

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

FILED

MAY 30 2023

Agency For Health  
Care Administration

[REDACTED]  
PETITIONER,

AHCA Case No.: 23-FH0267

vs.

AGENCY FOR HEALTH CARE  
ADMINISTRATION,

RESPONDENT.

---

**FINAL ORDER**

Pursuant to notice, the undersigned Hearing Officer convened a telephonic Medicaid Fair Hearing in the above-styled case on April 3, 2023, at 8:34 a.m. Eastern Standard Time ("EST").

**APPEARANCES**

For the Petitioner:

[REDACTED]  
Petitioner's Authorized Representative

For the Respondent:

Marielisa Amador  
Medical Health Care Program Analyst  
Agency for Health Care Administration

**STATEMENT OF ISSUE**

The issue is whether Petitioner proved by a preponderance of the evidence that Respondent's denial of additional personal care services was incorrect.

**PRELIMINARY STATEMENT**

All parties and witnesses appeared telephonically. [REDACTED] Petitioner's Authorized Representative and [REDACTED], appeared for the hearing and provided testimony on behalf of Petitioner.

Marielisa Amador, Medical Health Care Program Analyst for the Agency for Health Care Administration (“Agency” or “AHCA”), appeared as a representative for Respondent. Dr. Chris Kunis (“Dr. Kunis”), Medical Director for eQHealth Solutions, Inc., appeared as a witness for Respondent.

██████████ indicated on the record that ██████████ did not need a translator. Therefore, Interpreter Joseph, Translator ID No. 31579212, with Global Interpreting Network was dismissed.

Petitioner did not introduce any exhibits at the Fair Hearing.

Respondent introduced an eighty-seven (87)-page evidence package at the Fair Hearing. The packet is maintained in the Office of Fair Hearings’ case management system as “56234956 FH 04.03.2023.pdf.” Absent an objection from Petitioner, the undersigned admitted the evidence packet into evidence as Respondent’s Composite Exhibit 1.

Respondent introduced a fifty-two (52)-page evidence package at the Fair Hearing. The packet is maintained in the Office of Fair Hearings’ case management system as “23-FH0267 AHCA Evidence (pages 1-52).pdf.” Absent an objection from Petitioner, the undersigned admitted the evidence packet into evidence as Respondent’s Composite Exhibit 2.

#### **FINDINGS OF FACT**

1. AHCA is a single state agency responsible for administering the Medicaid program and for ensuring compliance with state and federal Medicaid Rules. See Respondent’s Composite Exhibit 2 at page 3.
2. Petitioner receives Medicaid services on a fee-for-service basis from the Agency. See Respondent’s Composite Exhibit 1 at page 22. eQHealth is a Quality Improvement Organization (“QIO”) contracted by the Agency to review prior authorization requests for services. See

Respondent's Composite Exhibit 2 at 2. The Agency through contractual agreement authorized eQHealth to make medical necessity determinations regarding requests for fee-for-service Medicaid services requiring prior authorizations. *Id.*

3. As of the date of the Fair hearing, Petitioner is a [REDACTED] [REDACTED] See Respondent's Composite Exhibit 1 at page 22. Petitioner lives with [REDACTED] *Id.* Petitioner [REDACTED] [REDACTED]

4. Regarding Activities of Daily Living ("ADLs"), Petitioner [REDACTED] [REDACTED] [REDACTED] *Id.* at 76.

5. Petitioner's physician Dr. Relando Penate ("Dr. Penate") provided a prescription for home health services and accompanying documentation. See Respondent's Composite Exhibit 1 at page 78-79. The documentation states:

Pt in need of personal care services for all [REDACTED] ADL's and IADL's (100% assistance), [REDACTED]

*Id.* at 79.

6. [REDACTED] works outside the home [REDACTED] *Id.* at 80. [REDACTED] contract work schedule is 8:00 a.m. to 3:30 p.m. Monday through Friday. *Id.* [REDACTED] testified that [REDACTED]

7. Petitioner requested fifteen hours (15) per week of personal care services and ten (10) hours per day of personal care services on non-school days. *Id.* at 23. On December 21, 2022, Respondent issued a Notice of Outcome (“NOO”) partially approving Petitioner’s request for personal care services. *Id.* at 35-38. The NOO stated as follows:

The request for services is denied in whole or in part because they are not medically necessary as defined in 59G-1.010, Florida Administrative Code. Specifically the requested services are not medically necessary under the following standard(s):

Individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness under treatment, and not in excess of the patient’s needs.

The rationale for our decision is as follows:  
PR Principal Reason – Denial:

Submitted information does not support the medical necessity for requested frequency and/or duration.

[REDACTED]

*Id.* at 37.

8. Petitioner requested reconsideration and Respondent issued a Notice of Reconsideration Determination (“NRD”), dated December 26, 2022, upholding the denial of additional personal care services. *Id.* at 50-53. The NRD stated, in pertinent part:

Specifically the services must be:

Individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness under treatment, and not in excess of the patient’s needs.

The medical basis for the reconsideration decision is as follows:

The patient [REDACTED]

After reconsidering the submitted information, the original decision has to be upheld

based on the severity of delay and the [REDACTED] PCS is not intended for monitoring and [REDACTED]

*Id.* at 53.

9. On February 6, 2023, [REDACTED] requested a Fair Hearing to challenge the denial of additional personal care services. *Id.* at 9. On March 6, 2023, the undersigned scheduled the Fair Hearing for April 3, 2023, at 8:30 a.m. EST, and all parties were duly notified. *Id.*

10. [REDACTED] testified that Petitioner needs personal care services when [REDACTED] is working at [REDACTED], and when Petitioner's [REDACTED]. She stated that a [REDACTED] [REDACTED]; however, [REDACTED] is no longer available to pick-up Petitioner from the program, and [REDACTED] schedule does not permit her to do so. She argued that Petitioner [REDACTED]

She testified that Petitioner is [REDACTED]

11. Dr. Kunis testified that he reviewed the documentation provided in this case and agrees with the previous two physician reviewers at eQHealth that additional personal care services are not medically necessary. Dr. Kunis argued that under the Florida Medicaid program, parents must provide as much care as possible, and that the Florida Medicaid program is intended to supplement the care provided by the parents. Referring to the Outpatient Review History, Dr. Kunis noted that Petitioner [REDACTED]

[REDACTED] *Id.* at 23-25. Dr. Kunis further noted that Petitioner [REDACTED]

[REDACTED] *Id.* Dr. Kunis pointed out that Petitioner has had no recent hospitalizations or ER visits. *Id.* Dr. Kunis asserted that personal care services are not intended for monitoring and supervision.

#### 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 AHCA under section 409.285(2)(a).

13. This hearing was held as a *de novo* proceeding pursuant to Rule 59G-1.100(17)(b), Florida Administrative Code ("F.A.C.").

14. The burden of proof in this proceeding is governed by Rule 59G-1.100(17)(g), F.A.C., 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 new services, Rule 59G-1.100(17)(g), F.A.C., 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. The Florida Medicaid Personal Care Services Coverage Policy (November 2016) ("PC Policy"), incorporated by reference in Rule 59G-4.215, F.A.C., governs Petitioners' request for personal care services. The PC Policy 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.

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

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

#### **1.3.2 Babysitting**

**Custodial care, daycare, afterschool care, supervision, or similar childcare unrelated to the services that are documented to be medically necessary for the recipient.**

...

#### **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.

...

### **2.0 Eligible recipient**

#### **2.1 General Criteria**

An eligible recipient must be enrolled in the Florida Medicaid program on the date of service and meet the criteria provided in this policy. Provider(s) must verify each recipient's eligibility each time a service is rendered.

#### **2.2 Who can receive**

Florida Medicaid recipients under the age of 21 years requiring medically necessary personal care services. Some services may be subject to additional coverage as specified in section 4.0.

Respondent's Composite Exhibit 2 at page 40-41.(emphasis added)

16. The PC Policy provides the following general and specific criteria for coverage of personal care services:

#### **4.0 Coverage Information**

##### **4.1 General Criteria**

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

- Are determined to be medically necessary

- Do not duplicate another service
- Meet the criteria as specified in this policy

**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

...

**4.2.1 Parental Responsibility**

Florida Medicaid reimburses for personal care services rendered to a recipient whose parent or legal guardian is not able to provide ADL or IALS care, and to supplement care provided by parents and legal guardians. Parents and legal guardians must participate in providing care to the fullest extent possible. Providers must offer training to enable parents and legal guardians to provide care they can safely render without jeopardizing the health or safety of the recipient when needed.

...

**7.0 Authorization**

**7.1 General Criteria**

The authorization information described below is applicable to the fee-for-service delivery system. For more information on general authorization requirements, please refer to Florida Medicaid’s General Policies on authorization requirements.

...

Personal Care Task	General Time Allowances
<b>Bathing</b>	
<b>Full-body Bath:</b> Tub, shower or sponge/bed bath.	Up to 30 minutes. May rotate with partial bath based on recipient’s needs
<b>Partial Bath:</b> A sponge bath includes, at a minimum, bathing of the face, hands, and perineum.	15–20 minutes per partial bath

<b>Dressing</b>	
Laying out clothing, handing and retrieving clothing, putting clothes on and taking them off, including handling fasteners, zippers, and buttons.	15 minutes
Application of prosthetic devices or application of therapeutic stockings.	May add 15 minutes for applying hose and/or Prosthesis
<b>Grooming and Skin Care</b>	
Brushing teeth, denture care, shaving, washing and drying face and hands. Applying lotion to non-broken skin.	15–30 minutes
Shampoo and comb hair, basic hair care, basic nail care.	15 minutes
<b>Positioning</b>	
Moving recipient to and from a lying position, turning side to side, and positioning recipient in bed.	10 minutes/every 2 hours when medically indicated
<b>Transfers</b>	
Moving recipient into and out of a bed, chair, or wheelchair. May include the use of assistive devices.	15 minutes/every 2 hours when medically indicated
<b>Toileting and Maintaining Continence</b>	
Includes transfer on or off the toilet, bedside commode, urinal, or bedpan. Includes cleaning the perineum and cleaning after an incontinent episode. Includes taking care of a catheter or colostomy bag or changing a disposable incontinence product.	15–45 minutes
<b>Eating</b>	
Taking in food by any method. Extra time may be allowed for preparing a special diet.	30 minutes per meal
<b>Delegated Medical Monitoring and Activities</b>	
Non-skilled medical tasks that are delegated to the aide by the RN, in accordance with Florida laws and practice acts. The tasks include, but are not limited to, assisting recipient with pre-poured medications,	15–30 minutes day for all monitoring tasks performed

monitoring vital signs, and measurement of intake/output.	
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Respondent's Composite Exhibit 2 at page 42, 47.

17. The PC Policy provides the following general and specific exclusions to the coverage of personal care services:

**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 1.0
- The recipient does not meet the eligibility requirements listed in 2.0
- The service unnecessarily duplicates another provider's service.

**5.2 Specific Non-Covered Criteria**

Florida Medicaid does not reimburse for the following:

...

- Assistance with homework
- Babysitting
- Companion sitting or leisure activities
- Respite care to facilitate the parent or legal guardian attending to personal matters
- Services furnished by relatives as defined in section 429.02(18), F.S., household members, or any person with custodial or legal responsibility for the recipient. (Except when a recipient is enrolled in the Consumer-Directed Care Plus Program),

....

Florida Medicaid may reimburse for some services listed in this section through a different service benefit.

Respondent's Composite Exhibit 2 at page 42-47.

18. The Florida Medicaid Authorization Requirements Policy ("Authorization Requirements Policy") (June 2016), incorporated by reference in Rule 59G-1.053, F.A.C., provides general requirements for providers to obtain authorization to render Florida Medicaid services. The Authorization Requirements Policy states:

**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.

...

#### **1.3.6 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).

...

### **2.0 Authorization Requirements**

...

#### **2.4.2 Requests for Additional Information**

The QIO may request additional information, as necessary, to determine medical necessity.

...

### **3.0 Determination Process**

#### **3.1 Review Criteria**

The QIO may use a national standardized set of criteria, or other set of criteria, approved by AHCA, as a guide for authorizations performed at the first review level. If services cannot be approved at the first level review, the QIO's physician peer reviewer will determine medical necessity using his or her clinical judgment, acceptable standards of care, state and federal laws, and AHCA's medical necessity definition.

#### **3.2 Review Process**

The QIO will review each authorization request and will approve, deny, or request additional information. The QIO may deny a portion of the requested units of service if it cannot substantiate medical necessity based upon the information submitted.

##### **3.2.1 Continued Authorization Requests**

The QIO shall not deny or reduce the amount, frequency, or duration of a service that is already being provided, unless:

- The reduction is to correct for factual errors or omissions in prior certifications.
- There is a documented improvement in the recipient's medical condition.

- There is a documented change in the recipient's circumstances.
- The reviewing physician determines the recipient will not gain any additional benefit by continuing services at the current level.

Respondent's Composite Exhibit 2 at pages 32-34.

19. The PC Policy provides the following with respect to Florida Medicaid recipients under the age of 21 years, requesting personal care services:

**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 General Policies on authorization requirements.

Respondent's Composite Exhibit 2 at page 42.

20. Given that Petitioner [REDACTED] the PC Policy permits coverage for the personal care services at issue. However, a state may place medical necessity limitations on Early and Periodic Screening, Diagnosis, and Treatment ("EPSDT") services. *See* 42 C.F.R. §§ 440.230(a), (b), (d). Pursuant to section 409.905(2), Florida Statutes:

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.

21. Once it is determined that EPSDT applies to a request for a service, the Florida Medicaid program determines the amount or necessity for that service based on the State of Florida's definition of medical necessity. The Florida Medicaid Definitions Policy ("Definitions Policy"),

which is incorporated by reference in Rule 59G-1.010, F.A.C., defines 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.

Respondent's Composite Exhibit 2 at page 23.

22. The evidence and testimony establish that Respondent denied Petitioner's request for additional personal care services because Respondent's QIO determined that the requested services are not medically necessary. Specifically, Respondent denied the services on the basis that they are "in excess of Petitioner's needs." *See supra* ¶ 7, 8, 11.

23. The PC Policy states that Florida Medicaid reimburses for services that meet all of the following: are determined to be medically necessary; do not duplicate another service; and meet the criteria as specified in this LTC Policy. *See supra* ¶ 16. In order for personal care services to be medically necessary, section 2.83 of the Definitions policy requires that all five medical necessity criteria must be met. *See supra* ¶ 21. This includes the following criterion: services must

be “individualized, specific, and consistent with the symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient’s needs.” *See supra* ¶ 21. The PC Policy further states that Florida Medicaid reimburses for personal care services rendered to a recipient whose parent or legal guardian is not able to provide ADL or IADL care, and to supplement care provided by parents and legal guardians. *See supra* ¶ 16. Parents and legal guardians must participate in providing care to the fullest extent possible. *See supra* ¶ 16. Section 5.2 of the PC Policy provides that personal care services cannot be used for babysitting purposes. *See supra* ¶ 17. Babysitting is defined as “custodial care, daycare, afterschool care, supervision, or similar childcare unrelated to the services that are documented to be medically necessary for the recipient.” *See supra* ¶ 15.

24. The record demonstrates that the requested additional personal care services were not demonstrated to be warranted in this this case. Personal care services are intended to provide assistance with activities of daily living (ADL) and age appropriate instrumental activities of daily living (IADLs) 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. Dr. Kunis provided credible and persuasive testimony that Petitioner [REDACTED]

[REDACTED] *See supra* ¶ 15. The record reflects that Petitioner needs [REDACTED] *See supra* ¶ 4, 11. As Dr.

Kunis testified, Petitioner is [REDACTED] [REDACTED] *See supra* ¶ 4, 11. Petitioner has had no recent hospitalizations or ER visits.

*See supra* ¶ 11.

25. The PC Policy provides general guidance for the amount of time allocated for ADLs, *supra* ¶ 16. Here, Petitioner has the burden of proof that additional hours are medically necessary. *See supra* ¶ 17. [REDACTED] did not provide any estimates to explain the amount of time Petitioner requires for each of her ADL tasks. Further, Petitioner provided no evidence (e.g., a daily schedule, a schedule of ADLs and IADLs, the amount of time needed for each ADL and IADL) to support the requested additional services. Petitioner did not explain what ADLs would no longer be covered if the requested additional hours personal care services are not approved in this matter. The PC Policy is clear that personal care services are intended for recipients whose parent or legal guardian is not able to provide ADL or IADL care, and to supplement care provided by parents and legal guardians. *See supra* ¶ 23. In this case, Petitioner's [REDACTED] did not provide any evidence that [REDACTED] is unable to provide ADL or IADL care after work hours. Based on the documentation provided, it was unclear what specific tasks Petitioner needed assistance with that [REDACTED] mother would be unable to provide. Based on the foregoing, the record does not demonstrate by a preponderance of the evidence that the additional personal care services are "not in excess of Petitioner's needs."

26. [REDACTED] testified that Petitioner needs the additional personal care services because [REDACTED] cannot be left alone while [REDACTED] is working [REDACTED]. *See supra* ¶ 10. However, the PC Policy prevents personal care services from being used for companion sitting or babysitting. *See supra* ¶ 15, 17. Moreover, a letter was provided from Petitioner's physician in this case. *See supra* ¶ 5. However, 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. *See supra* ¶ 21.

27. Because Petitioner did not demonstrate that the requested personal care services are “not in excess of Petitioner’s needs,” the undersigned concludes that the record does not demonstrate that the requested services are medically necessary. Looking at all of the evidence relevant to the particular needs of Petitioner, Petitioner did not demonstrate that the requested additional personal care services at issue in this case are necessary to correct or ameliorate defects and physical and mental illness and conditions.

28. In light of the testimony, Respondent’s Composite Exhibit 1 and 2, and the applicable laws and policies, the undersigned Hearing Officer finds that Petitioner failed to prove by a preponderance of the evidence that Respondent’s denial of additional personal care services was incorrect.

**DECISION**

Respondent’s denial of additional personal care services is **AFFIRMED**. Petitioner’s appeal based on Respondent’s denial in this matter is **DENIED**.

**DONE AND ORDERED** this 30th day of May 2023, in Tallahassee, Leon County, Florida.



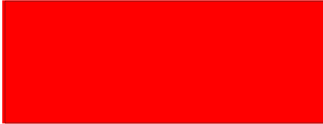
**LAURA GALLAGHER, Hearing Officer**  
**Agency for Health Care Administration**  
**Office of Fair Hearings**  
**2727 Mahan Drive, Mail Stop # 11**  
**Tallahassee, FL 32308-5407**

**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.

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