



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

FILED

Nov 10, 2020, 8:15 am

OFFICE OF FAIR HEARINGS

[REDACTED]

PETITIONER,

AHCA Case No.: 20-FH [REDACTED]

Plan ID No.: [REDACTED]

vs.

FLORIDA COMMUNITY CARE, LLC,

RESPONDENT.

_____ /

[REDACTED]

PETITIONER,

AHCA Case No.: 20-FH [REDACTED]

Plan ID No.: [REDACTED]

vs.

FLORIDA COMMUNITY CARE, LLC,

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned Hearing Officer convened a telephonic Medicaid Fair Hearing in the above-styled case on October 14, 2020, at [REDACTED]

[REDACTED]

APPEARANCES

For the Petitioner:

[REDACTED]

Petitioner's Authorized Representative

For the Respondent:

Stuart Williams
General Counsel
Florida Community Care

STATEMENT OF ISSUE

The first issue (AHCA Case Number 20-FH[REDACTED]) is whether Petitioner proved by a preponderance of the evidence that Respondent's denial of 28 hours per week of adult companion care services was incorrect.

The second issue (AHCA Case Number 20-FH[REDACTED]) is whether Petitioner proved by a preponderance of the evidence that Respondent's denial of an additional 10 hours per week of homemaker services was incorrect.

PRELIMINARY STATEMENT

All parties and witnesses appeared telephonically. [REDACTED] ("[REDACTED]"), Petitioner's Authorized Representative and friend, appeared at the Fair Hearing and provided testimony on Petitioner's behalf. Petitioner did not appear at the Fair Hearing.

Stuart Williams, General Counsel for Florida Community Care ("Florida Community Care" or "Respondent") represented Respondent at the Fair Hearing. Dr. Dennis Liotta ("Dr. Liotta"), Chief Medical Officer for Florida Community Care, provided testimony on behalf of Respondent.

Shelia Gonzalez, Medical/Health Care Program Analyst for the Agency for Health Care Administration ("Agency" or "AHCA"), appeared for observational purposes.

Prior to the hearing, Petitioner did not send an evidence packet to the Office of Fair Hearings and Respondent, and did not introduce any exhibits at the hearing. Prior to the hearing, Respondent sent to the Office of Fair Hearings and Petitioner a 94-page evidence packet for case number 20-FH[REDACTED]. The packet included the following documents: the Table of Contents; Medicaid Fair Hearing Checklist; the Order Scheduling Fair Hearing by Telephone and Prehearing Instructions, dated September 11, 2020; a cover letter from Florida Community Care; the Case

Summary, dated September 24, 2020; the Florida Department of Elder Affairs 701B Comprehensive Assessment (“701B”) with an assessment date of March 3, 2020; the Comprehensive Plan of Care with an effective date of March 3, 2020; a Notice of Adverse Benefit Determination (“NABD”), dated March 10, 2020; Petitioner’s plan appeal; the Oral Appeal Acknowledgement, dated May 8, 2020; the Notice of Plan Appeal Resolution, dated May 21, 2020; the Florida Community Care Appeal Summary Brief Referral to Independent Review Entity, dated May 21, 2020; and the Florida Medicaid Statewide Medicaid Managed Care Long-term Care Program Coverage Policy (March 2017). Absent an objection from Petitioner, the Hearing Officer admitted Respondent’s 94-page evidence packet for case number 20-FH[REDACTED] into evidence as Respondent’s Composite Exhibit 1.

Prior to the hearing, Respondent also sent to the Office of Fair Hearings and Petitioner a 94-page evidence packet for case number 20-FH[REDACTED]. The packet included the following documents: the Table of Contents; Medicaid Fair Hearing Checklist; the Order Scheduling Fair Hearing by Telephone and Prehearing Instructions, dated September 11, 2020; a cover letter from Florida Community Care; the Case Summary, dated September 24, 2020; the Florida Department of Elder Affairs 701B Comprehensive Assessment (“701B”) with an assessment date of March 3, 2020; the Comprehensive Plan of Care with an effective date of March 3, 2020; a Notice of Adverse Benefit Determination (“NABD”), dated March 10, 2020; Petitioner’s plan appeal; the Oral Appeal Acknowledgement, dated May 8, 2020; the Notice of Plan Appeal Resolution, dated May 21, 2020; the Florida Community Care Appeal Summary Brief Referral to Independent Review Entity, dated May 21, 2020; and the Florida Medicaid Statewide Medicaid Managed Care Long-term Care Program Coverage Policy (March 2017). Absent an objection from

Petitioner, the Hearing Officer admitted Respondent's 94-page evidence packet for case number 20-FH[REDACTED] into evidence as Respondent's Composite Exhibit 2.

FINDINGS OF FACT

1. Petitioner is an enrolled member of Florida Community Care's LTC plan. See Respondent's Composite Exhibit 1, pages 12 and 14. Florida Community Care is a managed care organization contracted by AHCA to provide services to eligible Medicaid recipients in Florida.

2. Petitioner is a widowed, 87-year old male who resides in a private residence. See Respondent's Composite Exhibit 1, page 17 and See Respondent's Composite Exhibit 2, page 17. The 701B reflects that Petitioner has the following health conditions: acid reflux; arthritis (osteoarthritis); high blood pressure; past broken bones (neck secondary to fall); occasional dizziness; constant bladder incontinence; kidney problems or renal disease; Parkinson's disease; shingles (past); dysphagia; muscle weakness; anxiety; depression; and "Demen." See Respondent's Composite Exhibit 1, pages 23 – 24 and Respondent's Composite Exhibit 2, pages 23 – 24.

3. The 701B reflects the following regarding Petitioner's Activities of Daily Living ("ADLs"). Petitioner uses assistive devices for transferring and walking/mobility. See Respondent's Composite Exhibit 1, page 21 and See Respondent's Composite Exhibit 2, page 22. Petitioner needs no assistance with eating. *Id.* Petitioner needs assistance (but not total help) with bathing, dressing, using the bathroom, and transferring. *Id.*

4. Regarding Petitioner's Instrumental Activities of Daily Living ("IADLs"), the 701B reflects that Petitioner needs no assistance with using the phone. See Respondent's Composite Exhibit 1, page 22 and See Respondent's Composite Exhibit 2, page 22. Petitioner needs supervision or

prompting with managing money. *Id.* Petitioner needs assistance (but not total help) with heavy chores, light housekeeping, preparing meals, shopping managing medication, and using transportation. *Id.*

5. The undated letter from [REDACTED] to Respondent reflects that Petitioner “requires constant assistance for safety concern,” and “is home bound due to being unsteady on his feet and high risk of falls.” Respondent’s Composite Exhibit 1, page 54 and Respondent’s Composite Exhibit 2, page 54. The letter also provides an accounting of Petitioner’s daily schedule. *See* Respondent’s Composite Exhibit 1, pages 54-55 and Respondent’s Composite Exhibit 2, pages 54-55. The letter reflects that Petitioner needs assistance with sitting, diaper changes and clean up, toileting, walking for exercise, feeding, and transferring. *See* Respondent’s Composite Exhibit 1, page 55 and Respondent’s Composite Exhibit 2, page 55. The letter reflects that an aide assists Petitioner with walks for exercise twice daily, at 10:00 a.m. and 10:45 a.m. *Id.*

6. On March 10, 2020, Respondent issued an NABD denying Petitioner’s request for 28 hours per week of adult companion care services. *See* Respondent’s Composite Exhibit 1, page 45. The NABD stated the reason for Respondent’s determination as follows:

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

...

Meet all of the following criteria for all extended state plan services used for the purposes of maintenance therapy and all other home and community-based services:

1. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient’s needs;
2. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available statewide; and

3. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider;

And one of the following:

1. Enable the enrollee to maintain or regain functional capacity; or
2. Enable an enrollee receiving long-term services and supports to have access to the benefits of community living, to achieve person-centered goals, and live and work in the setting of their choice.

...

The facts that we used to make our decision are: A request was received from your informal caregiver for 4 hours per day, 7 days per week for a total of 28 hours per week of ADULT COMPANION CARE (ACC) (S5135). This request [sic] comes following your discharge from the skilled nursing facility. The reason for this request is that your informal caregiver stated that she wants someone to sit with you so that you will not be alone. "Adult sitting" is not a medical necessity reason nor proper application of ACC. Therefore, I have DENIED the request for 28 hours per week of ACC.

Respondent's Composite Exhibit 1, pages 45 – 46.

7. On March 10, 2020, Respondent issued an NABD denied Petitioner's request for 10 additional hours per week of homemaker services. See Respondent's Composite Exhibit 2, page 45. The NABD stated the reason for Respondent's determination as follows:

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

...

Meet all of the following criteria for all extended state plan services used for the purposes of maintenance therapy and all other home and community-based services:

4. 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;
5. 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
6. 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:

3. Enable the enrollee to maintain or regain functional capacity; or
4. Enable an enrollee receiving long-term services and supports to have access to the benefits of community living, to achieve person-centered goals, and live and work in the setting of their choice.

...

The facts that we used to make our decision are: A request was made for 14 hours per week of HOMEMAKER (HMK) (S5130) by your informal caregiver. A complete assessment was made for your need of this service following your discharge from the skilled nursing facility. As you are receiving 3 home delivered meals per day for a total of 21 meals per week, your HMK requirements have significantly decreased. Your service needs are for 4 hours per day of HMK service, which you are already receiving. Therefore, this request for 14 hours per week of HMK service has been DENIED.

Respondent's Composite Exhibit 2, pages 45 – 46.

8. Petitioner requested an appeal of Respondent's denial. See Respondent's Composite Exhibit 1, page 54. On May 21, 2020, Respondent sent Petitioner an NPAR, denying Petitioner's plan appeal. *Id.* at 64. The NPAR stated as follows:

On 05/07/2020 we received your timely plan appeal request regarding Florida Community Care's Notice of Adverse Benefit Determination dated 3/10/2020, NABD Number [REDACTED], DENYING the (S5135) - Adult Companion (15 minute unit) 28 Hours/Week 7 Days/Week provided to [Petitioner].

On 05/21/2020, after consideration of the information you provided to Florida Community Care in support of your plan appeal, Florida Community Care hereby UPHELD your plan appeal. As a result, [Petitioner] will not receive (S5135) - Adult Companion (15 minute unit) 28 Hours/Week 7 Days/Week effective 03/09/2020.

Respondent's Composite Exhibit 1, page 64.

9. Petitioner requested an appeal of Respondent's denial. See Respondent's Composite Exhibit 2, page 54. On May 21, 2020, Respondent sent Petitioner an NPAR, denying Petitioner's plan appeal. *Id.* at 64. The NPAR stated as follows:

On 05/07/2020 we received your timely plan appeal request regarding Florida Community Care's Notice of Adverse Benefit Determination dated 3/10/2020, NABD Number [REDACTED], DENYING the Homemaker and Companion: (S5130) Homemaker (15 minute unit) 0 hours per day, 0 days a week, for 0 weeks. provided to [Petitioner].

On 05/21/2020, after consideration of the information you provided to Florida Community Care in support of your plan appeal, Florida Community Care hereby UPHELD your plan appeal. As a result, [Petitioner] will not receive Homemaker and Companion: (S5130) Homemaker (15 minute unit) 10 additional hours effective 03/09/2020.

Respondent's Composite Exhibit 2, page 64.

10. On August 25, 2020, [REDACTED] requested a Fair Hearing due to the denial of adult companion care services and homemaker services. On September 11, 2020, the undersigned scheduled the Fair Hearing for October 14, 2020, at [REDACTED], and all parties were duly notified.

11. Petitioner is currently authorized to receive the following home and community based services: 14 hours per week of personal care services; 4 hours per week of homemaker services; 21 home delivered meals per week; and 24-hour monitoring through the personal emergency response services ("PERS"). See Respondent's Composite Exhibit 1, page 15 and See Respondent's Composite Exhibit 2, page 15.

12. [REDACTED] is Petitioner's friend and former physical therapist. Petitioner does not have a caregiver in the home, but he has a roommate who is of no relation to him. Petitioner needs assistance with bathing, walking, transferring, diaper changes and cutting up his food. [REDACTED] believes that Petitioner should receive 24-hour care.

13. [REDACTED] explained that in [REDACTED] 2020, Petitioner was admitted to a rehabilitation facility after his discharge from a hospital stay due to a fall. Petitioner is still in the

rehabilitation facility, and is expected to be discharged home in the future. [REDACTED] did not provide a specific discharge date.

14. Dr. Liotta is the Chief Medical Officer for FCC. He has been a physician for 40 years, and has 30 years of experience in managed care. Dr. Liotta was accepted as an expert in medical necessity and coverage of the service types (adult companion care services and homemaker services) at issue in this case. Dr. Liotta personally reviewed all documentation submitted to Respondent in this case, including all documents admitted in evidence, and he agreed with Respondent's determinations in this matter. Dr. Liotta explained that when Respondent received Petitioner's request for adult companion services, it only specified that Petitioner needed someone to sit with him, so the request was denied as the SMMC LTC Policy for adult companion care services does not include someone sitting with Petitioner. Dr. Liotta explained that Petitioner did not submit any information to Respondent that would indicate a need for adult companion care services. Dr. Liotta explained that Respondent denied Petitioner's request for 10 additional hours of homemaker services on the basis of meal preparation, because Petitioner is already authorized to receive 21 home delivered meals per week. Dr. Liotta explained that the additional homemaker services would be a duplication of the 21 home delivered meals that Petitioner is already authorized to receive. Dr. Liotta explained that plan enrollees can make requests for changes at any time, and the new requests will be reviewed.

15. Dr. Liotta noted that the denials in this case took place prior to Petitioner's admission to the rehabilitation facility. Dr. Liotta explained that while Petitioner is in the rehabilitation facility and not in his home, his services are suspended. Dr. Liotta explained that once Petitioner is

discharged from the rehabilitation facility, Respondent will re-evaluate his service needs (types of services needed and amount of hours needed for services).

CONCLUSIONS OF LAW

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

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

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

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

19. Because Petitioner requested new services and 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.).

20. 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.

...

1.3.18 Plan of Care A description of the enrollee's goals for long-term care, the services and supports needed to meet those goals, and the specific service needs of each enrollee, showing the projected duration, desired frequency, and type of provider furnishing each service, and the scope of the services to be provided.

...

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:

4.2.1.1 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.

4.2.1.9 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.

...

4.2.2.5 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.

21. 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.

22. In the instant case, Petitioner requested 28 hours per week of adult companion care services and an additional 10 hours per week of homemaker services. *See supra* ¶¶ 6, 7, 8 and 9. 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.*

23. 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* ¶ 20.

24. Section 4.2.1.1 of the SMMC LTC Policy reflects that adult companion care services are "[t]he 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." *See supra* ¶ 20. Section 4.2.1.9 of the SMMC LTC Policy defines homemaker services as "[t]he 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.” See supra ¶ 20.

25. Regarding ADLs, Petitioner uses assistive devices for transferring and walking/mobility, and needs: no assistance with eating; and assistance (but not total help) with bathing, dressing, using the bathroom, and transferring. See supra ¶ 3. Regarding IADLs, Petitioner needs: no assistance with using the phone; supervision or prompting with managing money; and assistance (but not total help) with heavy chores, light housekeeping, preparing meals, shopping managing medication, and using transportation. See supra ¶ 4.

26. The evidence presented in this case does not reflect that Petitioner is in need of 28 hours per week of adult companion care services and an additional 10 hours per week of homemaker services. Specifically, Petitioner requires assistance with ADLs and IADs. See supra ¶ 25. Although the record reflects that Petitioner “is home bound due to being unsteady on his feet and high risk of falls,” supra ¶ 5, the record also reflects an aide assists Petitioner with walks for exercise twice daily, at 10:00 a.m. and 10:45. *Id.* [REDACTED] believes that Petitioner should receive 24-hour care. See supra ¶ 12. Although Petitioner does not have a primary caretaker in the home, he does have a roommate. See supra ¶ 12. [REDACTED]’s letter reflects that Petitioner needs assistance with sitting, diaper changes and clean up, toileting, walking for exercise, feeding, and transferring, supra ¶ 5, but Petitioner also receives other home and community-based services, including 24-hour monitoring through PERS. See supra ¶ 11. The record includes an accounting of Petitioner’s daily schedule, supra ¶ 5, but Petitioner did not explain how the 28 hours of adult companion care services and additional 10 hours of homemaker services will be utilized to meet Petitioner’s needs (e.g., social enrichment, or the amount of time needed for

non-medical care, supervision and social enrichment). Considering the totality of Petitioner's circumstances – including the fact that Petitioner has a roommate and receives other home and community-based services – Petitioner's evidence fails to justify the approval of 28 hours of adult companion care services weekly and 10 additional hours of homemaker services. Based upon the evidence presented by both parties, Petitioner failed to establish that the requested adult companion care services and homemaker services are warranted in this case.

27. Notwithstanding the above, the SMMC LTC Policy requires that services not duplicate another service. *See supra* ¶ 20. The record reflects that Petitioner needs assistance with meal preparation. *See supra* ¶ 4 and 25. However, Petitioner is already authorized to receive 4 hours per week of homemaker services and 21 home delivered meals per week. *See supra* ¶ 11. The SMMC LTC Policy's definition of homemaker service includes "[t]he provision of general household activities (such as meal preparation). . . ." *See supra* ¶ 20. Dr. Liotta explained that the additional homemaker services would be a duplication of the 21 home delivered meals that Petitioner is already authorized to receive. *See supra* ¶ 14. Petitioner offered no evidence to dispute Respondent's position regarding the duplication of services. Further, Petitioner did not explain why the currently approved 4 hours per week of homemaker services are not sufficient to meet Petitioner's needs, nor did she explain how the approval of an additional 10 hours of homemaker services will not be duplicative of the currently approved home delivered meals and homemaking services. Based upon the facts above, Petitioner failed to establish that the additional 10 hours of homemaking services are warranted in this matter.

28. Section 1.3.14 of the SMMC LTC Policy requires that the requested 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 ¶ 20. It should be noted that Petitioner is currently authorized to receive the following home and community-based services: 14 hours per week of personal care services; 4 hours per week of homemaker services; 21 home delivered meals per week; and 24-hour monitoring through the personal emergency response services ("PERS"). See supra ¶ 11. Considering the SMMC LTC Policy's definitions for adult companion care services, homemaking services, home delivered meals, and personal care services, supra ¶ 20, Petitioner did not demonstrate that his aforementioned needs, supra ¶ 3, 4, 5 and 25, are not sufficiently met by his currently authorized services. Given that Petitioner failed to establish that the additional adult companion care services and homemaker are warranted in this matter, supra ¶ 26, the requested additional adult companion care services and homemaker services are "in excess of [Petitioner's] needs." See supra ¶ 20.

29. In light of the both parties' testimony, Respondent's Composite Exhibit 1, Respondent's Composite Exhibit 2, the SMMC LTC Policy, the Authorization Requirements Policy, and the Definitions Policy, the undersigned Hearing Officer finds that Petitioner failed to meet her burden of proving that 28 hours per week of adult companion care services and an additional 10 hours per week of homemaker services are medically necessary.


30. Accordingly, the undersigned Hearing Officer finds that Petitioner failed to prove by a preponderance of the evidence that Respondent's denial of the adult companion care services and additional homemaker services was incorrect.

DECISION

Respondent's denial of the 28 hours per week of adult companion care services is **AFFIRMED**. Respondent's denial of the 10 additional hours per week of homemaker services is **AFFIRMED**.

Petitioner's appeal based on Respondent's denial in this matter is **DENIED**.

DONE AND ORDERED this 10th day of November, 2020, in Tallahassee, Leon County, Florida.

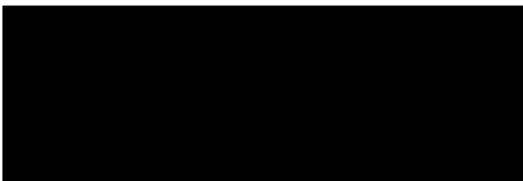
 Tracie Hardin
20-FH [REDACTED] & 20-FH [REDACTED]
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TRACIE HARDIN, Hearing Officer
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NOTICE OF A RIGHT TO JUDICIAL REVIEW

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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