



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

FILED

Dec 15, 2020, 12:04 pm

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 Fair Hearing in the above-styled case on November 16, 2020, at [REDACTED].

APPEARANCES

For the Petitioner:

[REDACTED]

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 fifteen (15) hours per week of Personal Care services was incorrect.

PRELIMINARY STATEMENT

All parties and witnesses appeared telephonically. [REDACTED] ("Petitioner's Authorized Representative" or "[REDACTED]"), appeared for the Fair Hearing as a representative

for Petitioner and did not call any witnesses. Davida Jones, State Fair Hearing Coordinator for UnitedHealthcare of Florida, Inc. (“United”), appeared for the Fair Hearing as a representative for Respondent. Dr. Albenah Baharieva (“Dr. Baharieva”), Medical Director for United, appeared for the Fair Hearing as a witness for Respondent. Sheila Gonzalez, Medical Health Care Program Analyst and Fair Hearing Liaison for the Agency for Health Care Administration (“Agency” or “AHCA”), appeared for the Fair Hearing as an observer. Interpreter Maurice (Identification #266911), Spanish Interpreter for Language Line Solutions, appeared for the Fair Hearing to provide language translation services for Petitioner. Interpreter Louis (Identification #224432), Spanish Interpreter for Language Line Solutions, also appeared for the Fair Hearing to provide language translation services for Petitioner.

Petitioner’s Authorized Representative did not introduce any exhibits at the Fair Hearing. Prior to the hearing, Respondent sent to the Office of Fair Hearings and Petitioner a two hundred and thirty-five (235)-page evidence packet. The evidence packet, which was admitted into evidence as Respondent’s Composite Exhibit 1 included the following documents: a Statement of Matters; a Notice of Adverse Benefit Determination (“NABD”) (dated May 26, 2020); a CSP – General Request Form (dated July 10, 2020); a Plan Appeal Acknowledgement letter (dated July 10, 2020) – English; a Print HSC History - HSR Production Environment; a Florida Department of Elder Affairs: 701-B Comprehensive Assessment (“701-B Comprehensive Assessment”) (dated November 4, 2019); United’s Appeal Review notes; a Notice of Plan Appeal Resolution (“NPAR”) (dated July 16, 2020) – English; a Plan Appeal Acknowledgement letter (dated July 10, 2020) – Spanish; an NPAR (dated July 16, 2020) – Spanish; an Exhibit 2 (References) Cover Page – Long Term Care; Florida Administrative Code Rule (“Fla. Admin. Code R.”) 59G-1; the Florida Medicaid

Statewide Medicaid Managed Care Long-term Care Program Coverage Policy (“LTC Policy”) (March 2017); the Florida Medicaid Authorization Requirements Policy (June 2016); the Florida Medicaid Personal Care Services Coverage Policy (November 2016); the Florida Medicaid Private Duty Nursing Services Coverage Policy (November 2016); the Home Health Visit Services Fee Schedule (January 2017); a Personal Care Services Fee Schedule (January 2017); a Private Duty Nursing Services Fee Schedule (January 2017); AHCA’s Participant Direction Option (PDO) Manual; 42 C.F.R. § 441.480; Florida Medicaid Hospice Services Coverage Policy (“Hospice Policy”) (June 2016); 42 C.F.R. 418 Subpart C – Conditions of Participation: Patient Care; Florida Statute (“Fla. Stat.”) § 400.6105 (2018); Fla. Stat. § 400.609 (2018); Fla. Stat. § 409.910 (2018); Fla. Stat. § 400.462 (2018); and an additional copy of Fla. Admin. Code R. 59G-1.

FINDINGS OF FACT

1. Petitioner receives Medicaid services through United’s Long-term Care (“LTC”) program. See Respondent’s Composite Exhibit 1, page 1. United is a Medicaid Managed Care organization contracted by AHCA to provide services to eligible Medicaid recipients in the State of Florida.
2. Petitioner is an eighty-five (85) year old woman residing in the community with her primary caregiver, Petitioner’s Authorized Representative. *Id.* at 23-24. Petitioner is bed bound and unable to talk. *Id.* at 25. Petitioner experienced strokes and hospitalizations in the past year. *Id.* at 27. Petitioner uses tube feeding. *Id.* at 30. Petitioner experiences the following physical health conditions: acid reflux/Gastroesophageal reflux disease (“GERD”); arthritis; high blood pressure; diabetes; frequent dizziness; heart problems; frequent bladder and bowel incontinence; Chronic obstructive pulmonary disease (“COPD”); osteoporosis; Urinary tract

infection (“UTI”); right side weakness; and neuropathy. *Id.* at 29-30. Petitioner also experiences depression (due to dementia). *Id.* at 31.

3. Petitioner needs total assistance with Activities of Daily Living (“ADLs”) that include bathing, dressing, eating, using the bathroom, and walking/transferring. *Id.* at 27. Petitioner needs assistance with transferring, but not total help. *Id.* Petitioner needs total assistance with Instrumental Activities of Daily Living (“IADLs”) that include heavy chores, light housekeeping, using the telephone, managing money, preparing meals, shopping, managing medication, and using transportation. *Id.* at 28.

4. Petitioner’s Authorized Representative is also Petitioner’s primary caregiver. *Id.* at 37-38. Petitioner’s Authorized Representative works full-time outside of the home. *Id.* Petitioner’s Authorized Representative does not have anyone to assist with providing care. *Id.* As testified to by ██████████, she has experienced health problems, including stress, from her caregiving duties for Petitioner. ██████████ is no longer employed at the time of the hearing and is not currently in the process of searching for new employment due to Petitioner’s health condition.

5. At the time of the request, Petitioner currently receives twenty-five (25) hours per week of Personal Care services. *Id.* at 43. As testified to by Dr. Baharieva, Petitioner distributes the current Personal Care services as follows: Monday through Friday, from 12:00 p.m. to 5:00 p.m. on a weekly basis. In addition, as of ██████████ 2020, Petitioner enrolled into Hospice Care after a recent hospitalization. ██████████ also confirmed at the hearing that Petitioner is currently enrolled into the Hospice Care program.

6. On May 26, 2020, United issued an NABD denying Petitioner’s request for an additional fifteen (15) hours per week of Personal Care services. *Id.* at 4-6. The NABD stated:

UnitedHealthcare Community Plan has reviewed your request for 15 more hours of personal care per week, which we received on May 20, 2020. After our review, this service has been:

DENIED as of May 26, 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 criteria as defined in Rule 59G-1.010(166), F.A.C., for all nursing facility services and mixed services; OR
- 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: Your assessment tells us you need help with your bathing, dressing, toileting, transfers, and feeding.

- **You live with your daughter and grandson who help you.**
- **You are getting 25 hours of personal care a week to help you.**
- **You can split these 25 hours or move them to the morning to meet your needs while your daughter is sleeping.**

In my clinical opinion, this is enough personal care to meet your care needs.

...

Sincerely,

Sloan B. Baharieva, MD

Long term Care Medical Director

Id. (Emphasis added).

7. Respondent's Appeal Review notes state the following:

CHRONOLOGY OF CARE AND MEDICAL RECORD REVIEW (Include all pertinent page numbers and dates of service): Services requested: Personal Care - Additional hours from 25 hours per week to 40 hours per week. (+15)

Current services:

- o Personal Care 25 hr per week
- o Personal Care Supplies (specify)-briefs, under pads, gloves, wipes

Age/diagnosis : Member is an 85-year old female who is A&Ox1 (self). Member's diagnoses include: Acid Reflux, Allergies, HTN, Cholesterol, Diabetes, Dizziness, Osteoporosis, COPD, Incontinence, UTI, Hx of stroke, Right side weakness, Neuropathy, Bedbound, Feeding tube.

Living situation/supports: Member lives with her daughter, [REDACTED] at daughter's home in Tampa.

...

Pertinent Case Manager Notes: Member's daughter [REDACTED] stated the member is bedbound, feeding tube, and total care and she is very stressed and overwhelmed with member's care at this time. [REDACTED] works at the [REDACTED] from 11pm -7am and she is going back to work starting this weekend. She stated that she sleeps during the day and she needs assistance 8 hrs/day Monday through Friday for member's care and supervision. Cg stated the member takes Jevity through a feeding tube a few times/day and she needs to be moved every 2 hrs to prevent wounds. [REDACTED] stated that member's grandson lives in the home and he supervises the member when Cg works at midnight. Member's grandson works during the day and he is unable to assist the Cg during the day. Cg stated that she went to see her own doctor this week and she was found to have high blood pressure and was given medication for this illness. CC talked to the Cg about Nursing Home placement, but she declined it today. She stated she needs somebody 8 hrs/day to help her during the day so she can rest and take care of herself.

Id. at 43-48.

8. On July 16, 2020, United issued an NPAR denying Petitioner's plan appeal. *Id.* at 55-56.

The NPAR stated as follows:

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

You asked for more personal care. You would like 15 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 25 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. This is why we cannot approve what you asked for. Please talk about this with your doctor.

...

Sincerely,
John Szafranski, M.D.
Medical Director
Appeals and Grievances
UnitedHealthcare Community and State
Board Certified in Family Medicine

Id. (Emphasis added)

9. On October 2, 2020, Petitioner's Authorized Representative timely requested a Fair Hearing to contest Respondent's denial of an additional fifteen (15) hours per week of Personal Care services. The undersigned scheduled the hearing to be conducted by telephone on November 16, 2020, at [REDACTED]

10. At the hearing and under oath, [REDACTED] argued that Petitioner's request for an additional fifteen (15) hours per week of Personal Care services should be approved based on her health complications stemming from being Petitioner's caregiver. [REDACTED] testified that Petitioner's grandson can provide some natural support, but Petitioner cannot rely on this natural support because he has employment outside of the home. [REDACTED] argued that Petitioner's request for an additional fifteen (15) hours per week of Personal Care services should also be approved because the Hospice Agency is only visiting the Petitioner once per week.

11. At the hearing and under oath, Dr. Baharieva argued that Petitioner's request is in excess of their needs because [REDACTED] has the ability to change when the current LTC services are rendered during the hours that [REDACTED] needs rest. Respondent also considered that Petitioner's grandson also resides with [REDACTED] and Petitioner, and is able to provide some amount of natural support. Respondent also considered that [REDACTED] is no longer employed and is able to provide natural support for Petitioner.

12. Dr. Baharieva also argued that in light on Petitioner's recent enrollment into Hospice Care, the Hospice Agency is responsible for providing care for the Petitioner's needs, not the Managed Care Plan.

CONCLUSIONS OF LAW

13. Pursuant to Fla. Stat. § 409.285(2) (2019), the Agency's Office of Fair Hearings has jurisdiction over the subject matter of this proceeding and the parties. This order is the final administrative decision of AHCA. See Fla. Stat. § 409.285(2)(a).

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

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.

(Emphasis added).

16. Because Petitioner requested new services, 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.).

17. The LTC Policy, incorporated by reference in Fla. Admin. Code R. 59G-4.192, establishes the provision and coverage of Long-term Care services under Florida Medicaid. See Respondent’s Composite Exhibit 1, pages 99-120. 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

...

4.2.2 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:

...

4.2.2.3 Hospice

In accordance with Rule 59G-4.140, F.A.C.

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.

Respondent’s Composite Exhibit 1, pages 99-120.

18. The Hospice Policy, which is incorporated by reference in Fla. Admin. Code R. 59G-4.140, establishes the provision and coverage of Hospice services under Florida Medicaid. See Respondent’s Composite Exhibit 1, pages 178-184. Hospice services provide palliative care to terminally ill recipients. See § 1.1 of the Hospice Policy. The Hospice Policy states as follows:

2.2 Who Can Receive

Florida Medicaid recipients requiring medically necessary hospice services who meet the following:

- Certified as terminally ill in accordance with 42 CFR 418.22
- Elected hospice in accordance with 42 CFR 418.24

- Recipients under the age of 21 years are not required to forego curative treatment as a result of their hospice election, and may continue to receive medically necessary covered services under the Florida Medicaid program.

....

4.1 General Criteria

Florida Medicaid reimburses for services that meet all of the following:

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

4.2 Specific Criteria

Florida Medicaid reimburses for 365/6 days of hospice services per year, per recipient, when the following criteria are met:

- The provider conducts an initial assessment in accordance with 42 CFR 418.54
- The provider develops and maintains a plan of care in accordance with section 400.6095, F.S.
- Services are rendered in accordance with 42 CFR 418.202 and 42 CFR 418.302

Providers must provide or arrange for the provision of necessary care and services to manage a recipient's terminal illness or related condition including:

4.2.1 Core Services

The following services, included in the per diem payment, must be provided in accordance with 42 CFR 418.64:

- Counseling services
- Dietitian services
- Medical social services
- Nursing services
- Physician services

4.2.2 Non-Core Services

The following services, included in the per diem payment, must be provided when specified in the recipient's plan of care and in accordance with 42 CFR 418.70-78 and 42 CFR 418.106-108:

- Hospice aide services
- Medical supplies and durable medical equipment
- Pharmacy services
- Therapy services
- Volunteer services

- Any other item or service specified in the plan of care as reasonable and necessary for the palliation and management of the recipient's terminal illness or related condition in accordance with 42 CFR 418.202

...

4.2.4 Physician Services

Florida Medicaid reimburses for the following separately, in addition to the per diem payment, in accordance with the applicable Florida Medicaid fee schedule(s) when rendered by a practitioner licensed within the scope of their practice:

- Consultations provided by a physician whose opinion or advice regarding the evaluation or management of a specific problem is requested by another physician or the hospice
- Hospital services for the evaluation and management of initial hospital admission, subsequent care, and discharge services
- Nurse practitioner services in accordance with 42 CFR 418.304(2)
- Office and home visits

Respondent's Composite Exhibit 1, pages 178-184.

19. Fla. Stat. § 400.609(1) – (2) states the following:

400.609 Hospice services.—Each hospice shall provide a continuum of hospice services which afford the patient and the family of the patient a range of service delivery which can be tailored to specific needs and preferences of the patient and family at any point in time throughout the length of care for the terminally ill patient and during the bereavement period. These services must be available 24 hours a day, 7 days a week, and must include:

- 1) SERVICES.—
 - a. The hospice care team shall directly provide the following core services: nursing services, social work services, pastoral or counseling services, dietary counseling, and bereavement counseling services. Physician services may be provided by the hospice directly or through contract. A hospice may also use contracted staff if necessary to supplement hospice employees in order to meet the needs of patients during periods of peak patient loads or under extraordinary circumstances.
 - b. Each hospice must also provide or arrange for such additional services as are needed to meet the palliative and support needs of the patient and family. These services may include, but are not limited to, physical therapy, occupational therapy, speech therapy, massage therapy, home health aide services, infusion therapy, provision of medical supplies and durable medical equipment, day care, homemaker and chore services, and funeral services.
- 2) HOSPICE HOME CARE.—Hospice care and services provided in a private home shall be the primary form of care. The goal of hospice home care

shall be to provide adequate training and support to encourage self-sufficiency and allow patients and families to maintain the patient comfortably at home for as long as possible. The services of the hospice home care program shall be of the highest quality and shall be provided by the hospice care team.

Respondent's Composite Exhibit 1, pages 198-199.

20. The Florida Medicaid Definitions Policy ("Definitions Policy") (August 2017), which is incorporated by reference in Fla. Admin. Code R. 59G-1.010, defines Medical Necessity and Medically Necessary 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. The evidence admitted and testimony presented established that Respondent denied Petitioner's request for an additional fifteen (15) hours per week of Personal Care services based on medical necessity. *See supra* ¶ 6. Specifically, Respondent determined that Petitioner's current Long-term Care services and Petitioner's natural support were sufficient to meet Petitioner's needs. *See supra* ¶ 6-8, 11. In addition, Respondent also argued that Petitioner's

request should be denied based on a duplication of another service (Hospice Care) that the Petitioner is receiving. *See supra* ¶ 12. Petitioner's Authorized Representative argued that Petitioner's request should be approved on the basis of her declining health affecting her ability to be Petitioner's primary caregiver. *See supra* ¶ 10.

22. Personal Care services 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. The LTC Policy covers Personal Care services that are determined to be medically necessary. *See supra* ¶ 17. Under the LTC Policy, Mixed services such as Personal Care services must meet the medical necessity criteria defined in Fla. Admin. Code R. 59G-1.010. *See supra* ¶ 17. To be medically necessary, the requested Personal Care services must meet the five criteria set forth in section 2.83 of the Definitions Policy. *See supra* ¶ 20. Based on the record, *supra* ¶ 6-8, 11, Respondent determined that Petitioner did not meet 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.

23. With respect to the medical necessity standard at issue, Respondent presented the following three Medical Directors who determined that Petitioner's request is in excess of the their needs: Dr. Sloan B. Baharieva who issued the NABD; Dr. John Szafranski who issued the NPAR; and Dr. Baharieva who testified at the hearing. *See supra* ¶ 6, 8, and 11. Respondent's three Medical Directors based their determination on Petitioner's needs, Petitioner's LTC services, and Petitioner's natural support. *See supra* ¶ 6, 8, and 11. The record indicates that Petitioner requires total assistance with all IADLs and all ADLs, excluding transferring. *See supra*

¶ 3. The record also indicates that Petitioner currently receives twenty-five (25) hours per week of Personal Care services, has the natural support of [REDACTED], and has the natural support of Petitioner's grandson. *See supra* ¶ 6-8, 11. Although Petitioner cannot rely on this natural support because he has employment outside of the home, [REDACTED] is no longer employed and is capable of providing care. *See supra* ¶ 6-8, 10-11. Petitioner's Authorized Representative argued that Petitioner's request should be approved because of Petitioner's Authorized Representative's health complications. *See supra* ¶ 10. Petitioner's Authorized Representative identified that she is experiencing stress as Petitioner's primary caregiver, but did not provide evidence to quantify the effects of how this stress has affected her ability to provide natural support. Further, Petitioner's Authorized Representative did not provide evidence regarding what tasks she is no longer able to assist the Petitioner with due to her declining health. Petitioner's Authorized Representative provided no testimony regarding an unmet need of fifteen (15) hours per week for assistance with ADLs and IADLs. Upon consideration of the aforementioned facts, Petitioner's Authorized Representative did not establish that the requested fifteen (15) hours per week of Personal Care services for assistance with ADLs and IADLs are not in excess of the Petitioner's needs. Thus, the Petitioner has not met the Definition Policy's criterion at issue for medical necessity.

24. The Hospice agency shall directly provide the following core services: nursing services, social work services, pastoral or counseling services, dietary counseling, and bereavement counseling services. *See Fla. Stat. § 400.609*. Florida Statute also requires that the Hospice agency provide additional services that include home health aide services. *See Fla. Stat. § 400.609(1)(b)*. *See supra* ¶ 18. In addition, the Hospice agency must provide "Any other item or service specified

in the plan of care as reasonable and necessary for the palliation and management of the recipient's terminal illness or related condition in accordance with 42 CFR 418.202." *Id.*

25. The LTC Policy covers Personal Care services that are not a duplication of services. *See supra* ¶ 17. At the hearing, Respondent argued that Petitioner's request should also be denied because the Personal Care services duplicate another service the Petitioner is receiving, Hospice services. *See supra* ¶ 12. Specifically, Dr. Baharieva argued that the Hospice agency is responsible for providing Personal Care services, not Respondent. Dr. Baharieva and Petitioner's Authorized Representative confirmed that Petitioner is currently enrolled into Hospice Care, as of [REDACTED] 2020. *See supra* ¶ 5. Petitioner's Authorized Representative argued that Petitioner's request for should also be approved because the Hospice Agency is only visiting the Petitioner once per week. Respondent asserted that Hospice services duplicate the requested Personal Care services. Petitioner's Authorized Representative argued that the Managed Care Plan should approve Petitioner's request because the Hospice Agency only visits Petitioner once per week. The record indicates that the Petitioner is enrolled into Hospice services with a provider. The fact that Petitioner may only be receiving a weekly visit from the Hospice Agency is not sufficient evidence, in itself, that Personal Care services are not a duplication of Hospice services, which require the provision of additional services as are needed to meet the palliative and support needs of the patient and family, including home health aide services. Thus, Petitioner's Authorized Representative did not demonstrate that Personal Care services and Hospice services do not duplicate one another.

26. Accordingly, in light of the both parties' sworn testimony, Respondent's Composite Exhibit 1, and the applicable rules and regulations, the undersigned Hearing Officer finds that

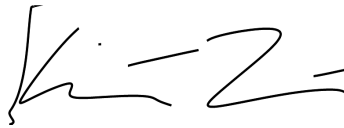
Petitioner did not prove by a preponderance of the evidence that Respondent's denial of Petitioner's request for an additional fifteen (15) hours per week of Personal Care services was incorrect.

DECISION

Respondent's denial of an additional fifteen (15) hours per week of Personal Care services is **AFFIRMED**. Petitioner's request for relief is hereby is **DENIED**.

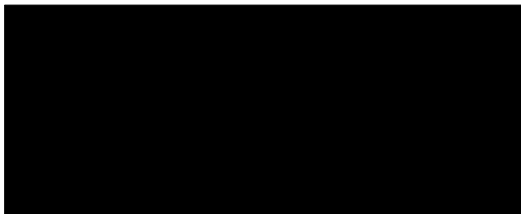
DONE and ORDERED this 15th day of December, 2020, in Tallahassee, Leon County, Florida.

Digitally signed by
Kristopher León
Reason: 20-FH [REDACTED]
Date: 2020.12.15
11:31:21 -05'00'



KRISTOPHER LEÓN, Hearing Officer
Agency for Health Care Administration
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