



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

FILED

Nov 06, 2020, 1:32 pm

OFFICE OF FAIR HEARINGS

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PETITIONER,

AHCA Case No.: 20-FH-█

Plan ID No.: █

vs.

SUNSHINE STATE HEALTH PLAN, INC.,

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned Hearing Officer convened a telephonic Fair Hearing in the above-styled case on October 7, 2020, at █.

APPEARANCES

For the Petitioner:

█
Petitioner

For the Respondent:

Kizzy Alleyne
Senior Paralegal
Sunshine State Health Plan, Inc.

STATEMENT OF ISSUE

The issue is whether Petitioner proved by a preponderance of the evidence that Respondent's denial of Homemaker services was incorrect.

PRELIMINARY STATEMENT

All parties and witnesses appeared for the Fair Hearing telephonically. Petitioner appeared for the Fair Hearing and provided testimony. The following persons appeared as

witnesses for Petitioner: [REDACTED] (“[REDACTED]”), Victim Advocate for Petitioner; [REDACTED] (“[REDACTED]”), Petitioner’s son; and [REDACTED] (“[REDACTED]”), Petitioner’s daughter.

Kizzy Alleyne, Senior Paralegal for Sunshine State Health Plan, Inc. (“Sunshine Health”), appeared as a representative for Respondent. The following persons appeared as witnesses for Respondent: Melissa Layne, Senior Manager for Member Appeals for Sunshine Health; Catherine Blanton, Supervisor of Case Management for Sunshine Health; Jennifer Corbett, Manager of Case Management for Sunshine Health; Dr. Erin O’Brien (“Dr. O’Brien”), Medical Director for Sunshine Health; and Alshenetha Williams, Case Manager Supervisor for Sunshine Health.

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

Petitioner did not introduce any exhibits at the Fair Hearing. Respondent introduced an evidence packet containing one hundred and eleven (111) pages, which was admitted into evidence as Respondent’s Composite Exhibit 1. Respondent’s Composite Exhibit 1 included the following: Table of Contents; Medicaid Fair Hearing Summary (dated September 17, 2020); Notice of Adverse Benefit Determination (“NABD”) (dated June 11, 2020); Long Term Care Person-Centered Plan (“Previous Plan of Care”) (signed by Care Manager on May 8, 2020); Long Term Care Person-Centered Plan (“Current Plan of Care”) (signed by Care Manager on September 9, 2020); Florida Department of Elder Affairs: 701B Comprehensive Assessment (“701B Assessment”) (dated May 8, 2020); 701B Assessment (dated September 9, 2020); Standard Appeal Acknowledgment letter (dated July 30, 2020); Notice of Plan Appeal Resolution (“NPAR”) (dated August 22, 2020); Sunshine Health Policy and Procedure: LTC (Long Term Care) Ancillary

Service Criteria (LT.UM.09) (“LTC Ancillary Service Criteria”); and Florida Administrative Code Rule (“Fla. Admin. Code R.”) 59G-1.010 (166).

FINDINGS OF FACT

1. Petitioner is an enrolled member of Sunshine Health’s Long-Term Care (“LTC”) Program. See Respondent’s Composite Exhibit 1, page 2. Sunshine is a Medicaid Managed Care organization contracted by the Agency to provide services to eligible Medicaid recipients in the State of Florida.

2. Petitioner is a sixty-seven (67) year old woman residing in the community alone with her daughter. *Id.* at 49-50. Petitioner’s son is her PDO Direct Service Worker and does not live in the home. *Id.* at 53. Petitioner is diagnosed in Anxiety and Depression. *Id.* at 51, 56. Petitioner experiences the following health conditions: acid reflux/GERD; allergies; osteoarthritis; high cholesterol; occasional dizziness; fibromyalgia; rare bladder incontinence; rare bowel incontinence; sleep apnea; tardid dyskinesia; adrenal gland mass; colon polyps; and sleep apnea. *Id.* at 55-56. Petitioner receives psychiatry services for anxiety, depression, and PTSD. *Id.* Petitioner is prescribed eleven (11) medications. *Id.* at 61. As testified to by Petitioner, her mental health (such as panic attacks and emotional episodes) has increased over the past few months due to traumatic episodes of assault. As testified to by Petitioner, Petitioner does not currently receive treatment from a neurologist.

3. Petitioner needs supervision or prompt with Activities of Daily Living (“ADLs”) such as, bathing. *Id.* at 53. Petitioner needs no assistance with dressing, eating, using the bathroom, transferring, and walking/mobility. *Id.* at 53. Petitioner needs total assistance with Instrumental Activities of Daily Living (“IADLs”) such as heavy chores. *Id.* at 54. Petitioner needs assistance (but

not total help) with light housekeeping, managing money, and shopping. *Id.* Petitioner needs supervision or prompt with preparing meals and managing medication. *Id.* Petitioner needs no assistance with using the telephone and using transportation. *Id.* As testified to by Petitioner, [REDACTED] and [REDACTED] perform her financial management, shopping, cleaning, dressing, meal preparation, and laundry on her behalf. As testified to by [REDACTED], [REDACTED] has witnessed Petitioner's forgetfulness and mental health episodes first hand.

4. Petitioner's current Plan of Care includes Homemaker services – 14 hours per week, and Personal Care services – 2 hours per week. *Id.* at 29.

5. On June 4, 2020, Sunshine received Petitioner's request for an additional seven (7) hours per week of Homemaker services. *Id.* at 4-5. On June 11, 2020, Sunshine issued an NABD denying Petitioner's request for Homemaker services. *Id.* The NABD stated as follows:

Sunshine Health has reviewed your request for an additional 7 hours starting 07/01/2020 of homemaker service (the person who cleans for you), which we received on 06/04/2020. After our review, this service has been:

DENIED as of 06/11/2020.

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

- We determined that your requested services are **not medically necessary** because the services do not meet 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: The request for an extra 7 hours per week of Homemaker Services starting 07/01/2020 is denied for lack of medical necessity. Based on the assessment, the member's currently approved services are adequate to meet the member's care needs.

The member's present care plan includes:

- 2 hours per week of Personal Care Services
- 21 hours per week of Homemaker Services until 06/30/2020 and then
- 14 hours per week of Homemaker Services resuming 07/01/2020

This decision was made with Sunshine Health Policy LT.UM.09 Long Term Care Ancillary Service Criteria.

Id.

6. On August 22, 2020, Sunshine issued an NPAR denying Petitioner's plan appeal. *Id.* at 73.

The NPAR stated as follows:

On July 24, 2020, we received your timely plan appeal request about Sunshine Health's Notice of Adverse Benefit Determination dated June 11, 2020, Notice of Adverse Benefit Determination Number [REDACTED], denying the additional 7 hours per week of homemaker service (the personal who cleans for you), provided to [Petitioner].

On August 18, 2020, after consideration of the information you provided to Sunshine Health in support of your plan appeal, Sunshine Health hereby denies your plan appeal. As a result, [Petitioner] will not receive the additional 7 hours per week of homemaker service effective August 18, 2020.

The reason for our decision was: The reconsideration request for an extra 7 hours per week of Homemaker Services starting 07/01/2020 is denied and the original denial is upheld. Based on the assessment, the member's currently approved services are adequate to meet the member's care needs. The member's present care plan includes 2 hours per week of Personal Care Services, 21 hours per week

of Homemaker Services until 06/30/2020 and then 14 hours per week of Homemaker Services resuming 07/01/2020. This decision was made with Sunshine Health Policy LT.UM.09 Long Term Care Ancillary Service Criteria.

This decision was made by a Medical Director who is Board Certified Physician in Family Medicine.

Id.

7. On September 3, 2020, Petitioner timely requested a Fair Hearing to contest the denial of Homemaker services.

8. At the hearing and under oath, Petitioner argued that the 701B Comprehensive Assessment does not reflect Petitioner's needs for Homemaker services. Petitioner testified that she has experienced conflict with Sunshine Health's Case Manager assigned to perform the 701B Comprehensive Assessment. Petitioner also argued that Respondent did not review all of Petitioner's medical records and Petitioner's medical history because if they did, they would conclude that Petitioner needs the requested Homemaker services.

9. At the hearing and under oath, [REDACTED] testified that he performs a majority of Petitioner's IADLs on the Petitioner's behalf. [REDACTED] is Petitioner's Direct Service Worker ("DSW") in the Florida Medicaid PDO Program. [REDACTED] also works a full-time job outside of being Petitioner's PDO DSW. [REDACTED] argued that he spends hours helping Petitioner with paperwork. [REDACTED] testified that he will still meet the Petitioner's needs for Homemaker services, even if the services are not approved, but [REDACTED] wishes to be compensated for his natural support.

10. At the hearing and under oath, [REDACTED] testified that she works a full-time job outside of the home and resides with the Petitioner due to her increased need for care. [REDACTED] performs a majority of home cleaning tasks for the Petitioner, and [REDACTED] performs

other home care such as taking out the trash. Petitioner receives services from her General Practitioner, Psychiatrist, and Therapist.

11. At the hearing and under oath, Dr. O'Brien testified that Respondent determined that Petitioner's request for Homemaker services was not medically necessary based on the 701B Comprehensive Assessment's information concerning ADLs and IADLs. See Respondent's Composite Exhibit 1, pages 35-36. In addition, Sunshine Health considered the natural support of Petitioner's children, [REDACTED] and Mr. O'Brien to determine that Petitioner's current LTC services and Petitioner's natural support are sufficient to meet her needs for Homemaker services. Dr. O'Brien stated if Sunshine Health's Case Manager completed the 701B Comprehensive Assessment incorrectly, then it would have affected the Sunshine Health's medical necessity determination. However, Dr. O'Brien had no reason to believe that the 701B Comprehensive Assessment was recorded inaccurately. Dr. O'Brien testified that she reviewed all of Respondent's Composite Exhibit 1 prior to the hearing to make a medical necessity determination, and that if Petitioner did not submit all of Petitioner's medical records and Petitioner's medical history, then it was not reviewed by Sunshine Health.

CONCLUSIONS OF LAW

12. The Agency's Office of Fair Hearings has jurisdiction over the subject matter of this proceeding and the parties pursuant to Florida Statutes ("Fla. Stat.") § 409.285(2) (2019). This order is the final administrative decision of AHCA under Fla. Stat. § 409.285(2)(a).

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

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

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

(Emphasis added).

15. Because Petitioner requested a new service, the burden of proof is on the Petitioner. *See* Fla. Admin. Code R. 59G-1.100(17)(g). The standard of proof in an administrative hearing is a preponderance of the evidence. *Id.* The preponderance of the evidence standard requires proof by “the greater weight of the evidence” (Black’s Law Dictionary at 1201, 7th Ed.).

16. The Florida Medicaid Statewide Medicaid Managed Care Long-term Care Program Coverage Policy (“LTC Policy”) (March 2017), incorporated by reference in Fla. Admin. Code R. 59G-4.192, governs LTC services available to eligible Medicaid recipients in the State of Florida.

The 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.

...

4.1 General Criteria

Florida Medicaid covers services that meet all of the following:

- Are determined medically necessary;
- Do not duplicate another service; and
- Meet the criteria as specified in the policy.

4.2 Specific Criteria

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

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

...

4.2.1 Home and Community-Based Supportive Services

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

4.2.1.9 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:

4.2.2.6 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.

17. The Florida Medicaid Definitions Policy (August 2017) (“Definitions Policy”), which is incorporated by reference in Fla. Admin. Code R. 59G-1.010, provides definitions of commonly used terms that are applicable to all sections of Fla. Admin. Code R. 59G, unless specifically stated otherwise in a service-specific coverage policy or rule. The Definitions Policy defines Medically Necessary or Medical Necessity as:

2.83 Medically Necessary or Medical Necessity

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

- Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain
- Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient’s needs
- Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational
- Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available statewide
- Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider

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

18. Respondent relied upon the LTC Ancillary Service Criteria to make its Medical Necessity determination. See Respondent’s Composite Exhibit 1, pages 80-110. The LTC Ancillary Service Criteria states as follows regarding Adult Companion Care services:

1. Determinants for Services

When considering the level of support the member requires and which of the ancillary services may support the member's cognitive, functional, environmental, and social needs, several elements are to be considered. The review for the medical necessity of the ancillary services includes consideration of the member's support needed due to ADL deficits, living situation, and supervision needs.

a) Activities of Daily Living (ADL's)/Instrumental Activities of Daily Living (IADL's)

- Independent where member is able to provide the task without support, with or without assistive devices
- Minimal functional impairment where the ADL's require one of the following:
 - Supervision
 - At least minimum assistance
 - Member ambulates with assistance of a person or a device
 - Member transfers require at least minimum assistance
- Moderate functional impairment where two of the follow apply
 - Member has ADLs requiring at least minimal assistance
 - Member ambulates with assistance of a person or device
 - Member transfers require at least minimum assistance
- Maximum and persistent functional impairment without available caregiver support where all of the following exist:
 - Member has ADLs requiring total assistance
 - Member is non-ambulatory
 - Member transfers require one (1) to two (2) person assist
 - Member's treating physician has certified that member meets Maximum unctional impairment.

b) Living situation consideration

- Lives alone.
- Lives with family (with consideration of the number of days and hours that family members are not available to assist the member). Lives with non-family (with consideration of the number of days and hours that nonfamily members are not available to assist the member).

c) Supervision needs, including:

- Wandering risk: Member has already been found to leave their home unsafely and/or is unable to find their way back.
- Confused/disoriented and at risk to themselves: Member is confused and/or disoriented to the point that they are unable to perform functional activities, and if they do are at risk of harm to themselves.
- Member has a cognitive impairment that prevents them from knowing when or how to carry out personal care tasks and caregivers are not able

to provide the services. The member is incapable of learning despite efforts to train in the care tasks. The member has memory deficits, which prevent them from managing care tasks.

- Member is unable to call for help, even with a personal emergency response unit. Member's medical status will not permit the member to all for help, even with assistance of a personal emergency response unit.

d) Available Supports

- No assistance needed or Always has assistance
- Has assistance most of the time
- Rarely has assistance
- Never has assistance

Services in Place

- Provided by Sunshine Health
- Provided by other Provider insurance

The criteria for each ancillary service is described below:

6. Homemaker Services

Homemaker provides assistance with essential shopping, light housework, laundry, and meal preparation. These services are provided to members who exhibit a functional deficit that impairs their ability to complete these tasks and lack an available support system. Services are provided to support member's health, safety, and ensure basic standards are met. Services are provided by a trained homemaker when the individual regularly responsible for these services is temporarily absent or unable to manage these activities.

Approval Criteria

Homemaker Service reviews include four (4) criteria:

- a) Instrumental Activity of Daily Living (IADL) limitations
- b) Living situation
- c) Supervision needs
- d) Available Supports

See Section C.1 for more details

Covered Homemaker service may include:

- a) Light housekeeping includes mopping floors, vacuuming, dusting, cleaning counters and sinks, cleaning the stove and refrigerator, washing dishes, taking out the trash, changing and making the bed, and cleaning the tub/shower and toilet.

Housekeeping Considerations:

- Includes cleaning tasks necessary to attain and maintain sanitary living conditions for the member and is incidental to care being provided to the member
- For members living alone, housekeeping may apply to the entire residence but is limited to areas the member uses, including bedroom, bathroom, kitchen, and sitting area.
- The entire size of the home may be considered if cleaning of specific areas not used by the member is needed to maintain sanitary living conditions.
- For members sharing a residence, housekeeping applies only to the areas used by the member. This area includes the member's bedroom and one bathroom.

b) Shopping for the recipient's food and essential household items, picking up prescriptions and needed medical supplies

Shopping Considerations:

- Member' ability to obtain groceries, household goods, and medications on their own
- Member's ability to put away groceries, household goods, and medications on their own
- Member lives with family who does the shopping for the member and puts away groceries, household goods and medications
- Member has other supports who do the shopping for the member and puts away groceries, household goods and medications

c) Meal preparation includes menu planning, storing, preparing, cooking, and serving food (buttering bread and cutting food into bite size pieces, plating). Meal preparation does not include the cost of the food.

Meal Preparation considerations

- Number of meals per days eaten by member or number of meals the member should eat per day
- Number of daily meals prepared by a caregiver and left in a location that the member can access, heat if necessary, and get to the table to eat.
- Meal preparation tasks member is able to complete independently. Is member able to use the microwave stove or oven?
- Amount of assistance needed in the preparation and cleanup, such as:
 - Meal planning
 - Meal preparation
 - Special diets
 - Special food preparation
 - Assembling food on plates

- Getting food to the table
- Will additional supports allow the member to eat more often or improve nutritional status

d) Laundry includes washing, drying, folding, and putting away the recipient's personal laundry. The recipient pays all Laundromat and/or cleaning fees.

Laundry Considerations:

Identify the amount of laundry to be done on a weekly basis, including washing, drying, folding and putting away member's clothes, bed linens and towels, including:

- Amount of clothing and other items to be laundered
- Identify if member soils their clothing or bedding due to incontinence, therefore more frequent laundry is needed, which results in more smaller loads
- Preparing clothes and other items to be washed
- Putting the clothes and other items in the washer and dryer
- Hanging clothes and other items to dry
- Other chores could be done while the member's clothes or other items are being washed, dried, folded, and put away.
- If laundry must be done in an apartment laundry room or a community laundry, additional time can be given for waiting for the laundry to be done.
- Routine changing of bed linens is considered part of bedroom housekeeping

Exclusions and Limitations for Homemaker include but are not limited to:

1. Service must be provided at member's residence.
2. Member must reside in a non-facility based setting.
3. For members sharing a residence, housekeeping applies only to the areas used by the member. This area includes the member's bedroom and one bathroom.
4. Homemaker services shall not be provided overnight.
5. Homemaker services provided by Sunshine Health may not duplicate services that are provided under by another provider.
6. Member/member's representative must be able to provide direction to aid when aid is in the home.
7. Care, grooming, or feeding of pets and animals
8. Yard work, gardening, or home maintenance work
9. Escort Services
10. Day care or afterschool care
11. Assistance with homework
12. Meal preparation does not include the cost of meals

Pest Control and Chore services are include under homemaker.

6a. Pest Control Services

For the purpose of this guideline, pests are defined as roaches, fleas, ticks, mice, and rats. Pest Control Services are services to regulate pests and to enhance safety, sanitation, and cleanliness of the member's residence. This service is provided due to health and safety issues associated with pest infestation in a tropical climate. Services are provided to regulate pests that can be hazardous to persons with declining health if present in the recipient's environment.

Prior to using the Pest Control Benefits, the LTC Care Coordinator is responsible for coordination of benefits and utilizing covered benefits under Medicare, Veterans Administration, MMA, LTC, and any additional insurances member has available.

The pest control benefit, if approved will be authorized for a period of 3 consecutive months to provide a reduction of pest infestation within the member's primary residence for each occurrence.

Approval Criteria

1. Pests are present inside the member's home residence. For the purpose of this guideline, pests are defined as roaches, fleas, ticks, mice, and rats.
2. CC observes pests or observable evidence of pest infestation and documents this on the 701B's Residential Living Environment section (page 11) in the comments section.
3. Pests must present a direct threat to the member's physical health
4. Member is the homeowner
5. CC reviews pest control handout with member/authorized representative

Exclusions and Limitations include but are not limited to:

1. Services must be provided at member's residence.
2. Pest Control can only be approved if no other relative, caregiver, landlord, community agency, volunteer agency or third party is capable of performing or is responsible for this service. If the member's home is a rental property, the landlord's responsibilities must be verified before services are approved.
3. If the member resides in the home with a family member who owns the home or is the lessee, the family member(s) is responsible for pest control.
4. If member is the lessee, the lease agreement is examined and states it is not the landlord's responsibility to provide pest control.
5. Member / authorized representative does not plan to move to another location within 90 days of the service delivery date as documented in the case notes.

6. CC determines prior to requesting the service that the member does not have any health conditions that need to be considered by the pest control provider.
7. Pest Control services provided by Sunshine Health may not duplicate services that are provided under by another provider.
8. Pest control provider must be allowed full access to residence for assessment and treatment purposes.
9. When the Provider gives member follow up instructions to prevent re-infestation, member or authorized representative will abide by guidelines provided. Case management will provide support as needed.

Bed bug requests are subject the general exclusions and limitations listed above in for general pest control in addition to these criteria:

- Service are only provided 1x/year
- Member / authorized representative must be able and willing to part with infested furniture as indicated by the pest control provider.
- Abide by the scope of work for the treatment (are we able to deny if member does not abide by post treatment instructions

When the Provider gives member follow up instructions to prevent re-infestation, member or authorized representative will abide by guidelines provided. Case management will provide support as needed.

6b. Chore Services

Those services needed to maintain the member in a home that is clean and sanitary and provides a safe environment. Chore services include heavy household chores such as washing floors, windows, and walls, tacking down rugs and tiles, and moving heavy items of furniture in order to provide safe access and egress. Chore services performed on the exterior of the member's home are limited to those promoting safe access and egress to the home.

Enhanced Chore Services: May include removal of debris, cleaning roofs and gutters, correcting code violations, cleaning carpet, as well as renting dumpsters, carpet cleaning machines, and protective clothing for the provider. This service is only provided when neither the member nor anyone else in the household is capable of performing or financially able to obtain this service. This can only be approved if no other relative, caregiver, landlord, community agency, volunteer agency or third party is capable of performing or is responsible for this service. If the member's home is a rental property, the landlord's responsibilities must be verified before services are approved. The services must be performed at the member's residence. A team of no more than three (3) people may be used

Respondent's Composite Exhibit 1, pages 80-110.

19. Petitioner is a 67-year-old woman residing in the community with her primary caregiver, [REDACTED]. See supra ¶ 2. Petitioner's current Plan of Care includes 14 hours per week of Homemaker services, and 2 hours per week of Personal Care services. See supra ¶ 4. Respondent relied upon the 701B Comprehensive Assessment to determine Petitioner's need for additional Homemaker services. See supra ¶ 11. The 701B Comprehensive Assessment documented Petitioner's needs for ADLs and IADLs. See supra ¶ 3. Respondent denied Petitioner's request for seven (7) hours per week of Homemaker services based on medical necessity. See supra ¶ 5-6, 11. Respondent used the 701B Comprehensive Assessment to determine that Petitioner's request was not medically necessary as well as Petitioner's natural supports. See supra ¶ 11.

20. The LTC Policy covers Homemaker services if they are deemed to be medically necessary. See supra ¶ 16. Because Personal Care services are classified as a "home and community-based supportive service," the LTC Policy's definition of medical necessity applies in this instance. See supra ¶ 16. To be medically necessary, a service must meet the criteria set forth in section 1.3.14 of the LTC Policy. See supra ¶ 16. Based on Dr. O'Brien's testimony, Respondent denied Petitioner's request for an additional seven (7) hours per week of Homemaker services for not meeting the following medical necessity standard: Services must be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs. See supra ¶ 11. This criterion is incorporated in section 1.3.14 of the LTC Policy. See supra ¶ 16.

21. Homemaker services provide assistance "general household activities (such as meal preparation) and routine household care (including laundry and pest control)." See supra ¶ 16. Because Petitioner requested an additional seven (7) hours per week of Homemaker services,

the undersigned considered Petitioner's current LTC services and natural supports to determine Petitioner's unmet need for Homemaker services. In order to be medically necessary, the quantity of hours for the instant request must be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the Petitioner's needs. Petitioner argued that the 701B Comprehensive Assessment does not reflect Petitioner's needs for Homemaker services. *See supra* ¶ 8. Dr. O'Brien testified that Sunshine Health's medical necessity determination would have been affected if Sunshine Health's Case Manager completed the 701B Comprehensive Assessment incorrectly. *See supra* ¶ 11. However, Respondent found no reason to believe that the 701B Comprehensive Assessment was completed incorrectly. *See supra* ¶ 11. Petitioner did not identify any information in the 701B Comprehensive Assessment that was inaccurate. Further, Petitioner argued that Respondent did not review all of Petitioner's medical records and Petitioner's medical history because if they did, they would conclude that Petitioner needs the requested Homemaker services. *See supra* ¶ 8. Dr. O'Brien testified that all of Petitioner's medical records and Petitioner's medical history was not reviewed because it was not submitted to Sunshine Health. *See supra* ¶ 11. Petitioner did not submit any medical records or medical history in preparation for the Fair Hearing.

22. The record indicates that Petitioner's children, [REDACTED] and [REDACTED], meet the Petitioner's needs for Homemaker services on their own both as a DSW ([REDACTED]) and as natural supports ([REDACTED] and [REDACTED]). [REDACTED] lives in the home and performs a majority of the cleaning. [REDACTED] testified that he will still meet the Petitioner's needs for Homemaker services, even if the services are not approved, but [REDACTED] wishes to be compensated for his natural support. Both Petitioner and [REDACTED] testified that Petitioner's

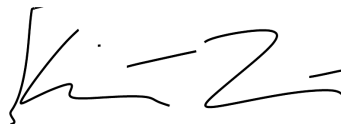
needs have increased, but neither witness specifically identified how Petitioner's needs have increased. Upon consideration of the testimony elicited, Petitioner and her witnesses provided insufficient evidence and testimony as it relates to Petitioner's additional need for seven (7) hours per week of assistance with general household activities (such as meal preparation) and routine household care (including laundry and pest control) by a trained homemaker. In light of the current LTC services and the natural support of Petitioner's children, the record does not indicate that the Petitioner has an unmet need of seven (7) hours per week of Homemaker services. Thus, the Petitioner did not meet the first criterion for medical necessity under § 1.3.14(b) of the LTC Policy.

23. Accordingly, in light of the both parties' sworn testimony, Respondent's Composite Exhibit 1, the LTC Policy, Petitioner's current Personal Care services and Homemaker services, Petitioner's natural supports, and the cited rules and regulations, the undersigned Hearing Officer finds that Petitioner did not prove by a preponderance of the evidence that Respondent's denial of an additional seven (7) hours per week of Homemaker services was incorrect.

DECISION

Respondent's denial of Homemaker services is **AFFIRMED**. Petitioner's request for relief is hereby is **DENIED**.

DONE AND ORDERED this 6th day of November, 2020, in Tallahassee, Leon County, Florida.



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Kristopher León
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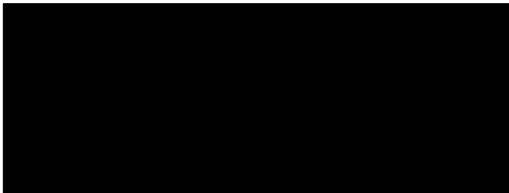
KRISTOPHER LEÓN, Hearing Officer
Agency for Health Care Administration

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NOTICE OF A RIGHT TO JUDICIAL REVIEW

A PARTY WHO IS ADVERSELY AFFECTED BY THIS FINAL ORDER IS ENTITLED TO JUDICIAL REVIEW, WHICH SHALL BE INSTITUTED BY FILING THE ORIGINAL NOTICE OF APPEAL WITH THE AGENCY CLERK OF AHCA, AND A COPY, ALONG WITH THE FILING FEE PRESCRIBED BY LAW, WITH THE DISTRICT COURT OF APPEAL IN THE APPELLATE DISTRICT WHERE THE AGENCY MAINTAINS ITS HEADQUARTERS OR WHERE A PARTY RESIDES. REVIEW PROCEEDINGS SHALL BE CONDUCTED IN ACCORDANCE WITH THE FLORIDA APPELLATE RULES. THE NOTICE OF APPEAL MUST BE FILED WITHIN 30 DAYS OF THE RENDITION OF THE ORDER TO BE REVIEWED.

COPIES FURNISHED TO:



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