

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



FILED

Sep 25, 2020, 4:42 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.

_____ /

[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.

_____ /

[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 Medicaid Fair Hearing in the above-styled case on September 21, 2020, at [REDACTED]

[REDACTED]

APPEARANCES

For the Petitioner:

[REDACTED]

Petitioner's Authorized Representative

For the Respondent: Davida Jones
 State Fair Hearing Coordinator
 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 an additional 42 hours per week of personal care services was incorrect.

The second issue is whether Petitioner proved by a preponderance of the evidence that Respondent’s denial of 1 intermittent and skilled nursing visit per day and medical equipment and supplies (Biatain Alginate 3x44cm/1x17in, Vashe wound solution 8.5oz, 3M Cavilon durable barrier creme, Zinc wound wash 4oz, Egosan Maxi diapers 2 cases per month, Mckession Lite Hydrocellular foam dressing with silicone adhesive border 3 boxes per month, Mckession saline wound flush monthly, fracture bed pan, commode chair, electric commode chair, air fluidized mattress, total care bariatric bed, heel or elbow protector, positioning cushion, customized manual wheelchair, and bed accessory table) is incorrect.

PRELIMINARY STATEMENT

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

Davida Jones, State Fair Hearing Coordinator for UnitedHealthcare of Florida, Inc. (“United”), appeared as a representative for Respondent. Dr. Sloan Karver (“Dr. Karver”), Long Term Care (“LTC”) Medical Director for United, appeared as a witness for Respondent.

Linda Latson, Registered Nurse Specialist and Fair Hearing Liaison for the Agency for Health Care Administration (“Agency” or “AHCA”), appeared for observational purposes.

Prior to the hearing, Petitioner sent to the Office of Fair Hearings and Respondent a 54-page evidence packet. The packet included the following documents: an email from [REDACTED] to the Office of Fair Hearings (“OFH”), dated September 21, 2020, sent at 8:39 a.m.; the Complaint Detail, dated July 11, 17, and 23, 2020, and August 5 and 7, 2020; a printout from Respondent; the Parent or Legal Guardian Work Schedule, dated September 18, 2020; the documentation from the State of Florida Department of State, dated May 14, 2020; [REDACTED]’s Business Plan, dated September 13, 2018; the Parent or Legal Guardian Work Schedule for September 24, 2020 through December 15, 2020; the Enrollment Verification Certificate, dated September 19, 2020; [REDACTED]’s schedule of classes; [REDACTED]’s Transcript; a Certificate of Membership from [REDACTED] a membership card from [REDACTED]; an [REDACTED] Credential Verification Report, dated September 20, 2020; a membership card from the [REDACTED] a certificate from [REDACTED], dated February 17, 2020; a certificate from [REDACTED], dated December 15, 2015; and the Principles of Best Practice, A world Union of Would Healing Societies’ Initiative. Absent an objection from Respondent, the undersigned admitted Petitioner’s 54-page evidence packet into evidence as Petitioner’s Composite Exhibit 1.

Prior to the hearing, Petitioner sent to the Office of Fair Hearings and Respondent a 39-page evidence packet. The packet included the following documents: an email from [REDACTED] to the OFH, dated September 21, 2020, sent at 9:15 a.m.; and photographs of Petitioner’s wounds, dressing, medications, and medical treatments. Absent an objection from Respondent,

the undersigned admitted Petitioner's 39-page evidence packet into evidence as Petitioner's Composite Exhibit 2.

Prior to the hearing, Petitioner sent to the Office of Fair Hearings and Respondent a 66-page evidence packet. The packet included the following documents: emails from [REDACTED] to the OFH, dated September 21, 2020, sent at 9:34 a.m., 9:13 a.m., and 9:16 a.m.; Petitioner's medical records, dated [REDACTED], 2020; Petitioner's laboratory results, dated [REDACTED] and [REDACTED] 2020; a letter from [REDACTED] ("[REDACTED]"), dated September 1, 2020; Petitioner's medical records, dated [REDACTED], 2014; 8 letters of Medical Necessity for Certified Nursing Assistant ("CNA") or Home Health Care Aide (T1021), dated August 28, 2020; the guidelines and recommendations on early mobilization in prophylaxis or therapy of pulmonary disorders, published online on September 3, 2015; and United's Air -Fluidized Bed (NCD 280.8), dated June 10, 2020. Absent an objection from Respondent, the undersigned admitted Petitioner's 66-page evidence packet into evidence as Petitioner's Composite Exhibit 3.

Prior to the hearing, Petitioner sent to the Office of Fair Hearings and Respondent a 31-page evidence packet. The packet included the following documents: an email from [REDACTED] to the OFH, dated September 21, 2020, sent at 9:49 a.m.; a list of AHCA cases; an Exhibit List; Petitioner's medical records, dated September 1 and 8, 2020; photographs of Petitioner's wounds; an emails in Spanish; an email from [REDACTED] to [REDACTED], dated September 15, 2020; the Wound Care Steps; Petitioner's medical records for July 31, 2020; Appendix 9.1 of the Florida Medicaid Personal Care Services Coverage Policy, November 2016; and United's coversheet for Exhibit 2 (References) Coverage Page – Long Term Care. Absent an objection from Respondent, the undersigned admitted Petitioner's 31-page evidence packet into evidence as

Petitioner's Composite Exhibit 4.

Prior to the hearing, Petitioner sent to the Office of Fair Hearings and Respondent a 10-page evidence packet. The packet included the following documents: an email from [REDACTED] to the OFH, dated September 21, 2020, sent at 10:01 a.m.; a list of AHCA cases; an Exhibit List; the Questions Related to Exhibit List; a document with the words Court of Appeal; a document entitled Contents; a document with the word Judges; a document with the word Broadcasting; and a document with the words Works cited. Absent an objection from Respondent, the undersigned admitted Petitioner's 10-page evidence packet into evidence as Petitioner's Composite Exhibit 5.

Prior to the hearing, Respondent sent to the Office of Fair Hearings and Petitioner a 384-page evidence packet. The packet included the following documents: a Medicaid Fair Hearing Statement of Matters; an address page; a blank page; a Notice of Adverse Benefit Determination ("NABD") (PLAN ID: [REDACTED]), dated August 6, 2020; 5 address pages; 5 blank pages; 5 NABDs, each dated August 7, 2020 (PLAN ID: [REDACTED], PLAN ID: [REDACTED], PLAN ID: [REDACTED] PLAN ID: [REDACTED] and PLAN ID: [REDACTED]); Respondent's CSP – General Request Form; an address page; a blank page; Respondent's letter to Petitioner, dated August 7, 2020; an address page; a blank page; Respondent's letter to Petitioner, dated August 27, 2020; 2 copies of Respondent's CSP – General Request Form; emails from Donna Eden, dated August 24 and 25, 2020; Respondent's internal file on Petitioner; the Florida Department of Elder Affairs: 701B Comprehensive Assessment ("701B"), reflecting an assessment date of July 28, 2020; a 13-page facsimile transmission ("fax") from [REDACTED], to Respondent, dated August 8, 2020; a 2-page fax from Isbel to [REDACTED], dated August 29, 2020; a 2-page fax from

██████████, dated September 1, 2020; a 3-page fax from ██████████, dated September 1, 2020; Respondent's Appeal Review notes; an address page; a blank page; a Notice of Plan Appeal Resolution ("NPAR"), dated August 24, 2020; an address page; a blank page; an NPAR, dated August 27, 2020; Respondent's CSP – General Request Form; a blank page; an address page; the Spanish version of the letter from Respondent to Petitioner, dated August 7, 2020; a blank page; an address page; the Spanish version of the letter from Respondent to Petitioner, dated August 27, 2020; a blank page; an address page; 2 copies of the Spanish version of the letter from Respondent to Petitioner, dated August 27, 2020; a Certification from Interpreting Services International, Inc., dated August 13, 2020; Exhibit 2 (References) Cover Page – Long Term Care; Fla. Admin. Code R. 59G-1; Florida Medicaid Statewide Medicaid Managed Care Long-term Care Program Coverage Policy (March 2017) ("SMMC LTC Policy"); Florida Medicaid Authorization Requirements Policy (June 2016); Florida Medicaid Personal Care Services Coverage Policy (November 2016) ("PC Policy"); Florida Medicaid Private Duty Nursing Services Coverage Policy (November 2016); Home Health Visit Services Fee Schedule (January 1, 2017); Personal Care Services Fee Schedule (January 1, 2017); Private Duty Nursing Services Fee Schedule (January 1, 2017); the Agency's Participant Direction Option Manual; 42 C.F.R. 441.480; Florida Medicaid Hospice Services Coverage Policy (June 2016); 42 C.F.R. 418 Subpart C – Conditions of Participation: Patient Care; Section 400.6105 of the Florida Statutes ("Fla. Stat.") (2018); Fla. Stat. § 400.609 (2018); Fla. Stat. § 409.910 (2018); Fla. Stat. § 400.462 (2018); and a second copy of Fla. Admin. Code R. 59G-1. Over Petitioner's objection, the undersigned admitted Respondent's evidence packet into evidence as Respondent's Composite Exhibit 1.

FINDINGS OF FACT

1. Petitioner is an enrolled member of United's Florida Medicaid Managed Medical Assistance ("MMA") plan. See Respondent's Composite Exhibit 1, page 90. United is a managed care organization contracted by AHCA to provide services to eligible Medicaid recipients in Florida.

2. Petitioner is a 55-year-old female who lives in a private residence with her daughter, [REDACTED]. See Respondent's Composite Exhibit 1, pages 105 and 106.

3. The 701B reflects the following regarding Petitioner's Activities of Daily Living ("ADLs"). Petitioner needs total assistance with all ADLs, which include: bathing; dressing; eating; using the bathroom; transferring; and walking/mobility. See Respondent's Composite Exhibit 1, page 109.

4. The 701B reflects the following regarding Petitioner's Instrumental Activities of Daily Living ("IADLs"). Petitioner needs total assistance (cannot do at all) with all ADLs, which include: heavy chores; light housekeeping; using the telephone; managing money; preparing meals; shopping; managing medication; and using transportation. See Respondent's Composite Exhibit 1, page 110. The 701B also states the following:

Due to member's medical condition, member needs supervision
.....
Member's daughter administers medications to member

Respondent's Composite Exhibit 1, pages 114 and 118.

5. On August 6, 2020, Respondent issued an NABD (PLAN ID: [REDACTED]) denying Petitioner's request for an additional 42 hours per week of personal care services, explaining that the requested services are not medically necessary. See Respondent's Composite Exhibit 1, page

6.

6. On August 7, 2020, Respondent issued an NABD (PLAN ID: [REDACTED]) denying Petitioner's request for medical equipment and supplies (air fluidized mattress; total care bariatric bed), explaining that the requested items are not medically necessary. See Respondent's Composite Exhibit 1, page 17.
7. On August 7, 2020, Respondent issued an NABD (PLAN ID: [REDACTED]) denying Petitioner's request for (standard bed pan; fracture bed pan; commode chair; electric commode chair), explaining that the requested items are not medically necessary. See Respondent's Composite Exhibit 1, page 29.
8. On August 7, 2020, Respondent issued an NABD (PLAN ID: [REDACTED]) denying Petitioner's request for (heel or elbow protector; positioning cushion; customized manual wheelchair; bed accessory table), explaining that the requested items are not medically necessary. See Respondent's Composite Exhibit 1, page 40.
9. On August 7, 2020, Respondent issued an NABD (PLAN ID: [REDACTED]) denying Petitioner's request for (Mckession Lite Hydrocellular foam dressing with silicone adhesive border 3 boxes per month; Mckession saline wound flush monthly), explaining that the requested items are not medically necessary. See Respondent's Composite Exhibit 1, page 51.
10. On August 7, 2020, Respondent issued an NABD (PLAN ID: [REDACTED]) denying Petitioner's request for (Biatain Alginate 3x44cm/1x17in; Vashe wound solution 8.5 oz; 3M Cavilon durable barrier crème; Zinc wound wash 4 oz; Egosan Maxi diapers 2 cases per month), explaining that the requested items are not medically necessary. See Respondent's Composite Exhibit 1, page 62.

11. Petitioner requested a plan appeal. See Respondent's Composite Exhibit 1, pages 74 and 80. On August 24, 2020, Respondent sent Petitioner an NPAR, denying Petitioner's plan appeal.

See Respondent's Composite Exhibit 1, page 184. The NPAR stated as follows:

On August 06, 2020 we received your timely plan appeal request regarding UnitedHealthcare Community Plan's Notice of Adverse Benefit Determination dated August 6, 2020, [REDACTED], denying the Personal Care (42 more hours/week) provided to [Petitioner].

On August 14, 2020, after consideration of the information you provided to UnitedHealthcare Community Plan in support of your plan appeal, UnitedHealthcare hereby denies your plan appeal.

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.

Ellen Dar MD, UnitedHealthcare Medical Director, who is a Medical Doctor, Board Certified in Family Medicine reviewed the appeal. This doctor did not make the original decision. The decision was based on Florida Medicaid rules: Other, FL LTC Definition of Medical Necessity: F.A.C. 59G-1.010(166).

You asked for personal care. You would like 42 more hours a week. You had a nurse assessment on July 28. You need help with all your activities of daily living. These are activities like bathing, dressing, grooming, toileting, and mobility. Based on my professional judgment, we are not approving the extra hours you asked for. **They are more hours than you need. You have been approved for PC 42 hours/week. These hours should meet your needs for personal care. These hours can be arranged to better meet your needs. In addition, you have family who can help.** This is why we cannot approve the extra PC hours that you asked for. Please talk about this with your doctor.

I have reviewed this case as a Florida licensed medical doctor. I am a board-certified neurosurgeon medical director and I agree with the decision to uphold the denial. I also agree with the rationale that has been utilized for this decision.

Robert F. Wayner, MD

Clinical Appeals & Grievances

UnitedHealthcare Appeals & Grievance Medical Director

Respondent's Composite Exhibit 1, pages 184 – 185.

12. On August 27, 2020, Respondent sent Petitioner an NPAR, denying Petitioner's plan appeal with regards to the medical equipment and supplies. See Respondent's Composite Exhibit 1, page 192. The NPAR stated as follows:

On August 06, 2020 we received your timely plan appeal request regarding UnitedHealthcare Community Plan's Notice of Adverse Benefit Determination dated August 7, 2020, [REDACTED], partially denying the Medical equipment and supplies (Biatain Alginate 3x44cm/1x17in; Vashe wound solution 8.5oz; 3M Cavilon durable barrier cr me; Zinc wound wash 4oz; Egosan Maxi diapers 2 cases per month) partial denial of intermittent and skilled nursing denial of 1 visit per day; medical equipment and supplies (Mckession Lite Hydrocellular foam dressing w/silicone adhesive border 3 boxes per month; Mckession saline wound flush monthly and denial of medical equipment and supplies (standard bed pan; fracture bed pan; commode chair; electric commode chair and denial of medical equipment and supplies (air fluidized mattress; total care bariatric bed and denial of medical equipment and supplies (heel or elbow protector; positioning cushion; customized manual wheelchair; bed accessory table to [Petitioner]).

On August 27, 2020, after consideration of the information you provided to UnitedHealthcare Community Plan in support of your plan appeal, UnitedHealthcare hereby partially denies your plan appeal.

As a result, [Petitioner] **will receive a standard bed pan**, effective August 27, 2020. 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 be partially approved.

John Szafranski, MD, UnitedHealthcare Medical Director, who is a Medical Doctor, Board Certified in Family Medicine, reviewed the appeal. This doctor did not make the original decision. The decision was based on Florida Medicaid rules: Florida Administrative Codes 59G-1.010 (166) and F.A.C. 59G-4.192).

Part 1 of 5. You asked for a specific bed and mattress. You would like a Total Care Bariatric bed with air fluidized mattress. We understand you are a 55-year-old woman. You are bedbound. You have wounds. One is a stage 4 wound over the lower spine. One is a stage 3 wound on the left buttock. One is on the back of your head. Medicaid is to allow for the least costly items that can meet your needs. In my clinical judgment, this bed and mattress are not medically needed and are in excess of your need. You have other type of bed and mattress approved. These are a Semi-Electric Bariatric hospital bed with alternating air mattress. These should meet your needs. You also have approved personal care help. They can help with your positioning and turning. You also have family who can help some,

too. This is why we cannot approve what you asked for. Please talk about this with your doctor.

Part 2 of 5 We are approving the standard bed pan. We are not approving the other three items. This does not meet Florida Medicaid rules. You asked for a fracture bed pan. You asked for a commode chair. You asked for an electric commode chair. We understand you are a 55-year-old woman. You are bedbound. Your assessment shows that you cannot get out of bed. Medicaid is to allow for the least costly items that can meet your needs. In my clinical judgment, these three items are not medically needed and are in excess of your need. You do not have a fracture. A fracture bed pan is not medically needed. You are bedbound. Any type of commode chair is not medically needed. You have a standard bed pan approved. You have personal care help. These should meet your needs. You also have family who can help some, too. This is why we cannot approve what you asked for. Please talk about this with your doctor.

Part 3 of 5 You asked for several things. You asked for a bed table/board. You asked for a customized manual wheelchair. You asked for a positioning cushion. You asked for a protector for the heel or elbow. We understand you are a 55-year-old woman. **You are bedbound.** Your assessment shows that you cannot get out of bed. Medicaid is to allow for the least costly items that can meet your needs. In my clinical judgment, these three items are not medically needed and are in excess of your need. **You cannot get out of bed** and sit in a wheelchair. You have a special bed approved for your use. You have personal care help. These should meet your needs. Your therapists are encouraged to give us progress notes. If they feel an item is medically needed, they can prepare a letter of medical need and have your doctor review it. This is why we cannot approve what you asked for. Please talk about this with your doctor.

Part 4 of 5 You asked for 3 month supplies of wound care items. You asked for McKesson Lite Hydrocellular foam dressing w/silicone adhesive border 3 boxes per month. You asked for McKesson saline wound flush. We understand you are a 55-year-old woman. You are bedbound. You have wounds. One is a stage 4 wound over the lower spine. One is a stage 3 wound on the left buttock. One is on the back of your head. Medicaid is to allow for the least costly items that can meet your needs. In my need. You have home skilled nursing help approved for 1 month. This is for your wound care. Thus, 1 month supplies of your requested items should meet your needs. If your needs do not change, the nurse can tell us monthly. If your needs change and you need more supplies, the nurse can tell us this too. This is why we cannot approve what you asked for. Please talk about this with your doctor.

Part 5 of 5 You asked for three groups of things. You would like extra wound care supplies. You would like a specific barrier cream. You would like brand name (non-

preferred) diapers. We understand you are a 55-year-old woman. You are bedbound. You have wounds. One is a stage 4 wound over the lower spine. One is a stage 3 wound on the left buttock. One is on the back of your head. Medicaid is to allow for the least costly items that can meet your needs. In my clinical judgment, this these are not medically needed and are in excess of your need. The wound care supplies your home care asked for were approved. These extra supplies are not medically needed. Your barrier cream can be obtained using your Over the Counter (OTC) benefit. This is designed to help you get certain items you desire. You must use preferred diapers. Brand name diapers are not part of your benefit. If the preferred diapers are not meeting your needs, your doctor can tell us why. This is why we cannot approve what you asked for. Please talk about this with your doctor.

The plan pays for required services and supplies provided for the purpose of preventing, diagnosing or treating a sickness, injury, disease or symptoms. The plan authorizes UnitedHealthcare to determine whether a service or supply is eligible for coverage under the plan.

Respondent's Composite Exhibit 1, pages 192 – 194. (Emphasis added.)

13. Petitioner has 8 letters of Medical Necessity for Certified Nursing Assistant ("CNA") or Home Health Care Aide (T1021), dated August 28, 2020, and signed by [REDACTED]. See Petitioner's Composite Exhibit 3, pages 27-34.

14. The letter from [REDACTED], dated September 1, 2020, states "Letter of Necessity" and that Petitioner "has been a patient in our office since [REDACTED], 2020." See Petitioner's Composite Exhibit 3, page 22. The letter reflects that Petitioner's conditions include:

- Type II Diabetes Mellitus with Hyperglycemia
- Long tern [sic] (Current) use of Insulin
- Essential Hypertension
- Traumatic Brain injury/Spinal Injury
- COPD with exacerbation
- Congestive Heart Failure
- Fecal and Urine Incontinence
- Bed Confinement Status
- Paraplegic Immobility Syndrome
- Pressure Ulcer of Sacral Region, Stage 4
- Pressure Ulcer of Occipital area, Stage 1
- Iron Deficiency Anemia

Fatty Liver
Depression/ Anxiety
Chronic Kidney Disease
Chronic Pain Syndrome
Morbid Obesity

Petitioner's Composite Exhibit 3, page 22.

15. [REDACTED] provided photographs of Petitioner's wounds. See Petitioner's Composite Exhibit 2, pages 8, 9, 17, 28, and 33. [REDACTED] also provided photographs of Petitioner's medications. See Petitioner's Composite Exhibit 2, pages 19, 20, 25, 26, 29, 36, and 39.

16. Petitioner is currently authorized to receive the following services: 42 hours per week of personal care services; and 3 hours per week of homemaking services. See Respondent's Composite Exhibit 1, page 158.

17. The record reflects that "Dr. Karver has approved a semi-electric/Bariatric hospital bed and alternating air mattress." Respondent's Composite Exhibit 1, page 162.

18. On August 25, 2020, Petitioner requested a Fair Hearing due to the denial of the additional 42 hours per week of personal care services, 1 intermittent and skilled nursing visit per day, and the denial of the medical equipment and supplies (Biatain Alginate 3x44cm/1x17in, Vashe wound solution 8.5oz, 3M Cavilon durable barrier creme, Zinc wound wash 4oz, Egosan Maxi diapers 2 cases per month, Mckession Lite Hydrocellular foam dressing with silicone adhesive border 3 boxes per month, Mckession saline wound flush monthly, fracture bed pan, commode chair, electric commode chair, air fluidized mattress, total care bariatric bed, heel or elbow protector, positioning cushion, customized manual wheelchair, and bed accessory table). On September 14, 2020, the undersigned scheduled the Fair Hearing for September 21, 2020, at [REDACTED], and all parties were duly notified.

19. [REDACTED] is Petitioner's daughter. Petitioner resides in the home with [REDACTED]. [REDACTED] works and goes to school. [REDACTED] works outside the home as well as remotely. Petitioner can stay home alone for approximately 1 hour. At the Fair Hearing, [REDACTED] explained that she cannot work, go to school and tend to Petitioner 24 hours per day.

20. [REDACTED] further explained that Petitioner's request for the air-fluidized mattress is not only for Petitioner's wounds, but also because Petitioner needs to sit at a 30-degree angle due to her congestive heart failure and chronic obstructive pulmonary disease ("COPD"). Petitioner can move her arms and legs, but she is weak. [REDACTED] believes that Petitioner needs the customized wheelchair, because Petitioner has short stature and weighs 216 pounds.

21. Dr. Karver reviewed all documentation submitted to Respondent for this case, but not the documents in Petitioner's Composite Exhibits 1 through 5. It is Dr. Karver's professional opinion that Respondent correctly denied the requested services and medical equipment. Dr. Karver explained that the 1 visit per day of intermittent and skilled nursing was not denied in this case. Dr. Karver explained that the following wound care supplies were denied as they are provided by the wound care specialist who comes during the 1 visit per day of intermittent and skilled nursing: Biatain Alginate 3x44cm/1x17in; Vashe wound solution 8.5oz; 3M Cavilon durable barrier creame; Zinc wound wash 4oz; Mckession Lite Hydrocellular foam dressing w/silicone adhesive border 3 boxes per month; and Mckession saline wound flush monthly.

22. Referring to page 162 of Respondent's Composite Exhibit 1, Dr. Karver testified that Respondent approved a semi-electric bed with an air-fluidized mattress, but it is not what Petitioner requested. Dr. Karver testified that the following medical equipment and supplies were denied because they were not on Respondent's formulary: fracture bed pan; commode

chair; electric commode chair; air fluidized mattress; total care bariatric bed; heel or elbow protector; positioning cushion; and the bed accessory table. Dr. Karver explained that the formulary is the list of the items that Respondent provides the patient if they meet the medical necessity of those items. Dr. Karver testified that the customized manual wheelchair was denied, as Petitioner requires total assistance with all ADLs.

23. Dr. Karver testified that in addition to the 42 hours per week of personal care services and 3 hours per week of homemaking services, Petitioner also receives physical therapy (“PT”) and (“OT”). Once services are authorized, Petitioner can adjust times the services are provided to meet her needs. Dr. Karver clarified during her testimony that Respondent already approved the standard bed pan. Regarding the 1 intermittent and skilled nursing visit per day, Dr. Karver explained that Petitioner requested 1 visit per day, and Respondent did approve the 1 visit per day.

CONCLUSIONS OF LAW

24. 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). This order is the final administrative decision of AHCA under Fla. Stat. § 409.285(2)(a).

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

26. 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.

27. Because Petitioner is requesting additional services, Fla. Admin. Code R. 59G-1.100(17)(g) assigns the burden of proof to the 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.).

28. 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’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 Home and Community-Based Supportive Services

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

...

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:

...

4.2.2.5 Medical Equipment and Supplies

In accordance with Rule 59G-4.070, F.A.C. This service includes the provision of medical equipment and supplies specified in the plan of care, including: devices, controls, or appliances that enable the enrollee to increase the ability to perform activities of daily living; devices, controls, or appliances that enable the enrollee to perceive, control, or communicate with the environment in which he or she lives; items necessary for life support or to address an enrollee's physical conditions, along with ancillary supplies and equipment necessary to the proper functioning of such items; such other durable and non-durable medical equipment not available under the State Plan that is necessary to address enrollee needs, including consumable medical supplies, such as adult diapers; and repair of such items or replacement parts.

...

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.

29. 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.

30. The Florida Medicaid Durable Medical Equipment and Medical Supply Services Coverage and Limitations Handbook (July 2010) ("DME Policy"), incorporated by reference in Fla. Admin. Code R. 59G-4.070, governs requested for DME services available under Florida Medicaid. The DME Policy provides the following:

Durable Medical Equipment (DME): Durable medical equipment (DME) is defined as medically-necessary equipment that can withstand repeated use, serves a medical purpose, and is appropriate for use in the recipient's home as determined by the Agency for Health Care Administration (AHCA).

...

Services Limited to Recipients Under 21 Years of Age:

Many durable medical equipment (DME) items and services are limited to recipients under 21 years of age.

To determine whether a service is available to all recipients or limited to recipients under age 21 years of age, refer to the DME and Medical Supply Services Provider Fee Schedules.

...

Service Criteria:

All DME, medical supplies, and orthotics and prosthetic devices must be:

- Medically necessary, and
- Functionally appropriate for the individual recipient, and
- Adequate for the intended medical purpose, and
- For conventional use, and
- For the exclusive use of the recipient.

DME items requested or supplied must not duplicate or perform the same function as other DME equipment or medical supplies currently in the recipient's possession.

...

Medical Necessity

Medicaid reimburses for services that do not duplicate another provider's service and are determined to be medically necessary. Per 59G-1.010, F.A.C., to be medically necessary, services 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; and
- 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.

...

Exceptions for Non-Covered Services and Exclusion are only for eligible recipients under 21 years of age. Exceptions for non-covered items are requested using the miscellaneous equipment procedure code. These requests require prior authorization. Requested items must correct or ameliorate a defect, physical or mental illness, or a medical condition.

...

Non-Covered Items

The following list of items and services are not reimbursed through the Medicaid DME and Medical Supply Services Program; however some of these items may be reimbursed through other Medicaid programs, such as the Medicaid State Plan, Home and Community-Based Waiver Programs, or other state-operated programs:

...

Disposable supplies customarily provided as part of a nursing or personal care service or a medical diagnostic or monitoring procedure

DME Policy, pages 1-1, 2-3, 2-5, and 2-9.

31. 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.

32. In the instant case, Petitioner requested an additional 42 hours of personal care services per week, 1 intermittent and skilled nursing visit per day, and medical equipment and supplies

(Biatain Alginate 3x44cm/1x17in, Vashe wound solution 8.5oz, 3M Cavilon durable barrier creme, Zinc wound wash 4oz, Egosan Maxi diapers 2 cases per month, Mckession Lite Hydrocellular foam dressing with silicone adhesive border 3 boxes per month, Mckession saline wound flush monthly, fracture bed pan, commode chair, electric commode chair, air fluidized mattress, total care bariatric bed, heel or elbow protector, positioning cushion, customized manual wheelchair, and bed accessory table). *See supra* ¶ 5 – 12. As established on the record by the evidence and testimony, Respondent denied Petitioner’s request, because the documentation submitted in support of Petitioner’s request failed to establish that the requested services were medically necessary. *Id.*

33. Section 4.1 of the SMMC LTC Policy provides that Florida Medicaid LTC plans cover services that: (a) are determined medically necessary, as defined in the SMMC LTC Policy; (b) do not duplicate another service; and (c) meet the criteria as specified in the SMMC LTC Policy. *See supra* ¶ 28.

Personal Care Services

34. Section 4.2.2.6 of the 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* ¶ 28.

35. The evidence presented in this case does not reflect that Petitioner is in need of an additional 42 hours per week of personal care services. Specifically, the 701B reflects that Petitioner requires assistance with all ADLs and IADLs. *See supra* ¶ 3 and 4. Petitioner has multiple medical conditions, *supra* ¶ 14, but she is able to move her arms and legs. *See supra*

¶ 20. Petitioner requires supervision, *supra* ¶ 4, but can stay home alone for approximately 1 hour. *See supra* ¶ 19. However, Petitioner resides in the home with [REDACTED]. *See supra* ¶ 19. [REDACTED] administers Petitioner’s medications. *See supra* ¶ 4. Although [REDACTED] provided testimony that she goes to school and works outside the home, as well as remotely, *supra* ¶ 19, Petitioner is currently authorized to receive 42 hours per week of personal care services and 3 hours per week of homemaking services. *See supra* ¶ 16. Given that these services are already authorized, Petitioner can adjust times the services are provided to meet her needs. *See supra* ¶ 23. Further, [REDACTED] provided photos of Petitioner’s wounds and medications, *supra* ¶ 15, but provided no evidence (i.e., a daily schedule, a schedule of ADLs and IADLs, the amount of time needed for each ADL and IADL) to justify the approval of an additional 42 hours of personal care services weekly. Based upon the evidence presented by both parties, Petitioner failed to establish that the requested personal care services are warranted in this case.

DME Services

36. Section 4.2.2.5 of the SMMC LTC Policy provides that medical equipment and supplies “includes the provision of medical equipment and supplies specified in the plan of care, including: devices, controls, or appliances that enable the enrollee to increase the ability to perform activities of daily living; devices, controls, or appliances that enable the enrollee to perceive, control, or communicate with the environment in which he or she lives; items necessary for life support or to address an enrollee’s physical conditions, along with ancillary supplies and equipment necessary to the proper functioning of such items; such other durable and non-durable medical equipment not available under the State Plan that is necessary to address

enrollee needs, including consumable medical supplies, such as adult diapers; and repair of such items or replacement parts.” See supra ¶ 28. The DME Policy provides that “All DME, medical supplies, and orthotics and prosthetic devices must be . . . medically necessary.” See supra ¶ 30.

37. The evidence presented in this case reflects that Respondent correctly denied Petitioner’s request for medical equipment and supplies. The DME Policy provides that “Medicaid reimburses for services that do not duplicate another provider’s service” and “DME items requested or supplied must not duplicate or perform the same function as other DME equipment or medical supplies currently in the recipient’s possession.” See supra ¶ 30. The record reflects that the following wound care supplies were denied, as they are provided by the wound care specialist who comes during the 1 visit per day of intermittent and skilled nursing: Biatain Alginate 3x44cm/1x17in; Vashe wound solution 8.5oz; 3M Cavilon durable barrier creame; Zinc wound wash 4oz; Mckession Lite Hydrocellular foam dressing w/silicone adhesive border 3 boxes per month; Mckession saline wound flush monthly. See supra ¶ 21. Petitioner offered no testimony to refute this information. Further, the DME Policy provides that “[d]isposable supplies customarily provided as part of a nursing or personal care service or a medical diagnostic or monitoring procedure” is a non-covered item. See supra ¶ 30. As such, Petitioner’s request for the aforementioned medical supplies fails to comply with the limitations set forth by the DME Policy, as they are duplicative of the medical supplies provided by the wound care specialist and they are a non-covered item.

38. ██████████ explained that Petitioner’s request for the air-fluidized mattress is not only for Petitioner’s wounds, but also because Petitioner needs to sit at a 30-degree angle due to her congestive heart failure and chronic obstructive pulmonary disease (“COPD”). See supra ¶ 20.

The record reflects that “Dr. Karver has approved a semi-electric/Bariatric hospital bed and alternating air mattress.” See supra ¶ 17. ██████████ did not dispute Respondent’s claim, nor did she offer evidence as to why the currently approved bed is not sufficient to meet her needs. Therefore, it appears that the approval of another bed would be duplicative of medical equipment that has already been authorized for Petitioner.

39. Respondent denied the requested customized manual wheelchair due to lack of medical necessity, noting that Petitioner requires total assistance with all ADLs. See supra ¶ 22. Further, the NPAR explains that the reason for the denial is that Petitioner is bedbound, and cannot get out of bed and sit in a wheelchair. See supra ¶ 12. Although Petitioner can move her arms and legs, but she is weak, this information does not negate Respondent’s position that Petitioner is “bedbound, and cannot get out of bed and sit in a wheelchair.” See supra ¶ 20. ██████████ believes that Petitioner needs the customized wheelchair due to Petitioner’s short stature and weight, supra ¶ 20, but she failed to explain why Petitioner needs this particular wheelchair and the consequences of Petitioner not having this particular wheelchair. As such, Petitioner did not establish that the requested customized manual wheelchair is medically necessary.

40. The record reflects that Respondent denied the following medical equipment and supplies: fracture bed pan; commode chair; electric commode chair; air fluidized mattress; total care bariatric bed; heel or elbow protector; positioning cushion; and the bed accessory table. See supra ¶ 22. It should be noted that Respondent already approved a standard bedpan, supra ¶ 12, so it appears that the approval of an additional bed pan would be a duplication of medical equipment. The NPAR explained that Petitioner is bedbound and does not have a fracture, and these items are in excess of Petitioner’s needs. *Id.* Aside from generalized statements, supra ¶

19, and testimony regarding the total care bariatric bed, the air fluidized mattress and the customized wheelchair, *supra* ¶ 20, ██████████ failed to offer testimony or evidence to explain how or why the remaining items (i.e., fracture bed pan; commode chair; electric commode chair; heel or elbow protector; positioning cushion; and the bed accessory table) are medically necessary as required by the criteria set forth in the Definitions Policy. Based upon the above, *supra* ¶ 37 – 39, Petitioner failed to meet her burden of establishing that Respondent’s denial of Petitioner’s request for a medical equipment and supplies was incorrect.

Intermittent Skilled Nursing Services

41. Pursuant to Rule 59G-1.100(9)(b)(6), Florida Administrative Code, the Hearing Officer is authorized to dismiss a request for a Fair Hearing because it is moot. The Florida Supreme Court explained in *Godwin v. State*, 593 So.2d 211 (1992) (*citing Dehoff v. Imeson*, 153 Fla. 553 (1943)) that “[a]n issue is moot when the controversy has been so fully resolved that a judicial determination can have no actual effect. . . . A case is ‘moot’ when it presents no actual controversy or when the issues have ceased to exist.”

42. In the instant case, Dr. Karver explained that Petitioner requested 1 intermittent and skilled nursing visit per day, and that Respondent did approve the 1 visit per day. *See supra* ¶ 23. Given that the 1 intermittent and skilled nursing visit per day is approved, the undersigned concludes that there is no relief that can be granted at a Fair Hearing at this time with regards to the issue of the 1 intermittent and skilled nursing visit per day.

Conclusion

43. 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 ¶ 28. Petitioner is currently authorized to receive 42 hours per week of personal care services and 3 hours per week of homemaking services. See supra ¶ 16. Considering that Petitioner is currently authorized to receive homemaking services, personal care services, a standard bedpan, a "semi-electric/Bariatric hospital bed and alternating air mattress," supra ¶ 12, 16, and 17, Petitioner did not demonstrate that her aforementioned needs, supra ¶ 3, 4, 14, 18 and 19, are not sufficiently met by his currently authorized services. Further, given that Petitioner failed to establish that the requested personal care services and medical equipment and supplies are warranted in this matter, supra ¶ 35 and 37-40, the requested personal care services and medical and equipment and supplies are "in excess of [Petitioner's] needs." See supra ¶ 28.

44. 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 ¶ 28. Petitioner resides in the home with her daughter, [REDACTED]. See supra ¶ 2. Also, the record reflects that "Member's daughter administers medications to member." See supra ¶ 4. Therefore, Petitioner has natural supports available to assist with her care and needs.

45. Petitioner has 8 letters of Medical Necessity for Certified Nursing Assistant ("CNA") or Home Health Care Aide (T1021), dated August 28, 2020, and signed by [REDACTED]. See supra ¶ 13. Additionally, Petitioner has a letter from [REDACTED], dated September 1, 2020, which states "Letter of Necessity." See supra ¶ 14. However, section 2.83 of the Definitions Policy mandates that "[t]he 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.” See *supra* ¶ 31. Therefore, the letters from [REDACTED] do not, in themselves, make the requested personal care services, medical equipment and medical supplies medically necessary.

46. In light of the both parties’ testimony and evidence, the PC Policy, the DME Policy, the Authorization Requirements Policy, the Definitions Policy, the undersigned Hearing Officer finds that Petitioner failed to meet her burden of proving that the additional 42 hours per week of personal care services and the requested medical equipment and supplies are medically necessary.

47. Accordingly, the undersigned Hearing Officer finds that Petitioner failed to prove by a preponderance of the evidence that Respondent’s denial of the requested additional personal care services and medical equipment and supplies was incorrect.


DECISION

Respondent’s denial of an additional hours per week of personal care services is **AFFIRMED**. Petitioner’s appeal based on Respondent’s denial in this matter is **DENIED**.

Respondent’s denial of medical equipment and supplies (Biatain Alginate 3x44cm/1x17in, Vashe wound solution 8.5oz, 3M Cavilon durable barrier creme, Zinc wound wash 4oz, Egosan Maxi diapers 2 cases per month, Mckession Lite Hydrocellular foam dressing with silicone adhesive border 3 boxes per month, Mckession saline wound flush monthly, fracture bed pan, commode chair, electric commode chair, air fluidized mattress, total care bariatric bed, heel or elbow protector, positioning cushion, customized manual wheelchair, and bed accessory table) is **AFFIRMED**. Petitioner’s appeal based on Respondent’s denial in this matter is **DENIED**.

Petitioner's request for a Fair Hearing regarding 1 intermittent and skilled nursing visit per day is dismissed as **MOOT**, and is now **CLOSED**.

DONE AND ORDERED this 25th day of September, 2020, in Tallahassee, Leon County, Florida.

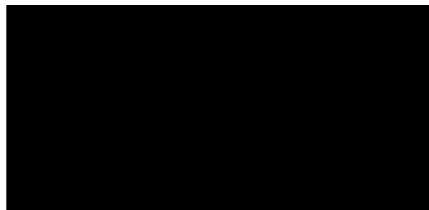

Tracie Hardin
20-FH [REDACTED], 20-FH [REDACTED], 20-FH [REDACTED], 20-FH [REDACTED], 20-FH [REDACTED], 20-FH [REDACTED], and 20-FH [REDACTED]
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NOTICE OF A RIGHT TO JUDICIAL REVIEW

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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