



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

FILED

Dec 21, 2020, 9:49 am
OFFICE OF FAIR HEARINGS

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PETITIONER,

AHCA Case No.: 20-FH-██████████
Plan ID No.: ██████████

vs.

UNITEDHEALTHCARE OF FLORIDA, INC.,

RESPONDENT.

_____ /

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PETITIONER,

AHCA Case No.: 20-FH-██████████
Plan ID No.: ██████████

vs.

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PETITIONER,

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vs.

UNITEDHEALTHCARE OF FLORIDA, INC.,

RESPONDENT.

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic Fair Hearing on the instant case on November 2, 2020, at [REDACTED]

APPEARANCES

For the Petitioner:

[REDACTED]
Petitioner

For the Respondent:

David Jones
State Fair Hearing Coordinator
UnitedHealthcare of Florida, Inc.

STATEMENT OF ISSUE

The first issue (AHCA Case Number 20-FH [REDACTED]) is whether Petitioner proved by a preponderance of the evidence that Respondent's denial of an additional one hundred and seven (107) hours per week of personal care services was incorrect.

The second issue (AHCA Case Number 20-FH [REDACTED]) is whether Petitioner proved by a preponderance of the evidence that Respondent's denial of twenty-one (21) hours per week of homemaker services was incorrect.

The third issue (AHCA Case Number 20-FH [REDACTED]) is whether Petitioner proved by a preponderance of the evidence that Respondent's denial of forty-eight (48) hours per week of adult companion care services was incorrect.

The fourth issue (AHCA Case Number 20-FH[REDACTED]) is whether Petitioner proved by a preponderance of the evidence that Respondent's denial of three (3) additional skilled nursing visits per day (on Monday through Friday) was incorrect.

PRELIMINARY STATEMENT

All parties and witnesses appeared telephonically. Petitioner appeared at the Fair Hearing and provided testimony on her own behalf.

Davida Jones, State Fair Hearing Coordinator for UnitedHealthcare of Florida, Inc. ("United" or "Respondent"), represented Respondent at the hearing. Dr. Sloan ("Dr. Karver"), Long Term Care ("LTC") Medical Director for United, appeared as a witness for Respondent. Steven Lobo appeared as witnesses on behalf of Respondent but did not testify.

Marielisa Amador, Program Analyst for the Agency for Health Care Administration ("Agency" or "AHCA"), appeared for observational purposes.

Prior to the hearing, Petitioner did not send to the Office of Fair Hearings and Respondent an evidence packet. Prior to the hearing, Respondent sent to the Office of Fair Hearings and Petitioner a two hundred and ninety-nine (299)-page evidence packet. The packet included the following documents: a Medicaid Fair Hearing Statement of Matters; an address page; a blank page; a Notice of Adverse Benefit Determination ("NABD") for Plan ID number [REDACTED] dated August 21, 2020; a NABD for Plan ID number [REDACTED] dated August 21, 2020; the CSP - General Request Form – [REDACTED]; a letter from United to Petitioner, dated August 24, 2020; prescription, dated [REDACTED] 2020; fax from [REDACTED], dated June 16, 2020; prescription, dated [REDACTED] 2020; letter from [REDACTED] ("[REDACTED]"), dated June 28, 2020; fax from [REDACTED], dated August 24, 2020; two prescriptions, dated [REDACTED] 2020;

letter from [REDACTED], dated June 28, 2020; Quote from [REDACTED]; Physician's Rx, signed [REDACTED], 2019; letter from therapist [REDACTED], dated August 26, 2019, with concurrence, dated October 8, 2019; Final Report, dated [REDACTED] 2019; Final Report, dated [REDACTED], 20219; Final Report, signed [REDACTED], 2018; To Whom It May Concern notes; Rehabilitation Clinic Note, dated [REDACTED], 2019; Rehabilitation Clinic Note, dated [REDACTED], 2019; rehabilitation equipment orders, dated [REDACTED], 2018; Home Accessibility Evaluation, dated December 11, 2018; Physician's Rx, dated [REDACTED], 2019; Final Report, dated [REDACTED] 2019; Respondent's internal file on Petitioner; the Florida Department of Elder Affairs: 701B Comprehensive Assessment ("701B Assessment"), dated March 7, 2019; Respondent's Appeal Review notes; a Notice of Plan Appeal Resolution ("NPAR"), dated September 14, 2020; Florida Administrative Code Rule ("Fla. Admin. Code R.") 59G-1; Florida Medicaid Statewide Medicaid Managed Care Long-term Care Program Coverage Policy (March 2017) ("LTC Policy"); Florida Medicaid Authorization Requirements Policy (June 2016) ("Authorizations Policy"); Florida Medicaid Personal Care Services Coverage Policy (November 2016); Florida Medicaid Private Duty Nursing Services Coverage Policy (November 2016); Home Health Visit Services Fee Schedule, dated January 1, 2017; Personal Care Services Fee Schedule, dated January 1, 2017; Private Duty Nursing Services Fee Schedule, dated 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. § 441.480, Subpart C – Conditions of Participation: Patient Care; sections 400.462, 400.609, 400.6105, and 409.910, Florida Statutes (2018); and a second copy of Fla. Admin. Code R. 59G-1. Absent an objection from Petitioner, the undersigned admitted

Respondent's two hundred and ninety-nine (299)-page evidence packet into evidence as Respondent's Composite Exhibit 1.

FINDINGS OF FACT

1. Petitioner is an enrolled member of United's LTC plan. See Respondent's Composite Exhibit 1 at page 24. United is a managed care organization contracted by the Agency to provide services to eligible Medicaid recipients in Florida.

2. Petitioner is 30-years old and quadriplegic with C4-C6 fracture polytrauma, severe spinal cord compression, respiratory problems, and incontinence *Id.* at 91. Petitioner lives with her parents, who work full time on different shifts. *Id.* at 91 and 101. Petitioner needs intermittent catheterizations and daily bowel program. *Id.* Petitioner is not bedbound and visits her boyfriend 3 – 4 times per week. *Id.* at 92. Petitioner is also attending school remotely. *Id.* at 94. Petitioner utilizes a catheter daily, and she is on a daily bowel program. *Id.* at 105 and 110.

3. Regarding Activities of Daily Living ("ADLs"), Petitioner needs total assistance (cannot do at all) with bathing, dressing, eating, using the bathroom, transferring, and walking/mobility. *Id.* at 105. Petitioner utilizes an electric wheelchair and a Hoyer Lift. *Id.* at 104. Petitioner always has assistance with her ADLs: bathing, dressing, and using the bathroom, and needs no assistance with eating, transferring, and walking/mobility. *Id.*

4. Regarding Instrumental Activities of Daily Living ("IADLs"), Petitioner needs total assistance (cannot do at all) with heavy chores, light housekeeping, using the telephone, managing money, preparing meals, shopping, and managing medication. *Id.* at 105. Petitioner always has assistance with her IADLs. *Id.* at 107. Petitioner's medications are managed by her parents. *Id.* at 116. Petitioner does not require constant supervision. *Id.* at 113 and 120.

5. Petitioner is currently approved for forty (40) hours per week of personal care services, and she requested an additional one hundred and seven (107) hours per week of personal care services. In addition to personal care services, Petitioner requested twenty-one (21) hours per week of homemaker services, forty-eight (48) hours per month of adult companion care services, and five (5) visits daily of intermittent and skilled nursing services. *Id.* at 1, 5, 16 and 28.

6. On August 21, 2020, Respondent issued an NABD denying Petitioner's request for 107 additional hours per week of personal care services, 21 hours per week of homemaker services, and 48 hours per week of adult companion care services. *Id.* at 5 – 9. The NABD stated the reason for the denial as follows:

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

...

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

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

And one of the following:

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

...

The facts that we used to make our decision are:

Your assessment tells us you need help with bathing, toileting, transfers, and dressing. You are getting 40 hours a week of personal care to help you.

You live with your parents that help you after work.

Your assessment tells us that you also need help with cleaning your home, chores and meals.

You live with your parents.

The personal care aide can clean your bedroom and bathroom after helping you with bathing and dressing.

Your assessment tells us you can be left home alone.

You can be social with the aides that visit your home.

You live with family who you can be social with.

In my clinical opinion, your needs are being met by your current services and support.

Id. at 6.

7. On August 21, 2020, Respondent issued an NABD concerning Petitioner's request for intermittent and skilled nursing. The NABD partially denied Petitioner's request as follows:

PARTIALLY DENIED as of August 21, 2020.

...

We made of decision because:

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[.]

...

The facts that we used to make our decision are:

Your assessment tells us that you need help with toileting.

You need a skilled nurse to help with catheterization.

The aide cannot help you with this.

You live with family who helps you every day.

I will approve 1 visit daily for help with catheterization while your mother is working.

In my clinical opinion, your needs can be met with 1 visit a day of attendant care.

Id. at 16 and 17.

8. On June 28, 2020, Petitioner's provider, [REDACTED], submitted a letter concerning Petitioner's medical conditions. The letter states, in pertinent part:

My name is [REDACTED], and I am the medical director of the spinal cord injury unit at [REDACTED]. I am writing today on behalf of my patient, [Petitioner]. She has a catastrophic spinal cord injury secondary to a traumatic event. As a result, she is a quadriplegic with significant comorbidities of neurogenic bowel and bladder. She is power wheelchair dependent for all her mobility needs.

As a result of these limitations, [Petitioner] is completely dependent for all ADL's including cooking, cleaning, housework. In addition, patient is total assist for self-care including transfers, dressing bathing, bowel program including suppository placement and digital stimulation, intermittent catheterization program 6 times per day, dental care, hair/makeup. The catheterization program has to be performed by a skilled nurse as it is a skilled medical task.

The patient also requires an escort for all doctor's appointments, school, and community outings. Patient will also require assistance with working on her laptop, assistance with the phone, completing forms for insurance/doctors/school, etc. The patient may require bathroom attendance while at school, appointments and outings.

This level of assistance will help keep the patient as functionally independent as possible given her diagnosis, and will prevent her from having preventable complications which could lead to re-hospitalizations as well as long term institutionalization.

Id. at 36.

9. Petitioner requested a plan appeal and received an NPAR, dated September 14, 2020, partially upholding United's decision to deny Petitioner's request for 107 additional hours per week of personal care services, 21 hours per week of homemaker services, and 48 hours per month of adult companion care services. It also partially denied Petitioner's request for 5 visits daily of intermittent and skilled nursing services. *Id.* at 131 - 11. The NPAR explained as follows:

On August 24, 2020 we received your timely plan appeal request regarding UnitedHealthcare Community Plan's Notice of Adverse Benefit Determination dated August 21, 2020, [REDACTED], denying the 107 more hours a week of

personal care, 21 hours a week of homemaker services, 48 hours a month of adult companion care, and partially denying the 5 visits daily of intermittent and skilled nursing provided to [Petitioner].

On September 3, 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.

John Szafranski, MD, specializing in Family Medicine, reviewed the appeal. This doctor did not make the original decision. The decision was based on Florida Administrative Code 59G-1.010(166).

Part 1 of 4: You asked for more personal care. You would like 107 more hours a week. You need help with daily activities. We have decided that what you asked for cannot be approved. This does not meet Florida Medicaid rules. Based on my professional judgment, we are not approving these extra hours because they are in excess of your needs. You have 40 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 Skilled Nursing visits to help some too. This is why we cannot approve what you asked for. Please talk about this with your doctor.

Part 2 of 4: You asked for 21 hours a week of homemaker service. We have decided that what you asked for cannot be approved. This does not meet Florida Medicaid rules. We cannot approve this because it is not medically needed. Based on my professional judgment, these hours are more than you need. You have approved 40 hours a week of paid personal care help. They can clean up some after caring for you. You also have family who can help some. These should meet your homemaker needs. This is why we cannot approve what you asked for. Please talk about this with your doctor.

Part 3 of 4: You asked for 48 hours a week of companion care. We have decided that what you asked for cannot be approved. This does not meet Florida Medicaid rules. We cannot approve this because it is not medically needed. Based on my professional judgment, these hours are more than you need. You have other help you can socialize with. You have personal care help you can talk too. You have daily skilled nurse visits you can talk too. You can also talk and spend time with your family. This is why we cannot approve what you asked for. Please talk about this with your doctor.

Part 4 of 4: You asked for more home skilled nurse visits. You would like 4 more visits a day. This is for them to do intermittent catheterizations and bowel

program. We have decided that what you asked for cannot be fully approved. This does not meet Florida Medicaid rules. You have one home skilled nurse (HSN) visit a day approved. We are approving HSN visits, 2 a day, on Monday through Friday. Based on my clinical judgment, the extra HSN visits are not medically needed. Part of the role of a HSN is to teach the family. Your mother can do your care when she is not working. The approved HSN visits are for use when she is working. This is why we cannot approve what you asked for. Please talk about this with your doctor.

Id. at 131 - 132.

10. At the hearing, Petitioner testified that she was paralyzed in a car accident and is a quadriplegic. She currently lives with her parents but she requested more assistance so that she can live independently. Petitioner testified that her mother is her primary caregiver, that her mother is 60 years old and her father is 57 years old, and that both of her parents have health concerns. Petitioner asserted that she wants a companion to accompany her anywhere she goes and to let the dog in and out of the house. She stated that she visits her boyfriend several times per week. Petitioner stated that her mother works the day shift and her father works the night shift so one of them is always able to assist her.

11. Dr. Karver is an internal medicine and home care physician. Dr. Karver testified that she reviewed Petitioner's case. She argued that 40 hours of combined services plus 2 skilled nursing visits per week and Petitioner's natural supports are adequate to meet Petitioner's needs. Dr. Karver argued that 40 hours is adequate to cover Petitioner while her primary caregiver (her mother) is at work. She asserted that Petitioner has the natural supports of her parents available to prevent social isolation and to provide supervision. Dr. Karver noted that Petitioner requested companion services to help her visit her boyfriend and to let the dog out. Dr. Karver asserted that despite work schedules of her parents, there is always a parent in the home who can administer Petitioner's medications. Dr. Karver asserted that three additional skilled nursing visits per day

(Monday through Friday) are not medically needed because part of the role of a skilled nurse is to teach the family. She argued that Petitioner's mother can be trained to provide the care when she is not working. She argued that the approved nursing visits (two per day on Monday through Friday) are for use when Petitioner's mother is working.

CONCLUSIONS OF LAW

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

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

14. Because Petitioner is requesting additional or new services, Fla. Admin Code R. 59G-1.100(17)(g) assigns the burden of proof to 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.)

15. The LTC Policy, incorporated by reference in Fla. Admin. Code R. 59G-4.192, governs Long-Term Care services available under Florida Medicaid. The LTC Policy provides the following with respect to adult companion care and homemaker services:

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.

...

1.3.1 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

...

1.3.9 Instrumental Activities of Daily Living (IADLs)

When necessary for the recipient to function independently, including:

- Grocery shopping
- Laundry
- Light housework
- Meal preparation
- 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 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

...

4.2.1.1. Adult Companion Care

The provision of non-medical care, supervision when necessary to protect the health, safety, and well-being of the enrollee, or social enrichment of a functionally impaired enrollee. This includes assistance or supervision with meal preparation, laundry, and light housekeeping tasks incidental to the care and supervision of the enrollee.

...

4.2.1.9 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:

...

4.2.2.4 Intermittent Skilled Nursing

In accordance with Rule 59G-4.130, F.A.C. This service includes the provision of skilled nursing services at intervals of more than one hour apart, and for the length of time necessary to complete the service, for enrollees who do not require continuous nursing care (see attendant nursing care services).

...

4.2.2.6 Personal Care

In accordance with Rule 59G-4.215, F.A.C., for enrollees under the age of 21 years. To provide assistance with ADLs and IADLs, including assistance with preparation of meals, and housekeeping chores which are incidental to the care furnished or are essential to the health and welfare of the enrollee. The scope and nature of these services do not otherwise differ from personal care services furnished to persons under the age of 21 years.

...

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.

16. 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.

17. 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.

18. The Florida Medicaid Definitions Policy (August 2017) ("Definitions Policy"), incorporated by reference in Fla. Admin. Code R. 59G-1.010, defines "Medically Necessary" or "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 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.

Personal Care Services

19. In the instant case, Petitioner is currently approved for 40 hours per week of personal care services, and she requested an additional 107 hours per week of personal care services. *See supra* ¶ 6 and 9. As established on the record by the evidence and testimony, Respondent denied Petitioner's request, because the documentation submitted in support of Petitioner's request failed to establish that the requested services were medically necessary. *See supra* ¶ 6 and 9.

20. 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* ¶ 15.

21. 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* ¶ 15.

22. The evidence presented in this case does not reflect that Petitioner needs an additional 107 hours per week of personal care services. Specifically, section Fla. Admin. Code R. 1.010 requires that a service "[b]e individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs." *See supra* ¶ 18. In this case, the 701B Assessment reflects that Petitioner requires total assistance with all ADLs and IADLs. *See supra* ¶ 3 and 4. Petitioner has multiple medical conditions including quadriplegia, respiratory problems, and incontinence. *See supra* ¶ 2. However, the

record reflects that Petitioner has natural supports available to assist with her 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 ¶ 15. Petitioner resides in the home with both of her parents. See supra ¶ 2. Although her parents work full time, they work different shifts so that one parent is always available to assist Petitioner. See supra ¶ 2 and 10. Petitioner does not require constant supervision. See supra ¶ 4.

23. Petitioner is currently authorized to receive 40 hours per week of personal care services. See supra ¶ 5, 6, and 9. Regarding the amount of assistance Petitioner has with ADLs, the 701B Assessment 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 Assessment 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 Assessment states that Petitioner’s parents manage her medications. See supra ¶ 4. Petitioner indicated that she wants to live as independently as possible but provided no additional evidence (i.e., a daily schedule, a schedule of ADLs and IADLs, the amount of additional time needed for each ADL and IADL) to justify the approval of an additional 107 hours of personal care services weekly.

24. Petitioner contends that she needs more personal care so that she can live independently of her parents. See supra ¶ 10. Petitioner did not submit any documentary evidence concerning what hands on care needs are not met or what additional hands on care needs she has.

Petitioner's physician submitted a letter stating that Petitioner needs assistance with all of her ADLs and IADLs, *supra* ¶ 8; however, the letter did not address what personal care needs, if any, are not met by the currently approved amount of personal care services or the appropriate mix of home and community based services and hours Petitioner should receive.

25. Therefore, considering Petitioner's currently authorized services, along with the LTC Policy definition for personal care services, Petitioner did not demonstrate that her aforementioned needs, *supra* ¶ 2, 3, 4, and 10, are not sufficiently met by her currently authorized personal care services. Given that Petitioner failed to establish that the requested personal care services are warranted in this matter, the requested personal care services are "in excess of [Petitioner's] needs." *See supra* ¶ 18.

26. In light of the both parties' testimony and evidence, the 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 107 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.

Homemaker Services

27. In the instant case, Respondent requested 21 hours per week of homemaker services. As established on the record by the evidence and testimony, Respondent denied Petitioner's request because the documentation does not support Petitioner's request. *See supra* ¶ 6 and 9.

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* ¶ 15.

29. The testimony and evidence presented in this case reflect that Petitioner failed to show that homemaker services are medically necessary. Specifically, Petitioner’s homemaker services failed to satisfy the medical necessity criteria, which requires that the requested services must “[b]e individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient’s needs.” *See supra* ¶ 15.

30. As stated in the LTC Policy, homemaker services provide for general household activities and routine household care by a trained homemaker, “when the individual regularly responsible for these activities is temporarily absent or unable to manage these activities.” *See supra* ¶ 15. The record reflects that Petitioner lives with her parents and her mother is her primary caregiver. *See supra* ¶ 2, 7, 9 and 10. Petitioner’s parents work different shifts so that one of them is home with Petitioner and they administer her medications. *See supra* ¶ 2 and 10.

31. Dr. Karver testified that she reviewed Petitioner’s medical history and current medical needs. *See supra* ¶ 11. Dr. Karver argued that, in her professional opinion, the additional homemaker hours requested by Petitioner in this case exceed her medical needs. *See supra* ¶ 11.

32. In light of the fact that Petitioner’s parents provide assistance with light housekeeping, managing money and medication, and preparing meals, and they have arranged their work schedules so that one can stay home with Petitioner, *supra* ¶ 2, 7, 9 and 10, Dr. Karver’s testimony, that additional homemaker services are not medically necessary, is credible. *See supra* ¶ 11. As provided above, homemaker services are intended for situations where the individual

regularly responsible for those activities is temporarily absent or unable to manage these activities, which at present, appears to not entirely be the case here. Based on the foregoing, Petitioner has not demonstrated an unmet need for homemaker services. Further, Petitioner's 701B Assessment indicates that Petitioner currently "always has assistance" with IADLs. *See supra* ¶ 4. As such, Petitioner has not shown that 21 hours per week of homemaker services are not in excess of Petitioner's needs.

33. Therefore, upon consideration of both parties' testimony, Respondent's Composite Exhibit 1, the LTC Policy, and the Definitions Policy, the undersigned finds that Petitioner failed to prove by a preponderance of the evidence that Respondent's denial of 21 hours per week of homemaker services was incorrect.

Adult Companion Care Services

34. As provided in the LTC Policy, the purpose of adult companion care services is to provide "non-medical care, supervision when necessary to protect the health, safety, and well-being of the enrollee, or social enrichment of a functionally impaired enrollee." *See supra* ¶ 15. Companion care is designed to prevent social isolation or to provide supervision. *See supra* ¶ 11 and 15.

35. Petitioner resides with her parents. *See supra* ¶ 2. She is currently approved for 40 hours per week of personal care services. *See supra* ¶ 6 and 9. The record reflects that Petitioner visits her boyfriend a few times per week. Petitioner's parents arrange their work schedules so that Petitioner is not left alone. *See supra* ¶ 2. Thus, Petitioner has the opportunity to socialize with other people, and Petitioner is not at risk for social isolation.

36. With regard to a medical need for companion care supervision, Petitioner testified that she would like to live more independently. She would like an escort to accompany her to and from her boyfriend's house and on other outings. See supra ¶ 10 - 11. Further, Petitioner does not need constant supervision. See supra ¶ 4.

37. Despite Petitioner's assertions at the Fair Hearing, Petitioner did not present any evidence specifying the amount of companion care Petitioner requires, nor did she demonstrate that Petitioner is left alone for extended period of time. To the contrary, Petitioner testified that her parents are available to assist her, and they manage her medications.

38. Based on the foregoing, the Petitioner is not at risk of social isolation because she lives with her parents, socializes with her caregiver, visits her boyfriend several times a week, and Petitioner is not left alone for extended periods of time. As such, Petitioner failed to demonstrate that the requested adult companion care service hours are individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment and are not in excess of the Petitioner's needs.

39. Therefore, upon consideration of both parties' testimony, Respondent's Composite Exhibit 1, the LTC Policy, and the Definitions Policy, the undersigned finds that Petitioner failed to prove by a preponderance of the evidence that Respondent's denial of adult companion care services was incorrect.

Skilled Nursing Services

40. In the instant case, Petitioner Petitioner's request for 5 visits daily of intermittent and skilled nursing services. See supra ¶ 9. The evidence admitted and testimony presented in this

establish that the request is due to Petitioner's need for intermittent catheterizations and daily bowel program. *See supra* ¶ 7 – 9.

41. It is undisputed that Petitioner needs an amount of skilled nursing services. Petitioner is currently approved for 2 skilled nursing visits per day, on Monday through Friday. *See supra* ¶ 9. The record reflects that Petitioner is a quadriplegic, utilizes a catheter daily, and is on a daily bowel program. *See supra* ¶ 2. The record also reflects that her mother, who is her primary caregiver, works full time. *See supra* ¶ 2, 9 – 11. The letter from Petitioner's physician confirms that Petitioner requires intermittent catheterization program 6 times per day and the catheterization program has to be performed by a skilled nurse as it is a skilled medical task. *See supra* ¶ 8.

42. Dr. Karver agreed that Petitioner *does* need some amount of skilled nursing services. *See supra* ¶ 11. However, Dr. Karver pointed out that Petitioner is approved for two skilled nursing visits per day on Monday through Friday. *See supra* ¶ 11. Dr. Karver asserted that three additional skilled nursing visits per day (Monday through Friday) are not medically needed because part of the role of a skilled nurse is to teach the family. *See supra* ¶ 11. She argued that Petitioner's mother can be trained to provide the care when she is not working. She argued that the approved nursing visits (two per day on Monday through Friday) are for use when Petitioner's mother is working. *See supra* ¶ 11. Petitioner did not provide any documentary evidence to indicate that more skilled nursing services are medically needed.

43. The record reflects that Petitioner's physician provided a letter in support of Petitioner's need for skilled nursing. *See supra* ¶ 8. The letter limits Petitioner's need for skilled nursing to intermittent catheterization program 6 times per day. *See supra* ¶ 8. Section 2.83 of the

Definitions Policy mandates that “[t]he 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.” *See supra* ¶ 15. As Dr. Karver testified, part of the role of a skilled nurse is to teach the family, and Petitioner’s mother can be trained to provide catheterization. *See supra* ¶ 9 and 11. Therefore, the two approved nursing visits (two per day on Monday through Friday) are adequate to meet Petitioner’s need when her mother is working. *See supra* ¶ 9 and 11. Further, even if the intermittent catheterization program requires a skilled nurse, Petitioner did not demonstrate that an additional three skilled nursing visits per day, Monday through Friday, were needed to perform the intermittent catheterization. As such, Petitioner failed to demonstrate that the requested skilled nursing services are individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment and are not in excess of the Petitioner’s needs.

44. In light of the both parties’ testimony, Petitioner’s Composite Exhibit 1, Respondent’s Composite Exhibit 1, LTC Policy, and the Definitions Policy, the undersigned Hearing Officer finds that Petitioner failed to meet her burden in proving that Respondent’s denial of additional skilled nursing services was incorrect.

IT IS THEREFORE ORDERED AND ADJUDGED THAT:


Respondent’s denial of one hundred and seven (107) additional hours per week of personal care services is **AFFIRMED**. Petitioner’s appeal based on Respondent’s denial is **DENIED**.

Respondent’s denial of twenty-one (21) hours per week of homemaker services is **AFFIRMED**. Petitioner’s appeal based on Respondent’s denial is **DENIED**.

Respondent's denial of forty-eight (48) hours per week of adult companion care services is **AFFIRMED**. Petitioner's appeal based on Respondent's denial is **DENIED**.

Respondent's denial of three (3) additional skilled nursing visits per day (on Monday through Friday) is **AFFIRMED**. Petitioner's appeal based on Respondent's denial is **DENIED**.

DONE and ORDERED this 21st day of December 2020, in Tallahassee, Leon County, Florida.

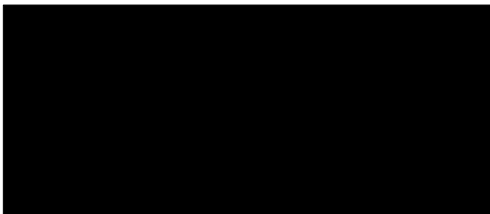

Laura Gallagher
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NOTICE OF A RIGHT TO JUDICIAL REVIEW

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 CHEADQUARTERS OR WHERE A PARTY RESIDES. REVIEW PROCEEDINGS SHALL BE CONDUCTED IN ACCORDANCE WITH THE FLORIDA APPELLATE RULES. THE NOTICE OF APPEAL MUST BE FILED WITHIN 30 DAYS OF THE RENDITION OF THE ORDER TO BE REVIEWED.

Copies Furnished To:



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