospice shall provide an ongoing assessment of the patient and family needs, update the plan of care to meet changing needs, coordinate the care provided with the patient's primary or attending physician, and document the services provided.
  - 7) In the event a hospice patient chooses to be discharged or transferred to another hospice, the hospice shall arrange for continuing care and services and complete a comprehensive discharge summary for the receiving provider.
  - 8) The Hospice team may withhold or withdraw cardiopulmonary resuscitation if presented with an order not to resuscitate executed pursuant to s. 401.45. The agency shall adopt rules providing for the implementation of such orders. Hospice staff shall not be subject to criminal prosecution or civil liability, nor be considered to have engaged in negligent or unprofessional conduct, for withholding or withdrawing cardiopulmonary resuscitation pursuant to such an order and applicable rules. The absence of an order to resuscitate executed pursuant to s. 401.45 does not preclude a physician from withholding or withdrawing cardiopulmonary resuscitation as otherwise permitted by law.
  - 9) The death of a person enrolled as a hospice patient shall be considered an attended death for the purposes of s. 406.11(1)(a)5. However, a hospice shall report the death to the medical examiner if any unusual or unexpected circumstances are present

27. 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.

28. 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.

29. The evidence admitted and testimony presented established that sixty-one (61) year old man residing in the community with [REDACTED]. See supra ¶ 2. Respondent currently provides the Petitioner with fifteen (15) hours per week of Personal Care services. See supra ¶ 5 and 10.

Petitioner is on oxygen twenty-four (24) hours per day and has PIC line that must be flushed daily. *See supra* ¶ 2. Petitioner needs supervision relating to physical health. *See supra* ¶ 2. Petitioner has a history of falls, emergency visits, and hospitalizations. *See supra* ¶ 5. In March 2020, Petitioner experienced hospitalization due to pneumonia, blood clot in left lung, congestive heart failure, renal failure, respiratory failure, and kidney failure. *See supra* ¶ 9. Petitioner has a history of burning himself, falls resulting in injuries, and setting himself on fire. *See supra* ¶ 9.

30. The LTC Policy covers Adult Companion Care services that are determined to be medically necessary. *See supra* ¶ 22. To be medically necessary, the requested Adult Companion Care services must meet the five criteria set forth in section 1.3.14 of the LTC Policy. *See supra* ¶ 27. Based on Respondent's NPAR, Respondent denied Petitioner's request for thirty-five (35) hours per week of Adult Companion Care services for not meeting the following medical necessity standard: must be individualized, specific, consistent with symptoms or diagnosis of illness or injury and not be in excess of the patient's needs. *See supra* ¶ 6. However, the record indicates that the Petitioner's well-being without supervision is at-risk due to evidence of oxygen tank failure preventing the Petitioner from breathing, falls resulting in injury, second-degree burns, and accidentally setting himself on fire in the home. *See supra* ¶ 9. Petitioner's medical condition is significant with a month-long hospitalization due to pneumonia, blood clot in left lung, congestive heart failure, renal failure, respiratory failure, and kidney failure. *See supra* ¶ 9. Petitioner's Authorized Representative testified that she provides care for the Petitioner when she is present in the home, but argued that the Petitioner needs supervision when she is working because the Petitioner has no other natural support. *See supra* ¶ 9. Respondent's case manager notes state, "[Petitioner] with Increased confusion, decline in condition and unable to be left

alone.” See supra ¶ 5. Further, the 701-B Comprehensive Assessment indicates, “Petitioner needs supervision relating to physical health.” See supra ¶ 2. The undersigned also considered the natural support of Petitioner’s Authorized Representative and the currently approved Personal Care services, and notes that, at the hearing, Respondent did not dispute the medical necessity of the requested Adult Companion Care services. Upon consideration of the aforementioned facts, Petitioner’s Authorized Representative established that the requested thirty-five (35) hours per week of Adult Companion Care services to provide supervision necessary to protect the Petitioner’s health, safety, and well-being is not in excess of the Petitioner’s needs. Thus, the Petitioner has met the LTC Policy’s criterion at issue for medical necessity.

31. However, Respondent also denied Petitioner’s request for thirty-five (35) hours per week of Adult Companion Care services because the Adult Companion Care services duplicate another service the Petitioner is receiving, Hospice services. See supra ¶ 4; see also Respondent’s Composite Exhibit 1, pages 5-6. Specifically, Dr. Karver argued that the Hospice agency is responsible for providing Adult Companion Care services, not United. Petitioner’s Authorized Representative argued that the Petitioner is not at the end of life stage, and that the Hospice agency only sends a nurse to the Petitioner’s home once biweekly to evaluate the Petitioner’s condition. Petitioner’s Authorized Representative testified that the Petitioner does not receive home health care services from the Hospice agency. Based on the record, both [REDACTED] and Dr. Karver are in agreement that the Petitioner is enrolled into Hospice services.

32. The LTC Policy covers Adult Companion Care services that do not duplicate another service. See supra ¶ 22. The Hospice Policy governs Hospice services available to terminally ill Medicaid recipients to provide palliative care to terminally ill recipients. See supra ¶ 23-24. The

LTC Policy defines Adult Companion Care services as, “non-medical care, supervision when necessary to protect the health, safety, and well-being of the enrollee.” *See supra* ¶ 22. Respondent asserted that Hospice services duplicate the requested Adult Companion Care services. The Hospice agency shall directly provide the following core services: nursing services, social work services, pastoral or counseling services, dietary counseling, and bereavement counseling services. *See Fla. Stat. § 400.609*. Florida Statute also requires that the Hospice agency provide additional services needed to meet the palliative and support needs of the patient and family. *See Fla. Stat. § 400.609(1)(b)*. The Hospice Policy requires that the following core and non-core services must be provided: counseling services, dietitian services, medical social services, nursing services, physician services, hospice aide services, medical supplies, durable medical equipment, pharmacy services, therapy services, and volunteer services. *See supra* ¶ 24. In addition, the Hospice agency must provide “Any other item or service specified in the plan of care as reasonable and necessary for the palliation and management of the recipient’s terminal illness or related condition in accordance with 42 CFR 418.202.” *See supra* ¶ 24. Respondent asserted Fla. Stat. § 400.6095 as proof that Adult Companion Care services and Hospice services duplicate one another. *See supra* ¶ 10.

33. Petitioner’s Authorized Representative argued that Adult Companion Care services and Hospice services do not duplicate one another because the Hospice agency only conducts a biweekly evaluation regarding the Petitioner’s condition. *See supra* ¶ 9. In addition, Petitioner’s Authorized Representative argued that the Petitioner is not at the end-of-life stage at this time. *See supra* ¶ 9. However, the record indicates that the Petitioner is enrolled into Hospice services with a provider. The fact that Petitioner may only be receiving a biweekly nursing assessment

from the Hospice agency is not sufficient evidence, in itself, that Adult Companion Care services are not covered by the Hospice Policy and Florida Statute. The record does not indicate that Petitioner proved by a preponderance of the evidence that Adult Companion Care services are not included in Hospice services as, “such additional services as are needed to meet the palliative and support needs of the patient and family,” given that Adult Companion Care services are “the non-medical care, supervision when necessary to protect the health, safety, and well-being of the enrollee.” See supra ¶ 22. Further, Fla. Stat. § 400.609(2)(b) mandates that such services covered are not limited to the services explicitly listed. It appears that the Petitioner should seek relief through the Hospice provider, not the LTC program. The undersigned finds that the approval of Adult Companion Care services provided by the Respondent under the LTC program would be a duplication of services already covered by Hospice services.

34. Accordingly, in light of the both parties’ sworn testimony, Respondent’s Composite Exhibit 1, the LTC Policy, Petitioner’s current LTC services, Petitioner’s natural support, and the applicable rules and regulations, the undersigned Hearing Officer finds that Petitioner did not prove by a preponderance of the evidence that Respondent’s denial of Petitioner’s request for thirty-five (35) hours per week of Adult Companion Care services was incorrect.

#### **DECISION**

Respondent’s denial of thirty-five (35) hours per week of Adult Companion Care services is **AFFIRMED**. Petitioner’s request for relief is hereby is **DENIED**.

Petitioner’s Medicaid Fair Hearing request regarding AHCA Case Number 20-FH [REDACTED] is hereby deemed **WITHDRAWN**, and this matter is now closed.

**DONE and ORDERED** this 10th day of August, 2020, in Tallahassee, Leon County, Florida.



Digitally signed by Kristopher León  
Reason: 20-FH[REDACTED]; 20-FH[REDACTED]  
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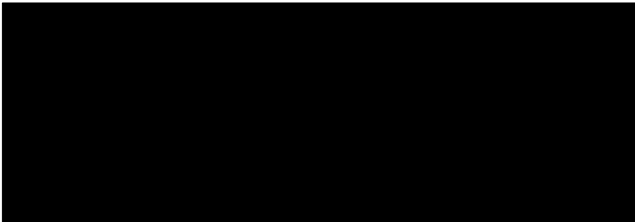
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**NOTICE OF A RIGHT TO JUDICIAL REVIEW**

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.

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