



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

FILED

Dec 15, 2020, 9:47 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 November 13, 2020, at 1 [REDACTED]

[REDACTED]

**APPEARANCES**

For the Petitioner:

[REDACTED]

Petitioner's Authorized Representative

For the Respondent:

David 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 50 hours per week of personal care services was incorrect.

## PRELIMINARY STATEMENT

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

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

Doris Rivera, 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 264-page evidence packet. The packet included the following documents: Case Documents cover sheet; Table of Contents; Exhibit List; Fair Hearing Request Brief; Florida Medicaid Statewide Managed Care Long-term Care Program Coverage Policy (March 2017) (“LTC Policy”); Florida Medicaid Definitions Policy (August 2017) (“Definitions Policy”); Florida Administrative Code Rule (“Fla. Admin. Code R.”) 59G-4.180; letter from Department of Veterans Affairs (“VA”), dated August 14, 2019; VA Health Care Catastrophically Disabled Veterans Fact Sheet 16 – 15, February 2011; denial letter, dated June 2, 2020; fax cover sheet, dated May 15, 2020; letter from [REDACTED], dated May 15, 2020; acknowledgement letter, dated May 18, 2020; fax cover letter, dated May 15, 2020; letter from [REDACTED], dated May 15 2020; Florida Department of Elder Affairs 701B Comprehensive Assessment (“701B Assessment”), dated February 21, 2020; email from [REDACTED], dated May 15, 2020; email from [REDACTED], dated May 15, 2020; [REDACTED], dated May 22, 2020; email from [REDACTED], dated June 2, 2020; Notice of Adverse

Benefit Determination, dated April 2, 2020; United mail tracking information; fax cover sheet from Department of Veterans Affairs, dated May 18, 2020; letter from [REDACTED], dated May 18, 2020; fax from [REDACTED], dated May 20, 2020; letter from [REDACTED], dated May 18, 2020; letter from [REDACTED], dated May 19, 2020; fax cover sheet, dated May 26, 2020; letter from [REDACTED], dated May 26, 2020; email from [REDACTED], dated May 20, 2020; letter from [REDACTED], dated May 22, 2020; fax from [REDACTED], dated May 15, 2020; four sets of Appeal Review notes; fax cover sheet, dated May 18, 2020; letter from [REDACTED], dated May 18, 2020; fax cover sheet, dated May 20, 2020; letter from [REDACTED], dated May 18, 2020; fax from [REDACTED], dated May 19, 2020; letter form [REDACTED], dated May 19, 2020; fax cover sheet, dated May 19, 2020; letter from [REDACTED], dated May 19, 2020; televisit notes from [REDACTED], dated [REDACTED] 2020; Progress Note from [REDACTED], dated [REDACTED] 2019; fax cover sheet, dated May 26, 2020; letter from [REDACTED], dated May 26, 2020; Medications, dated May 26, 2020; Progress Notes, dated [REDACTED] 2020; fax cover sheet, dated May 26, 2020; letter from [REDACTED], dated May 26, 2020; fax from [REDACTED], dated May 15, 2020; Florida Durable Power of Attorney, dated May 10, 2020; Notice of Plan Appeal Resolution (“NPAR”), dated June 2, 2020; letter from [REDACTED], dated May 26, 2020; letter from Robert Slaton, dated June 25, 2020; letter form [REDACTED], dated May 19, 2020; letter form [REDACTED], dated May 18, 2020; letter form [REDACTED], dated May 15, 2020; Florida Durable Power of Attorney, dated May 10, 2019; televisit notes, dated [REDACTED] 2020; Progress Notes, dated [REDACTED] 2019; and photograph of Petitioner. Absent an objection from Respondent, the undersigned admitted Petitioner’s 264-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 328-page evidence packet. The packet included the following documents: a Medicaid Fair Hearing Statement of Matters; an address pages; a blank page; a Notice of Adverse Benefit Determination (“NABD”), dated April 2, 2020; fax from [REDACTED], dated May 15, 2020; letter from [REDACTED], dated May 15, 2020; fax cover sheet, dated May 19, 2020; letter from [REDACTED], dated May 19, 2020; acknowledgement letter, dated May 15, 2020; fax cover sheet, dated May 15, 2020; Florida Durable Power of Attorney, dated May 10, 2020; acknowledgement letter, dated May 18, 2020; email from [REDACTED], dated May 15, 2020; email from [REDACTED], dated May 15, 2020; email from [REDACTED], dated May 20, 2020; email from [REDACTED], dated May 22, 2020; email from [REDACTED], dated June 2, 2020; email from [REDACTED], dated June 4, 2020; email from [REDACTED], dated June 4, 2020; Respondent’s Print HSC History; the Florida Department of Elder Affairs: 701B Comprehensive Assessment (“701B Assessment”), dated February 21, 2020; fax cover page, dated May 20, 2020; letter from [REDACTED], dated May 18, 2020; letter from [REDACTED], dated May 19, 2020; Televisit Notes of [REDACTED], dated [REDACTED] 2020; Progress Note, dated [REDACTED] 2019; fax cover sheet, dated May 26, 2020; letter form [REDACTED], dated May 26, 2020; list of medications, printed May 26, 2020; Progress Notes, printed May 26, 2020; fax cover sheet, dated May 26, 2020; letter from [REDACTED], dated May 26, 2020; fax cover sheet, dated May 18, 2020; letter form [REDACTED], dated May 18, 2020; an address page; a blank page; a NPAR, dated June 2, 2020; Exhibit 2 (References) Cover Page – Long Term Care; Fla. Admin. Code R. 59G-1; the Definitions Policy; the LTC Policy; Florida Medicaid Authorization Requirements Policy (June 2016); Florida Medicaid Personal Care Services Coverage Policy (November 2016) (“PC Policy”); Florida Medicaid Private

Duty Nursing Services Coverage Policy (November 2016); Home Health Visit Services Fee Schedule (January 1, 2017); Personal Care Services Fee Schedule (January 1, 2017); Private Duty Nursing Services Fee Schedule (January 1, 2017); the Agency's Participant Direction Option Manual; 42 C.F.R. 441.480; Florida Medicaid Hospice Services Coverage Policy (June 2016); 42 C.F.R. 418 Subpart C – Conditions of Participation: Patient Care; section 400.6105, Florida Statutes ("Fla. Stat.") (2018); section 400.609, Fla. Stat.; section 409.910, Fla. Stat.; section 400.462, Fla Stat.; and a second copy of Fla. Admin. Code R. 59G-1. Absent an objection from Petitioner, the undersigned admitted Respondent's 328-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 at page 50. United is a managed care organization contracted by AHCA to provide services to eligible Medicaid recipients in Florida.

2. Petitioner is an 89-year-old male who lives in a private residence with his wife who is 87 years old. *Id.* Petitioner's wife is his primary caregiver. *Id.* Petitioner has the following health conditions: Parkinson's disease and depression, Alzheimer's dementia, macular degeneration, skin cancer, Congestive Heart Failure with fluid overload, Coronary Artery Disease (quadruple bypass), spinal stenosis, Atrial Fibrillation, hypertension, bilateral hearing loss, and bowel and bladder incontinence. *Id.* at 50, 85, and 90 and Petitioner's Composite Exhibit 1 at page 9. Petitioner is categorized by the VA as "Catastrophically Disabled." See Petitioner's Composite Exhibit 1 at page 5. Petitioner is unable to walk and must be transferred with a hooyer lift from

the bed to chair, wheelchair or bathroom. See Respondent's Composite Exhibit 1 at pages 50 and 58. In the past 6 months, Petitioner has had 3 falls, 2 emergency room visits, and 2 hospitalizations. *Id.* at 50 and 57.

3. Regarding Petitioner's Activities of Daily Living ("ADLs"), Petitioner needs total assistance with bathing. *Id.* at 59. Petitioner needs assistance (but not total help) with dressing, eating, using the bathroom, transferring, and walking/mobility. *Id.* Regarding the amount of assistance Petitioner has with ADLs, the 701B Assessment reflects that Petitioner always has assistance with bathing, dressing, eating using the bathroom, transferring, and walking/mobility. *Id.* Petitioner uses a wheelchair, hooyer lift, walker and rollator. *Id.* at 58. He is not able to stand or walk on his own. *Id.* at 111.

4. Regarding Petitioner's Instrumental Activities of Daily Living ("IADLs"), Petitioner needs total assistance (cannot do at all) with heavy chores, light housekeeping, managing money, preparing meals, shopping, managing medication, and using transportation. *Id.* at 59. Petitioner needs assistance (but not total help) with using the phone. *Id.* Regarding the amount of assistance Petitioner has with IADLs, the 701B Assessment reflects that Petitioner always has assistance with heavy chores, light housekeeping, using the telephone, managing money, preparing meals, shopping, managing medication and using transportation. *Id.*

5. On April 2, 2020, Respondent issued an NABD partially denying Petitioner's request for an additional 66 hours per week of personal care services and explaining that the requested services are not medically necessary. *Id.* at 4 - 7. The NABD stated:

UnitedHealthcare Community Plan has reviewed your request for 66 more hours a week of Personal Care, which we received on 03/30/2020. After our review, this service has been:

PARTIALLY DENIED as of 04/02/2020.

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 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.

**Other authority:**

The facts that we used to make our decision are:

Your assessment tells us you need help with bathing, dressing, eating, and toileting.

You are getting 4 hours a week of personal care to help you.

You live with your spouse who helps you.

I will approve 20 hours a week of personal care to help you.

In my clinical opinion, your personal care needs can be met by these current services and supports.

*Id.* at 4 - 5.

6. On May 15, 2020, Petitioner requested a plan appeal. *Id.* at 18 - 19. [REDACTED] submitted a letter with Petitioner's plan appeal request. The letter states, "[w]e are requesting

an urgent reassessment of the medical and home care needs for [Petitioner], and the addition of a minimum of 56 hours to allow for greater support of [Petitioner's] care needs both day and night (emphasis added)." *Id.* at 12.

7. On May 19, 2020, Petitioner's in-home social worker, [REDACTED] from [REDACTED] [REDACTED] wrote a letter in support of Petitioner's appeal.

The letter states, in pertinent part:

[Petitioner] lives at home with the support of his wife, and he is in need of 24/7 care based on his health status and level of care needs. [Petitioner's] wife has health limitations of her own. . . . At this time, it does not appear she has enough in-home support to sustain him at home long-term which is their goal. In order to meet this goal of remaining home, they are requesting additional HHA hours from their long-term care Medicaid Waiver program through United Healthcare. It is my understanding that hiring in-home support would be more cost effective than placement in a facility, and is also in his best interest for him to remain at home. Without additional support, [Petitioner's] family may have to make the difficult decision to place him in a facility.

[Petitioner] currently receives the maximum support from the VA regarding in-home services based on his current VA eligibility. Due to this, it is requested that [Petitioner] be re-evaluated by United Healthcare for an increased amount of HHA support.

*Id.* at 81.

8. On May 19, 2020, Petitioner's physical therapist, [REDACTED], from [REDACTED] [REDACTED] wrote a letter in support of Petitioner's appeal.

The letter provides, in pertinent part, as follows:

Please accept this correspondence as a formal request to appeal the latest decision to provide only 23 hours per week of in-home. The current number of approved hours are insufficient to meet this gentleman's current complex health care needs.

...

[Petitioner] is in need of additional in-home assistance to meet the medical needs and ADL requirements of her husband. Without additional in-home case hours, [REDACTED] is not able to continue to manage all of his increasing demands.

It is both of their wishes to remain at home as long as possible. The addition of a minimum of 56 hours would allow for greater support of [Petitioner's] care needs.

*Id.* at 15.

9. Petitioner's wife reports financial and caregiver strain. *Id.* at 76 and 110. She is paying out of pocket for 9 hours per week of additional care. *Id.* Petitioner is deconditioning as a result of suspended therapy due to COVID-19, and his wife is unable to exercise him due to her own medical condition. *Id.* at 76. Petitioner's wife has reached physical and mental exhaustion. *Id.* at 77. As of Petitioner's [REDACTED] 2020, telehealth appointment with [REDACTED], physical therapy was discontinued two months prior to the appointment. *Id.*

10. On May 26, 2020, Petitioner's primary care physician, [REDACTED], wrote a letter in support of Petitioner's appeal request. *Id.* at 141. The letter stated, in pertinent part, as follows:

[Petitioner] is followed at the [REDACTED] [REDACTED] or the management of advanced Parkinson disease and Alzheimer's dementia. His clinical symptoms continue to progress and he requires assistance in all IADLS and most ADLs. At this point, this is being accomplished by a combination of help from his elderly wife and assisting staff. His needs continue to increase and his wife's health as related to her age is limiting how much she can offer in assistance.

The care for patients with Parkinson disease and Alzheimer's disease, especially when advanced, requires many hours of assistance in many basic activities as well as a significant caregiver strain.

Optimizing the level of support provided to the patient and their family improves quality of care, decreases morbidity, and decreases the need for hospitalization and institutionalization.

*Id.* at 141.

11. On June 2, 2020, Respondent sent Petitioner an NPAR, denying Petitioner's plan appeal. *Id.* at 148 – 150. The NPAR stated as follows:

On May 15, 2020 we received your timely plan appeal request regarding UnitedHealthcare Community Plan's Notice of Adverse Benefit Determination, dated April 2, 2020, [REDACTED], partially denying the Personal Care (66 more hours/week) provided to [Petitioner].

On May 27, 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 66 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 20 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 another paid service to help some too. This is why we cannot approve what you asked for. Please talk about this with your doctor.

*Id.* at 148 – 149.

12. Petitioner is currently authorized to receive twenty (20) hours per week of personal care services. *Id.* at 148. Fifteen (15) additional hours per week of in-home services are provided by the VA. *Id.* at 110. Petitioner currently receives the maximum support from the VA regarding in-home services based on his current VA eligibility. *Id.* at 81.

13. On September 16, 2020, Petitioner requested a Fair Hearing due to the denial of additional personal care services. At the Fair Hearing on October 27, 2020, the parties stipulated to a continuance. On October 28, 2020, the undersigned rescheduled the Fair Hearing for November 13, 2020, at [REDACTED] and all parties were duly notified.

14. At the Fair Hearing, [REDACTED] asserted that Petitioner requested an additional 56 hours of personal care services rather than the 50 hours stated in the NPAR. He asserted that Petitioner's wife is willing and able to provide approximately 70 hours per week of care.

Additionally, 23 hours per week of paid services are provided by United, and an additional 15 hours of services per week are provided by the VA.

15. [REDACTED] stated that Petitioner's primary caregiver is his 87-year-old wife, and there are no other relatives in the area. He asserted that Petitioner's wife is only able to provide a limited amount of assistance to Petitioner and that she is understandably limited by her age and medical conditions. *Id.* at 8.

16. [REDACTED] asserted that Petitioner's 701B Assessment contains numerous errors, which should be corrected as follows:

- a. Petitioner is at imminent risk of nursing home placement if his personal care needs are not met. *See* Petitioner's Composite Exhibit 1 at page 11;
- b. Petitioner has cognitive problems, and these are associated with Parkinson's Disease and Alzheimer Dementia diagnoses. *Id.*;
- c. Regarding ADLs, Petitioner requires total assistance (rather than partial assistance) with dressing, using the bathroom, transferring, and walking/mobility. *Id.* at 12;
- d. Petitioner's health conditions should include daily fluid management associated with congestive heart failure as well as Alzheimer Disease and Parkinson's Disease. According to [REDACTED], the Alzheimer and Parkinson's diagnoses were made shortly after the 701B Assessment was conducted. *Id.* at 12 – 13; and
- e. The caregiver is experiencing a physical and emotional crisis in addition to the financial crises mentioned in the 701B Assessment. *Id.* at 13.

[REDACTED] contrasted Petitioner's 701B Assessment, which was conducted by a care coordinator via telephone, to the written evaluations submitted by Petitioner's medical providers who have written comprehensive evaluations of Petitioner's symptoms and diagnosis based on in-person exams and first-hand knowledge of Petitioner. *Id.* at 17.

17. [REDACTED] believes that Petitioner's condition is deteriorating, and that Petitioner needs 24/7 care. [REDACTED] reiterated that Petitioner's condition has worsened since the 701B Assessment was conducted on February 21, 2020.

18. Dr. Karver is a Medical Director at United. Dr. Karver explained that the Respondent determined that the additional 50 hours per week of personal care services were not medically necessary, as Petitioner has paid support from the VA, natural supports, and resides with family members who can prepare meals, do shopping and laundry. She reiterated that a total of 20 hours of per week of personal care services, combined with 3 hours per week of homemaker services, are adequate to meet Petitioner's needs.

### **CONCLUSIONS OF LAW**

19. 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), Florida Statutes. This order is the final administrative decision of AHCA under section 409.285(2)(a).

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

21. 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.

22. 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.).

23. The Florida Medicaid policy that applies to the requested services is the LTC Policy. The Agency's LTC Policy has been incorporated, by reference, into Florida Administrative Code Rule 59G-4.192. 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.

...

### **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.

LTC Policy at pages 1-8.

24. 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 at pages 3 - 5.

25. 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 at pages 1 and 3.

26. 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.

27. In the instant case, Petitioner was receiving 4 hours per week of personal care services and requested 66 additional hours per week. Petitioner received approval for 16 additional hours per week of personal care services for a total of 20 hours per week of personal care services. At issue in this proceeding are an additional 50 hours of personal care services per week. See supra ¶ 5 and 6. ██████████ asserted at the Fair Hearing that Petitioner originally requested an additional 56 hours of personal care services; however, he did not provide any documents in support of this assertion. ██████████ letter, which was submitted with Petitioner's appeal, requests an additional 56 hours on appeal, but it does not shed any light on Petitioner's original request. As established on the record by the evidence and testimony, Respondent denied Petitioner's request for 50 additional hours per week of personal care services because the documentation submitted in support of Petitioner's request failed to establish that the requested services were medically necessary. *Id.*

28. Section 4.1 of the LTC Policy provides that Florida Medicaid LTC plans cover services that: (a) are determined medically necessary, as defined in the LTC Policy; (b) do not duplicate another service; and (c) meet the criteria as specified in the LTC Policy. *See supra* ¶ 18.

29. Section 4.2.2.6 of the LTC Policy reflects that personal care services are “[t]o provide assistance with ADLs and IADLs, including assistance with preparation of meals, and housekeeping chores which are incidental to the care furnished or are essential to the health and welfare of the enrollee.” *See supra* ¶ 18.

30. The evidence presented in this case does not support the need for an additional 50 hours per week of personal care services. Specifically, section 1.3.14 of the LTC Policy requires that “LTC supportive services must . . . [b]e individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient’s needs.” In this case, the 701B Assessment reflects that Petitioner needs total assistance with bathing and assistance (but not total help) with dressing, eating, using the bathroom, transferring, and walking/mobility. *See supra* ¶ 3. Petitioner needs total assistance with all of his IADLs except for using the telephone. *See supra* ¶ 4. Petitioner has multiple medical conditions, *supra* ¶ 2, including Parkinson’s disease, macular degeneration, skin cancer, Congestive Heart Failure, Coronary Artery Disease (quadruple bypass), spinal stenosis, pacemaker, fluid overload, dementia, and bowel and bladder incontinence. However, the record reflects that Petitioner has natural supports available to assist with his care and needs. Section 1.3.16 of the LTC Policy provides that natural supports are “[u]npaid supports that are provided voluntarily to the individual in lieu of home and community-based services and supports.” *See supra* ¶ 18. Petitioner resides in the home with his wife. *See supra* ¶ 10. Petitioner’s wife is 87

years old and she does not work outside the home. See supra ¶ 2. Petitioner receives 15 hours per week of in-home services from the VA (the maximum support based on his current VA eligibility) and other services he pays for out of pocket. See supra ¶ 7, 9, and 12. Regarding the amount of assistance Petitioner has with ADLs and IADLs, the 701B Assessment reflects that Petitioner always has assistance with his ADLs and IADLs. See supra ¶ 3. [REDACTED] 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 50 hours of personal care services weekly.

31. [REDACTED] contends that Petitioner's condition is deteriorating and that Petitioner needs additional personal care services per week. See supra ¶ 11 - 12. Although the record demonstrates that Petitioner was diagnosed with Alzheimer's and Parkinson's after the 701B Assessment in February 2020, the record does not reflect what specific level of support or mix of services Petitioner requires. Petitioner provided letters from his health care providers in support of Petitioner's appeal, supra ¶ 7, 8 and 10, but these do not detail the extent of Petitioner's declining medical condition, or what specific ADLs and IADLs Petitioner requires additional assistance with, how much additional time would be needed, and the appropriate mix of services to meet Petitioner's needs. [REDACTED] asserts that Petitioner's condition has changed since the 701B Assessment was conducted on February 21, 2020, and that Petitioner's wife is experiencing significant physical and financial strain in caring for Petitioner, but [REDACTED] did not explain which of Petitioner's ADLs and IADLs Petitioner requires additional assistance with and the specific amount of time required to complete each task. See supra ¶ 11.

32. Because the record does not support the need for 50 additional hours per week of personal care services, the record would also not support the need for 56 additional hours per week of personal care services. Therefore, even if Petitioner requested 56 additional hours as [REDACTED] asserted at hearing, Petitioner has not met his burden of proof in this matter.

33. Therefore, considering Petitioner's currently authorized services, along with the LTC Policy definition for personal care services, and natural support, Petitioner did not demonstrate that his 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.

34. 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 his burden of proving that the additional 50 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 50 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 15th day of December 2020, in Tallahassee, Leon County, Florida.



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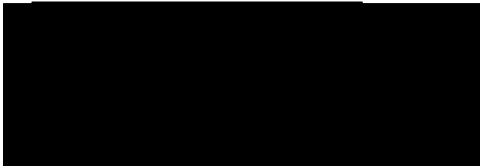
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**NOTICE OF A RIGHT TO JUDICIAL REVIEW**

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

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