



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

FILED

Nov 25, 2020, 8:28 am  
OFFICE OF FAIR HEARINGS

[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 October 29, 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 issue is whether Petitioner proved by a preponderance of the evidence that Respondent's denial of an additional 20 hours per week of personal care services was 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. Petitioner appeared for the hearing and did not provide testimony.

David Jones, State Fair Hearing Coordinator for UnitedHealthcare of Florida, Inc. ("United"), appeared as a representative for Respondent. Dr. Albenah Baharieva ("Dr. Baharieva"), Medical Director for United, appeared as a witness for Respondent.

Lisa Sanchez, Medical/Health Care Program Analyst 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 16-page evidence packet. The packet included the following documents: an email from [REDACTED] to the Office of Fair Hearings, dated October 17, 2020; Petitioner's Statement of Facts; the completed Designation of Authorized Representative for Medicaid Fair Hearing Participation (Sample), dated October 15, 2020; the Power of Attorney, dated August 27, 2014; Petitioner's medical records for a visit dated of [REDACTED] 2020; Petitioner's medical records for [REDACTED], 2020; a letter from [REDACTED] ("[REDACTED]"), dated June 17, 2020; and Petitioner's medical record, dated [REDACTED] 2020. Absent an objection from Respondent, the undersigned admitted Petitioner's 16-page evidence packet into evidence as Petitioner's Composite Exhibit 1.

Prior to the hearing, Respondent sent to the Office of Fair Hearings and Petitioner a 270-page evidence packet. The packet included the following documents: a Medicaid Fair Hearing Statement of Matters; 2 address pages; a blank page; a Notice of Adverse Benefit Determination ("NABD"), dated August 17, 2020; Respondent's CSP – General Request Form; the Authorization for Release of Information; an 11-page facsimile transmission ("fax"); a 13-page fax, dated

██████████, 2020; an address page; a blank page; Respondent’s letter to Petitioner, dated August 27, 2020; Respondent’s Print HSC History – HSR Production Environment; the Florida Department of Elder Affairs: 701B Comprehensive Assessment (“701B”), reflecting an assessment date of June 3, 2020; Respondent’s Appeal Review notes; an address page; a blank page; a Notice of Plan Appeal Resolution (“NPAR”), dated September 8, 2020 (English and Spanish versions); Exhibit 2 (References) Cover Page – Long Term Care; Fla. Admin. Code R. 59G-1; the Florida Medicaid Definitions Policy (August 2017) (“Definitions Policy”); 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); Private Duty Nursing Services Fee Schedule (January 1, 2017); Home Health Visit Services Fee Schedule (January 1, 2017); Personal Care 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. Absent an objection from Petitioner, the undersigned admitted Respondent’s 270-page 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, dual with Medicare and LTC Home and Community Based Services. *See*

Respondent's Composite Exhibit 1, page 47. United is a managed care organization contracted by AHCA to provide services to eligible Medicaid recipients in Florida.

2. Petitioner is a ■-year-old female who lives in a private residence. See Respondent's Composite Exhibit 1, page 51. Petitioner has the following health conditions: past and current acid reflux/gastroesophageal reflux disease; past and present allergies; past mild anemia; past and present arthritis – "OA, Generalized, Upand [sic] down her Spine;" past and present high blood pressure; past and present high cholesterol; past and present dizziness; past and present frequent bladder incontinence; past and present osteoporosis; and past urinary tract infection. See Respondent's Composite Exhibit 1, pages 57 – 58.

3. The 701B reflects the following regarding Petitioner's Activities of Daily Living ("ADLs"). Petitioner needs not assistance with eating. See Respondent's Composite Exhibit 1, page 55. Petitioner uses assistive devices for transferring and walking/mobility. *Id.* Petitioner needs assistance (but not total help) with bathing, dressing, and using the bathroom. *Id.* The 701B reflects that Petitioner "NEEDS ASSISTANCE WITH HER ADLS DUE TO HER UNSTEADY GAIT AND WEAKNESS." *Id.* Regarding the amount of assistance Petitioner has with ADLs, the 701B reflects that Petitioner always has assistance with bathing, dressing, and using the bathroom, and needs no assistance with eating, transferring, and walking/mobility. *Id.*

4. The 701B reflects the following regarding Petitioner's Instrumental Activities of Daily Living ("IADLs"). Petitioner needs total assistance (cannot do at all) with heavy chores. See Respondent's Composite Exhibit 1, page 56. Petitioner needs no assistance with using the phone. *Id.* Petitioner needs supervision or prompting with managing medication and using transportation. *Id.* Petitioner needs assistance (but not total help) with light housekeeping,

managing money, preparing meals, and shopping. *Id.* Regarding the amount of assistance Petitioner has with IADLs, the 701B reflects that Petitioner always has assistance with heavy chores, light housekeeping, managing money, preparing meals, shopping, managing medication and using transportation. *Id.* The 701B also reflects that Petitioner has assistance most of the time with using the telephone. *Id.* Further, the 701B reflects the following:

CLIENT NEEDS ASSISTANCE WITH HER IADLS. CLIENT CAN MANAGE MEDS ON HER OWN BUT HER DAUGHTER STILL PROVIDES SUPERVISION FOR IT. CLIENT HAS INCONTINENCE WITH DIAPERS WHICH SHE NEEDS HELP IN CHANGING AND THE DAUGHTER PROVIDES HELP DOING SO. EE HAS 2 hrs of HMK via UNITED HOME CARE.

5. On August 17, 2020, Respondent issued an NABD denying Petitioner's request for an additional 20 hours per week of personal care services, explaining that the requested services are not medically necessary. *See Respondent's Composite Exhibit 1, page 5.*

6. Petitioner requested a plan appeal. *See Respondent's Composite Exhibit 1, page 78.* On September 8, 2020, Respondent sent Petitioner an NPAR, denying Petitioner's plan appeal. *Id.*

The NPAR stated as follows:

On September 4, 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.

...

You asked for personal care. You would like 20 more hours a week. You need help with daily activities. Based on my professional judgment, we are not approving these extra hours because they are in excess of your needs. You have 5 hours a week of personal care approved by the health plan. You have family who can help some. These should meet your personal care needs. You have other paid services to help some too. This is why we cannot approve what you asked for. Please talk about this with your doctor.

Respondent's Composite Exhibit 1, pages 78 – 79.

7. Petitioner included in her evidence packet the medical record from her medical visit on [REDACTED] 2020, for back pain and lumbar pain. See Petitioner's Composite Exhibit 1, page 9. Petitioner's medical record for an office visit on [REDACTED], 2020, reflects a chief complaint of "[l]ow back pain with radiation into the bilateral lower extremities." *Id.* at 10.

8. Petitioner is currently authorized to receive the following services: 5 hours per week of personal care services; 2 hours per week of homemaker services; 5 home delivered meals per week; and personal care supplies (pull-ups, A&D ointment, and underpads). See Respondent's Composite Exhibit 1, page 72.

9. On September 16, 2020, Petitioner requested a Fair Hearing due to the denial of the additional 20 hours per week of personal care services. On September 23, 2020, the undersigned scheduled the Fair Hearing for October 29, 2020, at [REDACTED], and all parties were duly notified.

10. [REDACTED] is Petitioner's daughter and primary caregiver. Petitioner resides in the home with [REDACTED] and [REDACTED] husband. [REDACTED] does not work and is "disabled." [REDACTED] is blind, has health issues of her own, and is only able to provide limited assistance to Petitioner. [REDACTED] husband does not have a set work schedule, and Petitioner does not allow him to assist her with personal matters such as bathing. When [REDACTED] is not present or goes out, she has someone from the neighborhood to stay with Petitioner. [REDACTED] has someone to do the shopping for her, or she goes with someone. [REDACTED] explained that she can supervise Petitioner's needs, but she cannot assist Petitioner with the needs.

11. [REDACTED] believes that Petitioner's condition is deteriorating, and that Petitioner needs care 24 hours per day. [REDACTED] believes that Petitioner's condition has changed since the 701B assessment conducted on June 3, 2020, and [REDACTED] has not requested another assessment.

12. Dr. Baharieva is a Medical Director at United. Dr. Baharieva explained that the Respondent determined that the additional 20 hours per week of personal care services were not medically necessary, as Petitioner: has natural supports; resides with family members who can prepare meals, do shopping and laundry; and receives personal care services, homemaker services and home delivered meals.

#### **CONCLUSIONS OF LAW**

13. 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).

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

15. 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.

16. 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.).

17. 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:

...

#### **4.2.1.8 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 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.

18. 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.

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

#### **1.1 Description**

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

#### **1.1.1 Florida Medicaid Policies**

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

...

## **1.2 Definitions**

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

### **1.3.1 Authorization**

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

### **1.3.2 Claim Reimbursement Policy**

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

### **1.3.3 Coverage and Limitations Handbook or Coverage Policy**

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

### **1.3.4 General Policies**

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

### **1.3.5 Medically Necessary/Medical Necessity**

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

### **1.3.6 Provider**

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

### **1.3.7 Quality Improvement Organization**

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

...

## **2.4.3 Modifications**

Providers must submit a modification request to the QIO to update the authorization when the recipient requires a different level of service (amount, frequency, duration, or scope) than is currently authorized. Providers must submit

additional information documenting the need for the change, including an updated physician's order and plan of care (as applicable) with the request.

Authorizations Policy, pages 1 and 3.

20. 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.

21. In the instant case, Petitioner requested an additional 20 hours of personal care services per week. *See supra* ¶ 5 and 6. 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.*

22. 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* ¶ 17.

23. Section 4.2.2.6 of the SMMC LTC Policy reflects that personal care services are “[t]o provide assistance with ADLs and IADLs, including assistance with preparation of meals, and housekeeping chores which are incidental to the care furnished or are essential to the health and welfare of the enrollee.” See *supra* ¶ 17.

24. The evidence presented in this case does not reflect that Petitioner is in need of an additional 20 hours per week of personal care services. Specifically, section 1.3.14 of the SMMC 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.” In this case, the 701B reflects that Petitioner requires assistance with all ADLs and IADLs. See *supra* ¶ 3 and 4. Petitioner has multiple medical conditions, *supra* ¶ 2, including dizziness, arthritis, and frequent bladder incontinence. See *supra* ¶ 2. However, the record reflects that Petitioner has natural supports available to assist with her care and needs. Section 1.3.14 of the SMMC 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* ¶ 17. Petitioner resides in the home with [REDACTED] and [REDACTED] husband. See *supra* ¶ 10. [REDACTED] is blind and has health issues of her own, but she is still Petitioner’s primary caregiver and she does not work. See *supra* ¶ 10. When [REDACTED] is not present or goes out, she has someone from the neighborhood to stay with Petitioner. See *supra* ¶ 10. Although [REDACTED] is only able to provide limited assistance to Petitioner, *supra* ¶ 10, Petitioner is currently

authorized to receive the following services: 5 hours per week of personal care services; 2 hours per week of homemaker services; 5 home delivered meals per week; and personal care supplies (pull-ups, A&D ointment, and underpads). See supra ¶ 8. ██████████ explained that she can supervise Petitioner's needs, but she cannot assist Petitioner with the needs. See supra ¶ 10. However, regarding the amount of assistance Petitioner has with ADLs, the 701B reflects that Petitioner always has assistance with bathing, dressing, and using the bathroom, and needs no assistance with eating, transferring, and walking/mobility. See supra ¶ 3. Additionally, regarding the amount of assistance Petitioner has with IADLs, the 701B reflects that Petitioner always has assistance with heavy chores, light housekeeping, managing money, preparing meals, shopping, managing medication and using transportation. See supra ¶ 4. Additionally, the 701B states "CLIENT CAN MANAGE MEDS ON HER OWN BUT HER DAUGHTER STILL PROVIDES SUPERVISION FOR IT. CLIENT HAS INCONTINENCE WITH DIAPERS WHICH SHE NEEDS HELP IN CHANGING AND THE DAUGHTER PROVIDES HELP DOING SO." See supra ¶ 4. ██████████ provided no additional 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 20 hours of personal care services weekly.

25. ██████████ contends that Petitioner's condition is deteriorating, and that Petitioner needs care 24 hours per day. See supra ¶ 11. However, the record does not support either of these arguments. Although Petitioner provided medical records from health care visits that took place on ██████████ 2020, and ██████████, 2020, supra ¶ 7, neither appears to demonstrate a deterioration of Petitioner's medical condition, as they appear to address that Petitioner experiences back pain and lumbar pain. See supra ¶ 7. ██████████

believes that Petitioner's condition has changed since the 701B assessment was conducted on June 3, 2020, but [REDACTED] has not requested another assessment. See supra ¶ 11.


26. Therefore, considering Petitioner's currently authorized services, along with the SMMC LTC Policy definition for personal care services, homemaker services, home delivered meals, and natural support, Petitioner did not demonstrate that her aforementioned needs, supra ¶ 2, 3, and 4, are not sufficiently met by his currently authorized services. Given that Petitioner failed to establish that the requested personal care services are warranted in this matter, supra ¶ 24-25, the requested personal care services are "in excess of [Petitioner's] needs." See supra ¶ 17.

27. In light of the both parties' testimony and evidence, the SMMC LTC Policy, the PC 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 20 hours per week of personal care services are medically necessary. 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 was incorrect.

### **DECISION**

Respondent's denial of an additional 20 hours per week of personal care services is **AFFIRMED**. Petitioner's appeal based on Respondent's denial in this matter is **DENIED**.

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

 Tracie Hardin  
20-FH [REDACTED]  
2020.11.25 07:17:27 -05'00'

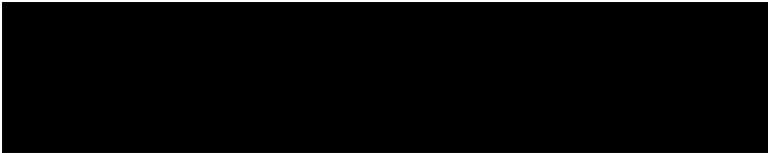
**TRACIE HARDIN, Hearing Officer**

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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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