



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

FILED
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OFFICE OF FAIR HEARINGS

[REDACTED]

PETITIONER,

AHCA Case No.: 20-FH [REDACTED]
Plan ID No.: [REDACTED]

vs.

SUNSHINE STATE HEALTH PLAN, INC.,

RESPONDENT.

_____ /

FINAL ORDER

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

APPEARANCES

For the Petitioner: [REDACTED]
Petitioner's Authorized Representative

For the Respondent: Kizzy Alleyne
Senior Manager - Compliance
Sunshine State Health Plan, Inc.

STATEMENT OF ISSUE

The issue is whether Petitioner proved by a preponderance of the evidence that Respondent's decision to deny Petitioner's request for additional Personal Care services was incorrect.¹

¹ Petitioner was authorized to receive (10) hours of Personal Care services per week of beginning July 1, 2020. Petitioner requested an additional thirty-two (32) hours of Personal Care services per week beginning July 1, 2020. Respondent approved the requested additional hours in total through August 31, 2020, denied the request in total from September 1, 2020, through October 2, 2020, approved twenty (20) of the requested additional hours through December 31, 2020, and approved ten (10) of the requested additional hours beginning January 1, 2021.

PRELIMINARY STATEMENT

All parties appeared telephonically. Petitioner Authorized Representative and husband,

██████████ (“██████████”) appeared on behalf of Petitioner.

Kizzy Alleyne, Senior Manager - Compliance for Sunshine State Health Plan, Inc. (“Sunshine”), appeared on behalf of Respondent. Wilfredo Rodriguez, Case Manager for Sunshine; Dr. John Carter (“Dr. Carter”), Long-term Care Medical Director for Sunshine; Solange Luna, Long-term Care Supervisor for Sunshine; and Melissa Layne, Senior Manager for Member Appeals for Sunshine, attended as witnesses for Respondent.

Lisa Sanchez, Medical/Health Program Analyst for the Agency for Health Care Administration (“Agency” or “AHCA”), appeared as an observer.

Prior to the hearing, Respondent sent to the Office of Fair Hearings and Petitioner a one hundred and sixteen (116)-page evidence packet. The evidence packet included: a table of contents; a Medicaid Fair Hearing Summary, dated November 13, 2020; the Notice of Adverse Benefit Determination (“NABD”), dated June 30, 2020; a Long Term Care Person-Centered Care Plan, reviewed May 15, 2020; a second Long Term Care Person-Centered Care Plan, reviewed October 21, 2020; a Florida Department of Elder Affairs 701B Comprehensive Assessment (“701B”), dated May 15, 2020; a 701B, dated October 20, 2020; an expedited plan appeal acknowledgment, dated July 1, 2020; a Notice of Plan Expedited Appeal Resolution (“NPAR”), dated July 2, 2020; Sunshine Health Policy and Procedure LT.UM.09, last revised November 2019; and Fla. Admin. Code R. 59G-1.010(166). Absent an objection from Petitioner’s Authorized

The level of Personal Care services at issue for Petitioner’s request is as follows: thirty-two hours (32) from September 1, 2020 through October 2, 2020; twelve (12) hours from October 3, 2020, through December 31, 2020; and twenty-two (22) hours effective January 1, 2021.

Representative, the undersigned admitted the one hundred and sixteen (116)-page evidence packet into evidence as Respondent's Composite Exhibit 1.

Prior to the hearing, Respondent also sent to the Office of Fair Hearings and Petitioner an updated 701B, dated November 18, 2020, and a Long Term Care Person-Centered Care Plan, reviewed, November 18, 2020. Absent an objection from Petitioner's Authorized Representative, the undersigned admitted the updated Long Term Care Person-Centered Care Plan as Respondent's Exhibit 2, and the updated 701B as Respondent's Exhibit 3.

Prior to the hearing, Petitioner sent to the Office of Fair Hearings and Respondent a copy of [REDACTED] medical records, dated November 24, 2020. Absent an objection from Respondent, the copy of [REDACTED] medical records was admitted as Petitioner's Exhibit 1.

FINDINGS OF FACT

1. Petitioner is an enrolled member of Sunshine. Sunshine is a managed care organization contracted by the Agency to provide services to eligible Medicaid recipients in Florida.
2. Petitioner is seventy-one (71)-years old and diagnosed with moderate Anemia, Arthritis, constant bowel and bladder incontinence, depression, Parkinson's Disease, paralysis on her left side, and advanced dementia. *See* Respondent's Exhibit 3 at 1 and 7 through 8.
3. Petitioner needs some assistance with bathing, dressing, eating, using the bathroom, transferring, and walking/mobility and has assistance most of the time. *Id.* at 5. Petitioner requires at least six minutes per transfer due to an unsteady gait and poor coordination. *Id.* Petitioner needs total assistance with heavy chores, light housekeeping, managing money, preparing meals, shopping and has assistance with those tasks most of the time. *Id.* Petitioner

needs some assistance with using the telephone, managing medication, using transportation and has assistance with those tasks most of the time. *Id.*

4. Petitioner lives with her husband who does not work outside of the home and is Petitioner's sole natural support. *See Id.* at 15. Petitioner's husband spends forty (40) hours per week caring for Petitioner. *Id.* at 16. Petitioner's husband had lumbar spine surgery on February 28, 2020, and has been ordered by his surgeon to not lift anything over fifty (50) pounds. *Id.* at 17. Petitioner's husband was examined by a physician on November 23, 2020, relating to his complaint of shoulder pain. Petitioner's Exhibit 1 at 6. Petitioner's husband received a discharge note following the visit ordering him to avoid pushing, pulling, or carrying objects over ten (10) pounds. *Id.* at 3.

5. Petitioner received forty-two (42) hours per week of Personal Care services from May 14, 2020, through June 30, 2020. Respondent's Composite Exhibit 1 at 5 and 40. Petitioner's Personal Care services were authorized for (10) hours per week beginning July 1, 2020. *Id.* at 5. Petitioner requested an additional thirty-two hours (32) of Personal Care services to begin on July 1, 2020. *Id.* On June 30, 2020, Respondent denied Petitioner's request. The NABD, dated June 30, 2020, explained as follows:

Sunshine Health has reviewed your request for an additional 32 hours weekly of personal care (the person who helps bathe and dress you), which we received on 06/25/2020. After our review, this service has been:

DENIED as of 06/30/2020. . .

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

. . .

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

1. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs;

2. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available statewide; and

3. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider; and one of the following:

1. Enable the enrollee to maintain or regain functional capacity; or

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

...

The facts that we used to make our decision are: The request for an extra 32 hours per week of Personal Care Services beginning 07/01/2020 is denied for lack of medical necessity. Based on the assessment, the member's currently approved services are adequate to meet the member's care needs. The member's present care plan includes:

- 42 hours per week of Personal Care Services through 06/30/2020
- 10 hours per week of Personal Care Services resuming 07/01/2020
- 7 hours per week of Homemaker Services through 06/30/2020
- 5 hours per week of Homemaker Services resuming 07/01/2020.

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

Id. at 4-5.

6. Petitioner requested a plan appeal and received an NPAR dated July 2, 2020, partially upholding the denial. The NPAR explained as follows:

The reason for our decision was :

Based on the assessment of the member's care needs and household and caregiver status, the denial of extra services is partially overturned. Sunshine Health will now approve an extra 32 hours/week of Personal Care Services through 08/31/2020, and will deny an ongoing extra 32 hours per week of Personal Care Services as of 09/01/2020. This decision was made with Sunshine Health Policy LT.UM.09 Long Term Care Ancillary Service Criteria.

Id. at 78.

7. The pertinent portion of Sunshine’s Long Term Care Ancillary Criteria, (“LT.UM.09”) relied upon to deny Petitioner’s request is as follows:

B. Medical Necessity Determination

To assist in determining the medical necessity of any ancillary services, the clinical criteria established in this policy will be applied. Any decision to deny, reduce, suspend, or terminate services must be made by a Sunshine Health Medical Director as outlined in the policy Medical Necessity Review FL.UM.02.01 and Use of Clinical Criteria FL.UM.02 Sunshine Health will respond to requests within the timelines as outlined in the policy Timeliness of UM Decisions FL UM 05.

C. Criteria for Type of Service:

Criteria for each of the benefits noted in the Policy section will be used when reviewing the medical necessity of any ancillary services. In addition, the Medical Necessity Review policy FL.UM.02.01 is considered when determining medical necessity of ancillary services. The Florida Coverage Policies and Limitations Handbooks are used to determine benefits, any benefit limitations, and additional criteria. The ancillary services of this policy are intended to augment and support the existing informal care and community services being provided to allow the member to remain safely in their home.

1. Determinants for Services

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

- a) Activities of Daily Living (ADL’s)/Instrumental Activities of Daily Living (IADL’s)
- Independent where member is able to provide the task without support, with or without assistive devices
 - Minimal functional impairment where the ADL’s require one of the following:
 - Supervision
 - At least minimal assistance
 - Member ambulates with assistance of a person or a device
 - Member transfers require at least minimum assistance

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

b) Living situation consideration

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

c) Supervision needs, including:

- Wandering risk: Member has already been found to leave their home unsafely and/or is unable to find their way back.
- Confused/disoriented and at risk to themselves: Member is confused and/or disoriented to the point that they are unable to perform functional activities, and if they do are at risk of harm to themselves.
- Member has a cognitive impairment that prevents them from knowing when or how to carry out personal care tasks and caregivers are not able to provide the services. The member is incapable of learning despite efforts to train in the care tasks. The member has memory deficits, which prevent them from managing care tasks.
- Member is unable to call for help, even with a personal emergency response unit. Member's medical status will not permit the member to all for help, even with assistance of a personal emergency response unit.

...

7. Personal Care Services

A service that provides assistance with eating, bathing, dressing and personal hygiene, and other activities of daily living. The service includes assistance with preparation of meals, but does not include the cost of meals. The service may also include housekeeping tasks such as bed making, dusting and vacuuming, which are incidental to the care furnished or are essential to the health and welfare of the member, rather than the member's family. Personal care services include the following:

- a. Assistance to the member to complete personal hygiene (bathing, grooming, mouth care, etc.)
- b. Assistance with bladder and bowel requirements that include assisting the member to and from the bathroom or with bedpan routines
- c. Assisting the member in following through with physician orders
The Personal Care provider cannot not administer any medications, but may bring medications to the member and remind the member to take the medicine at specific times
- d. Assisting with food, nutrition, and diet activities, including preparing meals, when required and other incidental services, (i.e. housekeeping chores) essential to the health and welfare of the member
- e. Performing household services (changing bed linen or arranging furniture), when such services are essential to the member's health and comfort.

Personal Care workers must be supervised by a registered nurse, licensed to practice nursing in Florida and who conducts a supervisory home visit every 60 days to observe the personal care worker. The services may be provided in the member's home or other location.

Approval Criteria

Personal Care Services reviews include four (4) criteria:

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

Id. at 89-91 and 102-103.

8. Effective October 3, 2020, Respondent approved a total of thirty (30) hours per week of Personal Care services, to expire December 31, 2020. Respondent's Exhibit 2 at 5. Respondent approved a total of twenty (20) hours per week beginning January 1, 2021. *Id.*

9. [REDACTED] requested Fair Hearing on behalf of Petitioner on October 15, 2020. On November 13, 2020, the undersigned issued an Order Scheduling Fair Hearing by Telephone and Prehearing Instructions, setting the hearing for December 2, 2020, at [REDACTED]

[REDACTED]

10. [REDACTED] testified at the hearing that, due to his shoulder pain and back surgery, Petitioner needs additional hours because he cannot assist the Petitioner with her unsteady gait alone without risking significant injury.

11. During the hearing, Dr. Carter testified that Respondent approved temporary increases to Petitioner's personal care hours to address her husband's limited ability to care for her while recovering from back surgery. Dr. Carter argued that the hours added are not medically necessary because Petitioner lives with her husband and only requires partial assistance with her ADLs.

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 Fla. Stat. § 409.285(2). This order is the final administrative decision of AHCA under Fla. Stat. § 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 a new service,² 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

² The 701B, dated May 15, 2020, and the Long Term Care Person-Centered Care Plan, reviewed on October 21, 2020, show that Respondent authorized forty-two hours (42) of Personal Care services per week from May 14, 2020, through June 30, 2020. *Respondent's Composite Exhibit 1* at 27 and 40. Respondent authorized Petitioner to receive Personal Care services at ten (10) hours per week, effective July 1, 2020. *Supra* ¶ 5. In the NPAR, dated July 2, 2020, Respondent partially approved Petitioner's request for an additional thirty-two (32) hours per week beginning July 1, 2020. *Supra* ¶ 6. Respondent authorized an increase from ten (10) hours of Personal Care services per week to forty-two (42) hours per week through August 31, 2020. *Id.* Effective October 3, 2020, Respondent authorized a total of thirty (30) hours of Personal Care services per week which Petitioner is currently received through December 31, 2020. *Supra* ¶ 8. Petitioner is authorized to receive a total of twenty (20) hours of Personal Care services per week, effective January 1, 2021. *See Id.*

As noted in D.R. v. United Healthcare of Florida, No. 3D19-1702 (Fla. 3d DCA March 18, 2020), "temporary" authorizations are not distinguishable from "permanent" authorizations. In United, the managed care plan authorized forty-five hours per week of combined personal care services and home maker services. *Id.* at 2. Less than two months later United informed the petitioner of its intent to reduce the approved hours. *Id.* Unlike United, the instant case does not involve a previously authorized service as the authorization has already expired.

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 Florida Medicaid Statewide Medicaid Managed Care Long-term Care Program Coverage Policy (March 2017) (“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:

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

When Petitioner requested the additional personal care service hours, the amount of services Petitioner was authorized to receive for the relevant time period was 10 hours of personal care services. Thus, Petitioner is requesting new services.

- Using the telephone to take care of essential tasks (examples include paying bills and setting up medical appointments)

...

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

...

4.2.1.9 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.

...

4.2.2.6 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.

16. The LTC Policy also addresses medical necessity:

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.

17. The Definitions Policy, incorporated by reference in Fla. Admin. Code R. 59G-1.010, defines "Medically Necessary" or "Medical Necessity" as follows:

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.

18. The Respondent denied Petitioner's request for Personal Care services on the basis that the service level requested is not medically necessary. *Supra* ¶ 5. As provided in the LTC Policy, Personal Care Services are intended 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. *Supra* ¶ 15.

19. The 701B, dated November 18, 2020, shows that Petitioner needs some assistance with her ADLs and has assistance with her ADLs most of the time. *Supra* ¶ 3. Petitioner needs total assistance with heavy chores, light housekeeping, managing money, preparing meals, shopping and has assistance. *Id.* Petitioner also needs some assistance with using the telephone, managing medication, and using transportation. *Id.* The most recent 701B assessment was taken nearly nine (9) months after ██████████ surgery. *Supra* ¶¶ 3-4. The 701B shows that Petitioner has assistance with her IADLs most of the time. *Supra* ¶ 3. The record shows that Petitioner is receiving twenty (20) hours of Personal Care services per week as of January 1, 2021 due to Petitioner's need for assistance with her IADLs and ADLs. *Supra* ¶ 9. The evidence does not provide any times required for assisting Petitioner, other than indicating that Petitioner requires approximately six minutes to be transferred. *Supra* ¶ 3. ██████████ testified that he has shoulder pain which limits his ability to assist Petitioner with moving. *Supra* ¶ 8.

20. The component of medical necessity at issue is whether Petitioner's request is 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. *Supra* ¶ 16. In this case Petitioner appears to have needs for care in excess of the ten (10) hours per week of Personal Care services and five (5) hours per week of Homemaker services the Petitioner was receiving when Petitioner requested additional services. Respondent's temporary approval of additional Personal Care services through December 31, 2020, due to ██████████ surgery recovery, seems to reflect that Respondent recognizes the additional time required to provide care for

Petitioner. Respondent has even approved ten of the (10) of the thirty-two hours at issue since Petitioner's request for a Fair Hearing.³

21. However, Petitioner still must show that the service level requested is not in excess of Petitioner's needs considering the current level of ongoing Personal Care services authorized and the extent that [REDACTED] is able to act as a natural support. Petitioner has not shown the change in time required to assist Petitioner with ADLs and IADLs given [REDACTED] current medical conditions. The sole evidence as to the time required to assist Petitioner is that Petitioner takes six (6) minutes to transfer with no additional details as to how often Petitioner must transfer. Not all IADL and ADL assistance needed by Petitioner involves tasks where [REDACTED] [REDACTED] physical limitations would impede on his ability to act as a natural support. Petitioner has not shown that the specific amount of additional Personal Care services requested are 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. Accordingly, Petitioner has not met the burden of proof to show that the Personal Care services requested are medically necessary.

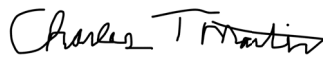
³ Where Respondent has approved the requested additional hours in total through August 31, 2020, approved twenty (20) of the requested additional hours through December 31, 2020, and approved ten (10) of the requested additional hours beginning January 1, 2021, the issue is moot. See *Godwin v. State*, 593 So.2d 211 (1992) (citing *Dehoff v. Imeson*, 153 Fla. 553 (1943)) (“[a]n issue is moot when the controversy has been so fully resolved that a judicial determination can have no actual effect. . . A case is ‘moot’ when it presents no actual controversy or when the issues have ceased to exist.”). See also *J.W. v. Agency for Health Care Admin.*, 178 So. 3d 542, 544–45 (Fla. 1st DCA 2015) (explaining that because J.W. received the requested treatment, “DCF was correct to dismiss J.W.’s fair hearing request under these circumstances because, once he received the continued psychiatric treatment he’d asked for, *he* no longer needed agency review of Magellan’s decision not to authorize the treatment. Rather, the issue at that point became whether Flagler Hospital could be paid by Medicaid for the services it had rendered *without prior authorization.*”) (emphasis in original).

22. Upon consideration of the testimony, evidence, and applicable polices, the undersigned concludes that Petitioner did not prove by a preponderance of the evidence that Respondent's decision to deny Petitioner's request for additional Personal Care services per week at issue was incorrect.

IT IS HEREBY ORDERED AND ADJUDGED THAT:

Respondent's decision to deny Petitioner's request for additional Personal Care services is **AFFIRMED**. Petitioner's appeal based on Respondent's decision to deny Petitioner's request for additional Personal Care services is **DENIED**.

DONE and ORDERED this 7th day of January, 2021, in Tallahassee, Leon County, Florida.



Charles Martin
20-FH [REDACTED]
2021.01.07 11:17:23 -05'00'

CHARLES MARTIN, Hearing Officer
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NOTICE OF A RIGHT TO JUDICIAL REVIEW

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

Copies Furnished To:



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