

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



FILED

Mar 16, 2023, 8:55 am

OFFICE OF FAIR HEARINGS

[Redacted]

PETITIONER,

AHCA Case No.: 22-FH2163

Plan ID No.: [Redacted]

vs.

UNITEDHEALTHCARE OF FLORIDA, INC.,

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, Hearing Officer Caylen Darbouze convened a telephonic Fair Hearing on the instant case on February 23, 2023, at 12:00 p.m. Eastern Standard Time ("EST").

APPEARANCES

For the Petitioner: [Redacted]
Authorized Representative

For the Respondent: Deborah Havey-Levey
Program Integrity Manager
UnitedHealthcare of Florida, Inc.

STATEMENT OF ISSUE

The issue is whether Petitioner proved by a preponderance of the evidence that Respondent's denial of Evaluation and Management services (out-of-network/out-of-state evaluation) was incorrect.

PRELIMINARY STATEMENT

All parties appeared for the scheduled Fair Hearing telephonically. [REDACTED] Petitioner's Authorized Representative and [REDACTED], appeared for the Fair Hearing to provide testimony on behalf of Petitioner, and did not call any witnesses.

Deborah Havey-Levey, a Program Integrity Manager for UnitedHealthcare of Florida, Inc. ("United"), appeared for the Fair Hearing as representative for Respondent. Albenah Baharieva, MD ("Dr. Baharieva"), a Medical Director for United, appeared for the Fair Hearing as a witness for Respondent.

The following persons appeared for the Fair Hearing as an observer: Doris Rivera, a Medical Health Care Program Analyst for the Agency for Health Care Administration ("Agency" or "AHCA"); and Benjamin Young, a Senior Clerk for AHCA.

Prior to the Fair Hearing, Petitioner sent to the Office of Fair Hearings a 14-page evidence packet, which was admitted into evidence a Petitioner's Composite Exhibit 1. Petitioner's Composite Exhibit 1 includes the following documents: an email from [REDACTED] and various internet articles; and a letter from Dr. Jun Ho Kim (dated September 12, 2022).

Prior to the Fair Hearing, Respondent sent to the Office of Fair Hearings and Petitioner a 286-page evidence packet, which was admitted into evidence a Respondent's Composite Exhibit 1. Respondent's Composite Exhibit 1 includes the following documents: a Statement of Matters; a Notice of Adverse Benefit Determination ("NABD") (dated September 1, 2022); Grievance and Appeals documents; a letter from Dr. Jun Ho Kim (dated September 12, 2022); a fax cover sheet; a copy of the NABD; a Plan Appeal Acknowledgement (dated September 29, 2022); Medical records; Print HSC History; Plan Appeal Review notes; a Notice of Plan Appeal Resolution ("NPAR") (dated October 27 2022); United policy – Processing In-Network vs. Out-of-Network

Medicaid Requests (Effective May 26, 2015); United Medicaid Member Handbook; EPSDT - A Guide for States: Coverage in the Medicaid Benefit for Children and Adolescents; a cover sheet; a letter from [REDACTED]; a letter from Dr. Jun Ho Kim (dated September 12, 2022); Various internet articles; Exhibit 2 (References) Cover Page – Managed Medical Assistance (MMA); Florida Medicaid Definitions Policy (August 2017) (“Definitions Policy”); Florida Administrative Code Chapter 59G-1; Florida Medicaid Authorization Requirements Policy (June 2016); and section 409.910, Florida Statute (“Fla. Stat.”) (2018).

FINDINGS OF FACT

1. Petitioner is an enrolled member of United. See Respondent’s Composite Exhibit 1, pages 1, 46-55. United is a managed care organization contracted by the Agency to provide services to eligible Medicaid recipients in the state of Florida.
2. As of the date of the Fair Hearing, Petitioner is [REDACTED]. *Id.* at 11. Petitioner is seeking to see an out-of-network/out-of-state provider that specializes in Petitioner’s medical condition. *Id.* at 9. Dr. Jun Ho Kim (“Dr. Kim”), a pediatric neurologist, recommends the Petitioner receive an evaluation from an out-of-network/out-of-state provider (North Carolina) that specializes in Petitioner’s medical condition. *Id.* at 11. Dr. Kim already evaluated the Petitioner, but requests a second opinion regarding neurosurgery. *Id.* at 11. Petitioner submitted medical records in support of the request. *Id.* at 24-45. According to Dr. Baharieva at the Fair Hearing, Dr. Kim made no attempt to speak with United’s recommended providers, *supra* 3 & 5, regarding Petitioner’s case to determine whether they are capable of evaluating the Petitioner; the instant request is for an evaluation, not the actual surgery.

3. On September 1, 2022, United issued an NABD denying Petitioner's request for Evaluation and Management services. *Id.* at 4-7, 15-17. The NABD explained the basis of the denial as follows, in pertinent part:

UnitedHealthcare Community Plan has reviewed your request for an office visit, which we received on 8/30/2022. After our review, this service has been:

DENIED as of 8/31/2022.

We made our decision because:

✓ We determined that your requested services are **not medically necessary** because the services do not meet the reason(s) checked below: (*See Rule 59G-1.010*)

...

- **Must be able to be 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.**

...

The facts that we used to make our decision are: Your child's doctor requested an office visit. This is for [REDACTED]. Your child's health plan is asked to cover expenses.

Clinical Rationale for Decision: Your child needs to get care with certain providers. These should be in the plan. The request to get care from a non-plan provider is not covered. The request is not approved. **Care with a non-plan provider can be covered if:**

- It is an emergency
- Receiving care that cannot be interrupted
- **There is not a doctor to give medically needed care**

The request is not approved. There are providers available in the network:

- Baumgartner, James E, MD 615 E Princeton St Ste 101, Orlando, FL 32803 (407) 236-0006
- Gegg, Christopher A, MD 3300 W Lake Mary Blvd Ste 100, Lake Mary, FL 32746 (407) 650-7000
- Johnson, Keyne K, MD 3300 W Lake Mary Blvd Ste 100, Lake Mary, FL 32746 (407) 650-7000

Criteria Guideline: The criteria we used to make our decision is: UnitedHealthcare® Clinical Services Medical Management Standard Operating

dated August 31, 2022, A167874225, denying the office visit provided to [Petitioner].

On October 25, 2022, 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.**

Samuel T Wilmit, MD, specializing in Pediatrics, reviewed the appeal. This doctor did not make the original decision. The decision was based on 1. UnitedHealthcare Clinical Services Medical Management Document Number: UCSMM.AMC.06.21.A1 Effective Date: May 20, 2015, Revision Date: September 22, 2021 2. United Healthcare Community Plan Medicaid Member Handbook 2021 Section 10: Accessing services pp 29 Providers not in our plan pp 30 3. Early and Periodic Screening, Diagnostic and Treatment services (EPSDT) - A Guide for States: Coverage in the Medicaid Benefit for Children and Adolescents, Page 9, Effective June 2014.

Your appeal was looked at by our Medical Director. The reviewer is a Doctor of Medicine. The reviewer is board certified in Pediatrics. You have asked to use a neurosurgeon that is not in your network. This is for your child with a [REDACTED]. **We checked and found 3 in network providers who have the experience and knowledge to provide this surgery for your child. There is no Clinical GAP. Therefore, the out of network provider is not covered.** There are providers available in the network:

Baumgartner, James E, MD
615 E Princeton St Ste 101,
Orlando, FL 32803
(407) 236-0006

Gegg, Christopher A, MD
3300 W Lake Mary Blvd Ste 100,
Lake Mary, FL 32746
(407) 650-7000

Johnson, Keyne K, MD
3300 W Lake Mary Blvd Ste 100,
Lake Mary, FL 32746
(407) 650-7000

...

Sincerely,
Dr. Samuel T Wilmit, M.D., FAAP ["Dr. Wilmit"]
Board Certified in Pediatrics
Appeals and Grievances Medical Director

Respondent's Composite Exhibit 1, pages 69-71. (Emphasis added).

6. United's Member Handbook states the following regarding a recipient's access to services provided by an out-of-network provider:

Before you get a service or go to a health care appointment, we have to make sure you need the service and that it is medically right for you. This is called **prior authorization**. To do this, we look at your medical history and information from your doctor or other health care providers. Then we will decide if that service can help you. We use rules from the Agency to make these decisions.

...

Providers not in our plan

There are some services that you may be able to get from providers who are not in our provider network. These services are:

- Family planning services and supplies
- Women's preventative health services, such as breast exams, screenings for cervical cancer, and prenatal care
- Treatment of sexually transmitted diseases
- Emergency care

If we cannot find a provider in our provider network for these services, we will help you find another provider that is not in our network. Remember to check with us first before you use a provider that is not in our provider network. If you have questions, call Member Services.

Respondent's Composite Exhibit 1, pages 105-106. (Emphasis added).

7. On November 17, 2022, [REDACTED] requested a Fair Hearing on behalf of Petitioner regarding the denial of Evaluation and Management services. On February 2, 2023, the undersigned Hearing Officer issued a notice, to all parties of records, scheduling the Fair Hearing to be convened by telephone on February 23, 2023, at 12:00 p.m. EST.

8. According to [REDACTED] testimony presented at the Fair Hearing, Petitioner is requesting an evaluation from a specialist at Duke University (Durham, North Carolina) because Petitioner's in-network neurologist, Dr. Kim, recommends it and the out-of-network provider (Dr. Gerald A. Grant, MD) specializes in Petitioner's complex medical condition ([REDACTED]). [REDACTED] speculated that United's recommended providers, *supra* ¶ 3 & 5, have no experience with Petitioner's medical condition and even if they do have experience with Petitioner's medical condition, it does not compare that of the out-of-network provider (Dr. Grant). [REDACTED] did not present any evidence to this effect. [REDACTED] provided Dr. Grant's hospital profile page. See Petitioner's Composite Exhibit 1, pages 7-8. [REDACTED] wants Petitioner to receive an evaluation by a provider who only treats [REDACTED], not just a neurosurgeon who may have experience with [REDACTED].

9. According to Dr. Baharieva's testimony presented at the Fair Hearing, Petitioner was already evaluated by United's in-network provider regarding a recommendation for neurosurgery. United's position is that if Petitioner's [REDACTED] is seeking an in-network provider, then Petitioner may see another in-network provider, just like they were seen by an in-network provider who completed the first evaluation. United identified three in-network providers, all of whom are pediatric neurosurgeons, who can evaluate the Petitioner. Dr. Baharieva asserted that all three pediatric neurosurgeons, *supra* ¶ 3 & 5, have experience treating children with [REDACTED]. Dr. Baumgartner has 38 years of experience in the field. Dr. Gegg and Dr. Johnson each have approximately 22 years of experience in the field. Dr. Gegg also published medical literature on [REDACTED]. Dr. Baharieva is not aware how long each of the providers have experience in [REDACTED]. Dr. Baharieva opined that Dr. Baumgartner, Dr. Gegg,

and Dr. Johnson can evaluate the Petitioner. Dr. Baharieva also opined that it has been 7 months since Petitioner's last neurology appointment, and Petitioner should have still seen one of the three specialists for an evaluation while going through the plan appeal and Fair Hearing process so that there is no gap in Petitioner's care.

CONCLUSIONS OF LAW

10. 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) (2022). This Order is the final administrative decision of AHCA under Fla. Stat. § 409.285(2)(a).

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

12. Because Petitioner is requesting 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.).

13. Petitioner's requests for additional Evaluation and Management services are governed by the Florida Medicaid Evaluation and Management Services Coverage Policy (June 2016) ("Florida Medicaid Evaluation Policy"), which is incorporated by reference in Fla. Admin. Code R. 59G-4.087. The Florida Medicaid Evaluation Policy provides the following, in pertinent part:

1.0 Description and Program Goal

Florida Medicaid evaluation and management services provide for physician visits to maintain a recipient's health, prevent disease, and treat illness.

1.1.1 Florida Medicaid Policies

This policy is intended for use by providers of evaluation and management services that render services to eligible Florida Medicaid recipients. 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.

Note: All Florida Medicaid policies are promulgated in Rule Division 59G, Florida Administrative Code (F.A.C.). Coverage policies are available on the Agency for Health Care Administration's (AHCA) Web site at <http://ahca.myflorida.com/Medicaid/review/index.shtml>.

1.1.2 Statewide Medicaid Managed Care Plans

This Florida Medicaid policy provides the minimum service requirements for all providers of evaluation and management services. This includes providers who contract with Florida Medicaid managed care plans (i.e., **provider service networks** and health maintenance organizations). Providers must comply with the service coverage requirements outlined in this policy, unless otherwise specified in AHCA's contract with the Florida Medicaid managed care plan. The provision of services to recipients in a Florida Medicaid managed care plan must not be subject to more stringent service 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.

1.3.5 Medically Necessary/Medical Necessity

As defined in Rule 59G-1.010, F.A.C.

1.3.7 Provider

The term used to describe any entity, facility, person, or group that has been approved for enrollment or registered with Florida Medicaid.

1.3.8 Recipient

For the purpose of this coverage policy, the term used to describe an individual enrolled in Florida Medicaid (including managed care plan enrollees).

...

3.0 Eligible Provider

3.1 General Criteria

Providers must be at least one of the following to be reimbursed for services rendered to eligible recipients:

- Enrolled directly with Florida Medicaid if providing services through a fee-for-service delivery system
- Enrolled directly or registered with Florida Medicaid if providing services through a managed care plan

3.2 Who Can Provide

- Practitioners licensed within their scope of practice to perform this service
- County health departments administered by the Department of Health in accordance with Chapter 154, F.S.
- Federally qualified health centers approved by the Public Health Service
- Rural health clinics certified by Medicare

4.0 Coverage Information

4.1 General Criteria

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

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

4.2 Specific Criteria

Florida Medicaid reimburses for services in accordance with the American Medical Association's Current Procedural Terminology and the applicable Florida Medicaid fee schedule(s), or as specified in this policy:

4.2.1 Adult Health Screening Services

One adult health screening every 365 days, for recipients age 21 years and older.

4.2.2 Child Health Check-Up Services

Preventative medicine services for recipients under the age of 21 years, in accordance with the American Academy of Pediatrics periodicity schedule.

4.2.3 Custodial Care Facility Services and Nursing Facility Services

One evaluation and management visit per month, per recipient.

4.2.4 Office Visits

- As medically necessary for recipients under the age of 21 years and pregnant recipients age 21 years and older.
- Up to two office visits per month, per specialty, for recipients age 21 years and older.

4.3 Early and Periodic Screening, Diagnosis, and Treatment

As required by federal law, Florida Medicaid provides services to eligible recipients under the age of 21 years, if such services are medically necessary to correct or ameliorate a defect, a condition, or a physical or mental illness. Included are diagnostic services, treatment, equipment, supplies, and other measures described in section 1905(a) of the SSA, codified in Title 42 of the United States Code 1396d(a). As such, services for recipients under the age of 21 years exceeding the coverage described within this policy or the associated fee schedule may be approved, if medically necessary. For more information, please refer to Florida Medicaid's authorization requirements policy.

5.0 Exclusion

5.1 General Non-Covered Criteria

Services related to this policy are not reimbursed when any of the following apply:

- The service does not meet the medical necessity criteria listed in section 1.0
- The recipient does not meet the eligibility requirements listed in section 2.0
- The service unnecessarily duplicates another provider's service

14. States must provide Early and Periodic Screening, Diagnostic, and Treatment ("EPSDT") services to Medicaid-eligible children under age 21 when requested under the Medicaid state plan. See 42 U.S.C. § 1396a(a)(43); 42 U.S.C. § 1396d(a)(4). According to 42 U.S.C. § 1396d(r)(5), EPSDT services mean, in relevant part, the following items and services:

Such other necessary health care, diagnostic services, treatment, and other measures described in subsection (a) of this section to correct or ameliorate defects and physical and mental illness and conditions discovered by the screen services, whether or not such services are covered under the state plan.

15. Petitioner is under the age of 21 years, and therefore EPSDT applies to request for services. However, a state may place medical necessity limitations on EPSDT services. See 42 C.F.R. §§ 440.230(a), (b), (d). Fla. Stat. § 409.905(2) limits EPSDT services with a medical necessity standard:

The [Agency] shall pay for early and periodic screening and diagnosis of a recipient under age 21 to ascertain physical and mental problems and conditions and all services determined by the agency to be medically necessary for the treatment, correction, or amelioration of these problems and conditions, including personal

care, private duty nursing, durable medical equipment, physical therapy, occupational therapy, speech therapy, respiratory therapy, and immunizations.

16. The Florida Medicaid Definitions Policy, incorporated by reference in Fla. Admin. Code R. 59G-1.010, provides definitions of commonly used terms that are applicable to all sections of Rule Division 59G, Florida Administrative Code (F.A.C.), unless specifically stated otherwise in a service-specific coverage policy or rule. The Florida Medicaid Definitions Policy states 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.

Respondent's Composite Exhibit 1, page 243. (Emphasis added).

16. Based on the NABD, and the NPAR, Respondent denied Petitioner's request for out-of-network/out-of-state evaluation for [REDACTED] based on medical necessity. See supra ¶ 3, 5. Based on Dr. Baharlieva's testimony, Respondent determined that an out-of-network/out-of-state evaluation was not medically necessary as Petitioner's request was not "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.” *See supra* ¶ 3, 5, 9. Respondent’s position is that they have three in-network providers capable of performing an evaluation on the Petitioner and an in-network evaluation is reflective of the level of service that can be safely furnished, and for which is equally effective and more conservative or less costly treatment than Petitioner’s request. *See supra* ¶ 3, 5, 9.

19. The Florida Medicaid program covers Evaluation and Management services that are determined to be medically necessary. *See supra* ¶ 13. Evaluation and Management services includes, “physician visits to maintain a recipient’s health, prevent disease, and treat illness.” *See supra* ¶ 13. Medicaid services such as a physician evaluation must meet the Florida Medicaid program’s medical necessity criteria (*see* section 2.83 of the Florida Medicaid Definitions policy). *See supra* ¶ 16. To be medically necessary, Petitioner must show that an out-of-network/out-of-state evaluation is 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. Thus, Petitioner must show that there is no Florida Medicaid provider who can perform an equally effective and more conservative or less costly evaluation that would be performed by the provider at Duke University in Durham, North Carolina. This is a requirement of medical necessity stated in section 2.83 of the Florida Medicaid Definitions Policy. *See supra* ¶ 16.

17. The record also indicates that in order for an out-of-network/out-of-state evaluation to be approved as medically necessary by Respondent, one of the following conditions must be met: (1) It is an emergency; or (2) the recipient is receiving care that cannot be interrupted; or (3) there is not an in-network provider to give medically needed care. *See supra* ¶ 3, 5. It appears both parties agree that the Petitioner’s request does not meet the first two criteria as no

documentation or testimony was presented addressed them. Respondent determined that Petitioner did not meet the final criterion after they identified three in-network providers deemed capable to evaluate the Petitioner. See supra ¶ 3, 5, 9. [REDACTED] argued that the identified three in-network providers are not competent to evaluate the Petitioner. See supra ¶ 8. However, [REDACTED] provided no documentary evidence to support this argument. Simply, [REDACTED] did not prove that neither Dr. Gegg nor Dr. Baumgartner nor Dr. Johnson are qualified to evaluate a child diagnosed with [REDACTED]. [REDACTED] merely bolstered Dr. Grant's qualifications to evaluate a child diagnosed with [REDACTED], which is neither in dispute nor the subject of the Fair Hearing. It appears there is no dispute that Dr. Grant is qualified and competent [REDACTED] [REDACTED] specialist. However, there is no evidence that it cannot be said for Dr. Gegg, Dr. Baumgartner, or Dr. Johnson. There is an underlying premise, which neither party disputes, that an in-network provider visit would be more conservation and less costly than traveling from the state of Florida to Durham, North Carolina. The crux of this case rests on whether an in-network provider evaluation can be *equally effective* as an out-of-network evaluation. Petitioner's position is that effectiveness is measured in terms of years of experience treating a specific medical condition. See supra ¶ 8. However, there is no evidence that supports this position (e.g., a doctor with 10 years' experience cannot perform an effective evaluation that a doctor of 15 years' of experience would). The undersigned Hearing Officer found Dr. Baharieva's testimony regarding the experience and qualifications of the identified three in-network providers to be credible and reliable.

18. The remaining documentary evidence to support Petitioner's request for an out-of-network/out-of-state evaluation is Dr. Kim's recommendation, who himself is an in-network


provider. With respect to the recommendations of a provider (e.g., Dr. Kim), Florida law states, “[t]he fact that a provider has . . . recommended . . . services does not, in itself, make such . . . services medically necessary.” See supra ¶ 16. Simply, just because Dr. Kim declared an out-of-network/out-of-state evaluation is medically necessary does not mean that is the final determination whether a service is approved by the Florida Medicaid program. The provider and recipient must prove that all five criteria for medical necessity, a legal and medical concept, have been met. Nonetheless, the undersigned Hearing Officer considered Dr. Kim’s recommendation. Here, there is no evidence that Dr. Kim evaluated the qualifications of the identified three in-network providers (e.g., a telephone conversation regarding Petitioner’s medical condition and whether the physicians could evaluate the child). It appears that Dr. Kim made no effort to do so and assumed that these other physicians, in-network, were unqualified to perform an evaluation. Further, [REDACTED] made no attempt to speak with these providers directly or have them evaluate the Petitioner while waiting for the Fair Hearing to occur, to gain first hand knowledge of the provider’s competency rather than Google searching a physician’s hospital profile page and conducting a surface-level comparison. Neither [REDACTED] testimony nor Dr. Kim’s letter establish that the three identified providers are not just as competent as Dr. Grant.

19. Upon consideration of the testimony provided by both parties at the Fair Hearing, documentary evidence submitted, and applicable policies, the undersigned Hearing Officer concludes that Petitioner *did not* prove by a preponderance of the evidence that the requested Evaluation and Management services are medically necessary. Accordingly, the undersigned Hearing Officer finds that Petitioner *has not* proved by a preponderance of the evidence that Respondent’s denial of Evaluation and Management services was incorrect.

IT IS THEREFORE ORDERED AND ADJUDGED THAT:

Respondent's denial of Evaluation and Management services is **AFFIRMED**. Petitioner's appeal based on Respondent's denial of Evaluation and Management services is **DENIED**.

DONE and ORDERED this 16th day of March, 2023, in Tallahassee, Leon County, Florida.

 Laura Gallagher
22-FH2163
2023.03.16
07:57:46 -04'00'

LAURA GALLAGHER, Hearing Officer
Agency for Health Care Administration
Office of Fair Hearings
2727 Mahan Drive, Mail Stop # 11
Tallahassee, FL 32308-5407

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:

[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]

UnitedHealthcare of Florida, Inc.
UHC_Hearings@uhc.com

AHCA Medicaid Hearing Unit
MedicaidHearingUnit@ahca.myflorida.com