



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

FILED

Jan 20, 2021, 8:27 am  
OFFICE OF FAIR HEARINGS

[REDACTED]

PETITIONER,

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

vs.

UNITEDHEALTHCARE OF FLORIDA, INC.,

RESPONDENT.

\_\_\_\_\_ /

**FINAL ORDER**

Pursuant to notice, the undersigned convened a telephonic Fair Hearing on December 23, 2020, at [REDACTED]

**APPEARANCES**

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

For the Respondent: Davida Jones  
State Fair Hearing Coordinator  
UnitedHealthcare of Florida, Inc.

**STATEMENT OF ISSUE**

The issue is whether Petitioner proved by a preponderance of the evidence that Respondent’s denial of fourteen (14) hours per week of personal care services was incorrect.

**PRELIMINARY STATEMENT**

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

witness for Petitioner. Petitioner's Authorized Representative and witnesses did not require a Spanish interpreter at the hearing.

David Jones, State Fair Hearing Coordinator for UnitedHealthcare of Florida, Inc. ("United"), appeared as a representative for Respondent. Dr. Sloan Karver ("Dr. Karver"), Long Term Care ("LTC") Medical Director for United, appeared as a witness for Respondent.

Chrissie Simmons, Medical Healthcare Program Analyst for the Agency for Health Care Administration ("Agency" or "AHCA"), appeared for observational purposes.

Prior to the hearing, Petitioner did not submit an evidence packet to the Office of Fair Hearings. Prior to the hearing, Respondent sent to the Office of Fair Hearings and Petitioner a two hundred and fifty-three (253)-page evidence packet. The packet included the following documents: Medicaid Fair Hearing Statement of Matters; address page; blank page; Notice of Adverse Benefit Determination ("NABD"), dated September 8, 2020; CSP-General Request form, dated September 23, 2020; letter from United to Petitioner, dated September 24, 2020, in Spanish and English; Respondent's internal file on Petitioner; Florida Department of Elder Affairs: 701B Comprehensive Assessment ("701B Assessment"), dated September 3, 2020; Respondent's Appeal Review and MD Director notes; Notice of Plan Appeal Resolution ("NPAR"), dated October 9, 2020; letter from United, dated October 7, 2020; letter from United, dated September 24, 2020; letter from United dated October 9, 2020; Exhibit 2 (References) Cover Page – Long Term Care; Florida Administrative Code Rule ("Fla. Admin. Code R.") 59G-1; Florida Medicaid Statewide Medicaid Managed Care Long-term Care Program Coverage Policy (March 2017) ("SMMC LTC Policy"); Florida Medicaid Authorization Requirements Policy (June 2016) ("Authorizations Policy"); Florida Medicaid Personal Care Services Coverage Policy (November 2016) ("PC Policy");

Florida Medicaid Private Duty Nursing Services Coverage Policy (November 2016); Home Health Visit Services Fee Schedule (January 1, 2017); Personal Care Services Fee Schedule (January 1, 2017); Private Duty Nursing Services Fee Schedule (January 1, 2017); Agency's Participant Direction Option Manual; 42 C.F.R. 441.480; Florida Medicaid Hospice Services Coverage Policy (June 2016); 42 C.F.R. 418 Subpart C – Conditions of Participation: Patient Care; section 400.6105, Florida Statutes ("Fla. Stat.") (2018); sections 400.609, 409.910, and 400.462, Fla. Stat.; and a second copy of Fla. Admin. Code R. 59G-1. Absent an objection from Petitioner, the undersigned admitted Respondent's evidence packet into evidence as Respondent's Composite Exhibit 1.

#### **FINDINGS OF FACT**

1. Petitioner is an enrolled member of United's Long-term Care ("LTC") plan. See Respondent's Composite Exhibit 1 at page 34. United is a managed care organization contracted by AHCA to provide services to eligible Medicaid recipients in Florida.
2. Petitioner is an 89-year-old female, whose medical conditions include: Alzheimer's disease, poor balance, mitral valve insufficiency, age related physical debility, acid reflux, osteoarthritis, incontinence of bowel and bladder, and depression. *Id.* at 34, 39, 43, and 45. Petitioner lives in a private residence with her elderly husband, who receives long term care services, and her niece is her caregiver. *Id.* at 35 and 38.
3. Petitioner became enrolled in hospice care services in [REDACTED] 2020, while she was at [REDACTED], and she is currently receiving in-home hospice services. *Id.* at 35, 41, 58 – 59, 63. Petitioner's hospice provider, [REDACTED], provides a medical bed and personal care service limited to assistance with bathing. *Id.* at 24, 34 – 35.

4. With regard to Petitioner's Activities of Daily Living ("ADLs"), Petitioner needs total assistance with bathing, dressing, using the bathroom, transferring, and walking/mobility. *Id.* at 41. Petitioner needs supervision or prompt with eating. *Id.* Petitioner is bed bound and non-ambulatory. *Id.* Petitioner always has assistance with ADLs. *Id.*

5. With regard to Petitioner's 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, managing medication, and using transportation. *Id.* at 42. Petitioner always has assistance with IADLs. *Id.*

6. On September 8, 2020, Respondent issued an NABD denying Petitioner's request for fourteen (14) hours of personal care services weekly. *Id.* at 8 – 16. The NABD stated the reason for Respondent's determination as follows:

UnitedHealthcare Community Plan has reviewed your request for 14 hours of personal care, which we received on September 3, 2020. After our review, this service has been:

DENIED as of September 8, 2020

We made our decision because:

...

**X Other authority:** F.A.C. 59G-4.192 – Statewide Medicaid Managed Care Long-Term Care Program, Coverage Policy. A service cannot duplicate another service.

The facts that we used to make our decision are:

A Long Term Care doctor reviewed your request for 14 hours of personal care per week.

You are getting hospice care.

The service you asked for should be provided by hospice.

*Id.* at 8 - 10.

7. On September 23, 2020, Petitioner requested a plan appeal. *Id.* at 70. On October 9, 2020, Respondent sent Petitioner a letter, denying Petitioner's plan appeal. *Id.* at 70 - 72. The NPAR stated as follows:

On September 23, 2020 we received your timely plan appeal request regarding UnitedHealthcare Community Plan's Notice of Adverse Benefit Determination dated September 10, 2020, [REDACTED], denying the 14 hours a week of personal care provided to [Petitioner].

On October 9, 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 a 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-4.192 - Statewide Medicaid Managed Care Long-Term Care Program Coverage Policy.

We have decided that what you asked for cannot be approved. This does not meet Florida Medicaid rules. You asked for personal care help. You would like 14 hours a week. You are under hospice care. Hospice is required to give any care needed to treat your illness or effects of illness. Based on my professional judgment, what you asked for is not covered. The health plan will cover any Medicare copayment for this service given through hospice. This is why we cannot approve what you asked for. Please talk about this with your doctor.

*Id.* at 70.

8. On November 11, 2020, Petitioner requested a Fair Hearing due to the denial of fourteen (14) hours per week of personal care services. On December 2, 2020, the undersigned scheduled the Fair Hearing for December 23, 2020, at [REDACTED], and all parties were duly notified.

9. [REDACTED] testified that Petitioner began receiving hospice services on [REDACTED] 2020. She asserted that Petitioner needs personal care services to assist with her ADL's and IADLs on a round-the-clock basis. She testified that neither [REDACTED] nor United will approve

the personal care services and the only services hospice currently provides Petitioner is assistance with bathing.

10. [REDACTED] argued that Petitioner hospice services do not duplicate the requested personal care services because hospice will only provide assistance with bathing. He asserted that Petitioner needs full-time personal care services.

11. Dr. Karver argued that the issue is not whether the requested personal care services are medically necessary but, rather, the issue is who should pay for the services. *Id.* at 66. Dr. Karver explained that the services requested from United are duplicative of services provided by hospice. *Id.* at 62 and 64. She argued that Petitioner is currently receiving in-home hospice care under Medicare and did not request approval for personal care services from United until September 3, 2020. *Id.* at 35 and 64. Dr. Karver argued that Petitioner's hospice provider is required by law to provide the requested personal care services. Based on this information and due to the duplication of services, United denied the requested fourteen (14) hours of personal care services. *Id.* at 47.

#### **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), Fla. Stat. This order is the final administrative decision of AHCA 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. 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.

15. Because Petitioner is requesting a new service, Fla. Admin. Code R. 59G-1.100(17)(g) assigns the burden of proof to the Petitioner. The standard of proof in an administrative hearing is a preponderance of the evidence. The preponderance of the evidence standard requires proof by “the greater weight of the evidence” (Black’s Law Dictionary at 1201, 7th Ed.).

16. Pursuant to 42 C.F.R. § 418.64 (Condition of Participation: Core Services), a hospice must routinely provide substantially all core services directly by hospice employees. These services include nursing services, medical social services and counseling (bereavement, dietary, and spiritual). *See* 42 C.F.R. § 418.64.

17. Pursuant to 42 C.F.R. § 418.70 (Condition of Participation: Furnishing of Non-core Services), a hospice must ensure that the services described in § 418.72 through § 418.78 are provided directly by the hospice or under arrangements made by the hospice as specified in § 418.100.

18. Pursuant to 42 C.F.R. § 418.100(a) and (c)(1) (Condition of Participation: Organization and Administration of Services),

(a) Standard: Serving the hospice patient and family. The hospice must provide hospice care that -

(1) Optimizes comfort and dignity; and

(2) Is consistent with patient and family needs and goals, with patient needs and goals as priority.

...

(c) Standard: Services.

(1) A hospice must be primarily engaged in providing the following care and services and must do so in a manner that is consistent with accepted standards of practice:

(i) Nursing services.

(ii) Medical social services.

(iii) Physician services.

(iv) Counseling services, including spiritual counseling, dietary counseling, and bereavement counseling.

(v) Hospice aide, volunteer, and homemaker services.

(vi) Physical therapy, occupational therapy, and speech-language pathology services.

(vii) Short-term inpatient care.

(viii) Medical supplies (including drugs and biologicals) and medical appliances.

19. Covered services under 42 C.F.R. § 418.202(g) states:

Home health or hospice aide services furnished by qualified aides as designated in 418.76 and homemaker services. Aides (also known as hospice aides) may provide personal care services as defined in § 409.45(b) of this chapter. Aides may perform household services to maintain a safe and sanitary environment in areas of the home used by the patient, such as changing bed linens or light cleaning and laundering essential to the comfort and cleanliness of the patient. Aide services must be provided under the general supervision of a registered nurse. Homemaker services may include assistance in maintenance of a safe and healthy environment and services to enable the individual to carry out the treatment plan.

20. Pursuant to 42 C.F.R. § 409.45(b)(1)(i), home health aide services may include, but are not limited to:

Personal care services such as bathing, dressing, grooming, caring for hair, nail and oral hygiene that are needed to facilitate treatment or to prevent deterioration of the beneficiary's health, changing the bed linens of an incontinent beneficiary, shaving, deodorant application, skin care with lotions and/or powder, foot care, ear care, feeding, assistance with elimination (including enemas unless the skills of a licensed nurse are required due to the beneficiary's condition, routine catheter care, and routine colostomy care), assistance with ambulation, changing position in bed, and assistance with transfers.

21. Pursuant to section 400.609, Florida Statutes, 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. 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. See § 400.609(1)(a), Fla. Stat. Additionally, each hospice must:

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.

§ 400.609 (1)(b), Fla. Stat.

22. Fla. Admin. Code R. 59G-1.052(2) requires third-party resources to meet their legal obligations to pay claims before the Florida Medicaid program pays for a member's health care services. Providers must exhaust all third-party sources of payment, such as, Medicare, TRICARE, private health insurance, AARP plans, or automobile coverage prior to submitting or resubmitting a claim for reimbursement to Florida Medicaid. *Id.* at (6)(a). Florida Medicaid is the payer of last resort. *Id.* Providers may not refuse to furnish a covered Florida Medicaid service to a recipient solely because of the presence of other insurance, including Medicare, in accordance with 42 C.F.R. 447.20(b). *Id.* at (7).

23. The Florida Medicaid policy that applies to the provision of personal care services in this case is the SMMC LTC Policy. The Agency's SMMC LTC Policy has been incorporated, by reference, into Fla. Admin. Code Rule 59G-4.192. According to section 4.1 of the LTC Policy, Florida Medicaid

Long-term Care plans cover medically necessary services that do not duplicate another service and that meet the criteria specified in the SMMC LTC Policy.

24. The SMMC LTC Policy provides as follows:

### **1.1 Description and Program Goal**

Under the Statewide Medicaid Managed Care Long-term Care (LTC) program, managed care plans (LTC plans) are required to provide an array of home and community-based services that enable enrollees to live in the community and to avoid institutionalization.

...

### **1.3 Definitions**

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

#### **1.3.1 Activities of Daily Living (ADLs)**

ADLs include:

- Bathing
- Dressing
- Eating (oral feedings and fluid intake)
- Maintaining continence (examples include taking care of a catheter or colostomy bag or changing a disposable incontinence product when the recipient is unable to control bowel or bladder functions)
- Toileting
- Transferring

...

#### **1.3.5 701-B Comprehensive Assessment**

An individualized, complete assessment of an individual's medical, developmental, behavioral, social, financial, and environmental status. The assessment is conducted by a trained individual employed by the Department of Elder Affairs Comprehensive Assessment and Review for Long-Term Care Services (CARES) program or the LTC plan, to determine eligibility for the LTC program based on the need for a nursing facility level of care.

...

#### **1.3.9 Instrumental Activities of Daily Living (IADLs)**

When necessary for the recipient to function independently, including:

- Grocery shopping
- Laundry
- Light housework
- Meal preparation

- Medication management
- Money management
- Personal hygiene
- Transportation
- Using the telephone to take care of essential tasks (examples include paying bills and setting up medical appointments)

...

### **1.3.14 Medically Necessary or Medical Necessity**

For the purposes of this policy, the service must meet either of the following criteria:

- (a) Nursing facility services and mixed services must meet the medical necessity criteria defined in Rule 59G-1.010, F.A.C.
- (b) All other LTC supportive services must meet all of the following:
  - Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs
  - Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available statewide
  - Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider

And, one of the following:

- Enable the enrollee to maintain or regain functional capacity; or
- Enable the enrollee to have access to the benefits of community living, to achieve person-centered goals, and to live and work in the setting of his or her choice.

...

## **2.2 Who Can Receive**

Florida Medicaid recipients requiring medically necessary LTC services who are enrolled in a LTC plan and have a nursing facility level of care determined by the CARES program. Some services may be subject to additional coverage criteria as specified in section 4.0.

...

## **4.0 Coverage Information**

### **4.1 General Criteria**

Florida Medicaid LTC plans cover services that meet all of the following:

- Are determined medically necessary, as defined in this rule
- Do not duplicate another service

- Meet the criteria as specified in this policy

#### **4.2 Specific Criteria**

Florida Medicaid LTC plans cover services that meet all of the following:

- Consistent with the type, amount, duration, frequency, and scope of services specified in an enrollee's authorized plan of care
- Provided in accordance with a goal in the enrollee's plan of care
- Intended to enable the enrollee to reside in the most appropriate and least.

...

##### **4.2.1.9 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:

...

##### **4.2.2.3 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.

...

#### **6.0 Documentation**

...

##### **6.2 Specific Criteria**

In order to receive LTC services, services must be documented on an individualized plan of care based upon a comprehensive needs assessment. The comprehensive assessment includes the completion of the 701-B Comprehensive Assessment and the LTC Supplemental Assessment.

SMMC LTC Policy at pages 1-8.

25. The PC Policy, which is incorporated by reference in Fla. Admin. Code R. 59G-4.215, states as follows:

### **1.1 Description**

Florida Medicaid personal care services provide medically necessary assistance, in the home or in the community, with activities of daily living (ADL) and age appropriate instrumental activities of daily living (IADL) to enable recipients to accomplish tasks they would normally be able to do for themselves if they did not have a medical condition or disability.

...

#### **1.1.2 Statewide Medicaid Managed Care Plans**

Florida Medicaid managed care plans must comply with the coverage requirements outlined in this policy, unless otherwise specified in the AHCA contract with the Florida Medicaid managed care plan. The provision of services to recipients enrolled in a Florida Medicaid managed care plan must not be subject to more stringent coverage limits than specified in Florida Medicaid policies.

...

### **1.3 Definitions**

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

...

#### **1.3.6 Home Health Services**

Medically necessary services that can be safely provided to the recipient in their home or in the community that include home health visits (skilled nursing and home health aide services), private duty nursing, and personal care services.

...

### **4.2 Specific Criteria**

Florida Medicaid reimburses for up to 24 hours of personal care services per day, per recipient, in order to provide assistance with ADLs and age appropriate IADLs when the recipient meets the following criteria:

- Has a medical condition or disability that substantially limits their ability to perform ADLs or IADLs and do not have a parent or legal guardian able to provide the required care
- Is under the care of a physician and has a physician's order for personal care services
- Requires more extensive and continual care than can be provided through a home health visit
- Requires services that can be safely provided in their home or the community

PC Policy at pages 3 - 5.

26. The Florida Medicaid Definitions Policy (August 2017) ("Definitions Policy"), which is 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 severe pain
- Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs
- Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational
- Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available statewide
- Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider

The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services does not, in itself, make such care, goods or services medically necessary or a medical necessity or a covered service.

27. In the instant case, Petitioner requested fourteen (14) hours of personal care services per week. *See supra* ¶ 6 - 7. As established on the record by the evidence and testimony, Respondent denied Petitioner's request, because the additional personal care services are duplicative of hospice care. *See supra* ¶ 6 - 7, 8, and 11.

28. In support of Petitioner's position, [REDACTED] testified that Petitioner needs personal care services for her daily activities and that hospice declined to provide the assistance. *See supra* ¶ 9 - 10. Respondent argued that issue is not whether the requested personal care services are medically necessary, but rather who should pay for the services. *See supra* ¶ 11. Personal care services are available through Petitioner's election of hospice services, and would constitute a duplication of benefits if provided by United. *See supra* ¶ 11.

29. Pursuant to 42 C.F.R. § 418.64, a hospice must routinely provide substantially all core services directly by hospice employees. Cores services include nursing services, medical social

services and counseling services. *See supra* ¶ 16. A hospice must also ensure that non-core services are provided directly by the hospice or under arrangements made by the hospice as specified in 42 C.F.R. § 418.100. *See supra* ¶ 18.

30. Pursuant to 42 C.F.R. § 418.202(g), a home health aide (“hospice aide”) may perform personal care services as defined in § 409.45(b). *See supra* ¶ 19. These services may include, but are not limited to: bathing, dressing, grooming, and hygiene that are needed to facilitate treatment or prevent deterioration of the beneficiary’s health. *See* 42 C.F.R. § 409.45(b)(1)(i). Under Florida law, each hospice shall provide a continuum of hospice services to address the specific needs and preferences of the patient and family. *See supra* ¶ 20. These services may include home health aide services, homemaker, and chore services. *See supra* ¶ 20.

31. Despite the aforementioned statutes, regulations, and policies, there is no evidence of record as to why [REDACTED] declined to provide the level and frequency of personal care services requested by Petitioner. *See supra* ¶ 9 - 10. The record reflects that the current hospice services only assist with bathing and do not provide any personal care services. *See supra* ¶ 3 and 9. However, as Dr. Karver testified, *supra* ¶ 11, hospice is the party responsible for the provision of personal care services as required by federal and state law and regulation.

32. In light of the both parties’ testimony, Respondent’s Composite Exhibit 1, the SMMC LTC Policy, the Authorization Requirements Policy, the PC Policy, and the Definitions Policy, the undersigned Hearing Officer finds that Petitioner failed to meet her burden of proving that the fourteen (14) hours per week of personal care services are not duplicative of the services provided by hospice.

33. Accordingly, the undersigned Hearing Officer finds that Petitioner failed to prove by a preponderance of the evidence that Respondent's denial of the requested personal care services was incorrect.

**DECISION**

Respondent's denial of fourteen (14) hours of personal care services is **AFFIRMED**.  
Petitioner's appeal based on Respondent's denial in this matter is **DENIED**.

**DONE AND ORDERED** this 20th day of January 2021, in Tallahassee, Leon County, Florida.



Laura Gallagher  
20-FH [REDACTED]  
2021.01.20 08:25:15  
-05'00'

---

**LAURA GALLAGHER, Hearing Officer**  
**Agency for Health Care Administration**  
**Office of Fair Hearings**  
**2727 Mahan Drive, Mail Stop # 11**  
**Tallahassee, FL 32308-5407**  
**Office: (850) 412-3649**  
**Fax: (850) 487-1423**  
**E-mail: OfficeOfFairHearings@ahca.myflorida.com**

**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:**





**UnitedHealthcare of Florida, Inc.**  
**UHC\_Hearings@uhc.com**

**AHCA Medicaid Hearing Unit**  
**MedicaidHearingUnit@ahca.myflorida.com**