



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

FILED

May 16, 2023, 10:58 am

OFFICE OF FAIR HEARINGS

[REDACTED]

PETITIONER,

AHCA Case No.: 23-FH0302

[REDACTED]

vs.

FLORIDA COMMUNITY CARE, LLC,

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic Fair Hearing on the instant case on March 14, 2023, at 2:02 p.m. Eastern Standard Time (“EST”).

APPEARANCES

For the Petitioner:

[REDACTED]

Petitioner’s Authorized Representative

For the Respondent:

Jill Bennett

Counsel

Florida Community Care, LLC

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.

PRELIMINARY STATEMENT

All parties and witnesses appeared telephonically. Petitioner's Authorized Representative and [REDACTED] appeared on behalf of Petitioner. Petitioner appeared as [REDACTED] own witness.

Jill Bennett, Counsel for Florida Community Care ("FCC"), appeared on behalf of Respondent. Dr. Frank C. Astor ("Dr. Astor"), Interim Chief Medical Officer ("ICMO"); Ashley Cabrera, Case Manager Supervisor; and Sally Ingino, Clinical Appeal Specialist, attended as witnesses for Respondent.

The following attended as observers: Suzanne Chillari, Medical/Health Care Program Analyst for the Agency for Health Care Administration ("Agency" or "AHCA"); and Joseph Mabry, Hearing Officer for the Agency.

Prior to the hearing, Petitioner sent to the Office of Fair Hearings and Respondent a five (5)-page evidence packet. The evidence packet appears in the Office of Fair Hearings document management system as the file title "23-FH0302 Faxed Evidence.pdf". Absent an objection from the Respondent, the undersigned admitted the five (5)-page evidence packet into evidence as Petitioner's Composite Exhibit 1 ("PCE 1").

Prior to the hearing, Respondent sent to the Office of Fair Hearings and Petitioner a one hundred and eighty-eight (188)-page evidence packet. The one hundred and eighty-eight (188)-page packet appears in the Office of Fair Hearings document management system as the file titles "23-FH0203 [Petitioner Name] Evidence Packet.pdf" and "23-FH0302 Notice of Filing Additional Evidence 03-13-23.pdf". Absent an objection from the Petitioner, the undersigned admitted the one hundred and eighty-eight (188)-page evidence packet into evidence as Respondent's Composite Exhibit 1 ("RCE 1").

FINDINGS OF FACT

1. Petitioner is an enrolled member of FCC. See page 14 of RCE 1. FCC is a managed care organization contracted by the Agency to provide services to eligible Medicaid recipients in Florida. *Id.*

2. Petitioner is [REDACTED]. *Id.* at 17. Petitioner lives with [REDACTED]. *Id.*

Petitioner has [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED] *Id.* Petitioner requires [REDACTED]

[REDACTED]

[REDACTED]

3. As provided in the Florida Department of Elder Affairs: 701B Comprehensive Assessment (“701B”), Petitioner’s needs for activities of daily living (“ADLs”) are as follows: [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]. *Id.* at 164.

4. Petitioner is currently approved for thirty (30) hours of personal care services, weekly, and twelve (12) hours of homemaker services, weekly. *Id.* at 17.

5. Petitioner requested an additional fourteen (14) hours of personal care services, weekly.

Respondent issued a Notice of Adverse Benefit Determination (“NABD”), dated October 10, 2022, denying fourteen (14) hours of personal care services. *Id.* at 48 – 50. The NABD explained the basis of the denial as follows:

We determined that your requested services are not medically necessary because the services do not meet either of the reasons 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:

Current Service = 30 hours/week 7d/week

Requested Service = 44 hours/week 7d/week

MD review and calculation of need = 30 hours/week 7d/week

Denial

A request was made for an increase of 14 hours of personal care service (T1019). After a complete review of the review and your plan of care and all documents submitted by providers stating your need for the increase in personal care service hours, I find that you do not require an increase of personal care services. Additionally, the documentation submitted by your providers did not specifically delineate why the personal care services need to be increased by a specific

number of hours. Your request does not meet the following element required for medical necessity consideration by Medicaid LTC that states the service needs to:

"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". Without knowing specifically what your needs are and how the additional personal care service hours would be toward your benefit, I cannot approve the request for the increased hours. Therefore, I have denied the request as there is no medical necessity to attribute to an increase in 14hours of personal care service at this time.

...

Id.

6. Petitioner requested a plan appeal and received a Notice of Plan Appeal Resolution ("NPAR") dated November 10, 2022, upholding the denial of 14 hours of personal care services.

The NPAR explained as follows:

...

On 11/09/2022, after consideration of the information you provided to Florida Community Care in support of your plan appeal, Florida Community Care hereby UPHELD your plan appeal. As a result, [Petitioner] will not receive Personal Care: Total hours per week: 44, effective 10/10/2022. [REDACTED] will continue to receive 30 hours of Personal Care/week.

...

Id. at 71.

7. On February 15, 2023, Petitioner requested a Fair Hearing to challenge the denial of personal care services. On February 22, 2023, the undersigned issued an Order Scheduling Fair Hearing by Telephone and Prehearing Instructions, setting the hearing for March 14, 2023, at 2:00 p.m. EST.

8. On March 9, 2023, Respondent increased the personal care hours by ten (10) hours per week, for a total of forty (40) personal care service hours per week. See *infra* ¶ 10.

9. [REDACTED] wrote a letter to the Office of Fair Hearings in support of Petitioner's request for personal care services. The letter states as follows:

I am submitting these reports to the Office of Fair Hearings as proof of [REDACTED] [REDACTED]. As to date, [Petitioner] still has issues [REDACTED] [REDACTED].

As a result of this, someone needs to be with [REDACTED] at all times. As [REDACTED] caregiver, [Petitioner] needs more Personal Care hours. There are times I have to go out and leave [REDACTED] alone to do food shopping, medical appointments, pick up medical supplies, prescriptions, or any errands that need to be done. Also, I have been putting off my own physical therapy for the last 2 months because I fear what may happen to [Petitioner] leaving [REDACTED] home alone.

...

See page 3 of PCE 1.

10. [REDACTED]
 - a. Petitioner was admitted to the hospital in April of 2019, with a [REDACTED] [REDACTED] [REDACTED] In May of 2020, Petitioner [REDACTED] full-time. [REDACTED] that it is difficult for Petitioner [REDACTED] Petitioner cannot move by himself; [REDACTED] can only feed himself. Petitioner is currently [REDACTED] believes it is progressing slowly because Petitioner has no core strength. [REDACTED] has to Hoyer lift [REDACTED] out of bed into a chair or wheelchair. Petitioner wears diapers but [REDACTED] has to hold [REDACTED]. Petitioner can verbally report when [REDACTED] changed.
 - b. After the extra hours were requested, [REDACTED] asserts that Petitioner's [REDACTED] got worse. Petitioner recently had [REDACTED] [REDACTED] [REDACTED]

changed color. [REDACTED] argues that [REDACTED] was not much of a concern when Petitioner initially came home from the hospital. [REDACTED] confirmed that as of the week before the hearing, Respondent approved ten (10) additional personal care hours per week. [REDACTED] requests the remaining four hours to cover Saturday and Sunday and when [REDACTED] is out of the home, which is approximately 2 hours each trip. [REDACTED] believes someone needs to be with Petitioner as a safety precaution because [REDACTED] will not be able to get out of the house on [REDACTED] own in the case of an emergency.

- c. [REDACTED] lives in the home with Petitioner and [REDACTED] and [REDACTED] to provide personal care service to Petitioner through the Patient Directed Option (PDO) program. With the additional ten hours recently approved, [REDACTED] will be providing those services hours to Petitioner. Respite care service was offered to Petitioner, but [REDACTED] was not sure how it works. Adult day care services were offered and discussed with Petitioner but are not currently being used as Petitioner does not want to go there.
11. Ms. Ingino is a Clinical Appeal Specialist. Ms. Ingino testified to the following:
- a. Ms. Ingino handles incoming cases and coordinates between the members and the Plan through the appeal process. Ms. Ingino has been in communication with [REDACTED] as Petitioner's representative during the appeal. Ms. Ingino discussed the option of respite care for Petitioner as those hours can provide those needed

services including holding a [REDACTED]

- [REDACTED].
- b. Ms. Ingino referenced Appendix 9.1 titled Review Criteria for Personal Care Services, *infra* ¶ 20, and asserts this was the criteria used to determine Petitioner’s request for personal care services. The 701B form was used to gather information from the enrollee and [REDACTED] representatives to determine their health conditions, their needs, unmet needs, and any available support in the home. *See* ¶ 3. The ADL Section of the 701B form measures how much assistance the enrollee needs with various tasks which was used to evaluate Petitioner. *Id.*
 - c. The HCBS Assessment tool (“HCBS Tool”) is used for making determinations for requested home and community-based services and establishes the ADLs and IADLs generated from Petitioner’s 701B form responses and the Florida Medicaid Statewide Managed Care Long-term Care Program Coverage Policy. *See* page 159 – 162 of RCE 1. The HCBS Tool was used to assess Petitioner’s personal care service duration and determined thirty (30) weekly hours of service was medically necessary for Petitioner. *Id.* at 162. In response to Petitioner’s plan appeal with additional information regarding [REDACTED] a new 701B form and HCBS Tool was completed on March 9, 2023. *Id.* at 163 – 179, 183 – 186. The new HCBS Tool determined forty (40) weekly hours of personal care was medically necessary for Petitioner. *Id.* at 186.

12. Dr. Astor is an ICMO. Dr. Astor testified to the following:

- a. After review of the October 2022 NABD, the November 2022 NPAR, the February 2023 701B Form, the February 2023 HCBS Tool, the independent review completed by Dr. Michael Yanuck in November 2022, the March 2023 701B Form, and March 2023 HCBS Tool, it is Dr. Astor’s medical opinion that forty (40) hours of personal care services indicated on the March 2023 HCBS Tool meets the definition of medical necessity. Dr. Astor asserts that Respondent’s decision was based on the 701B Form responses, the HCBS Tool, and the medical necessity guidelines.

CONCLUSIONS OF LAW

13. 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).

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

15. Because Petitioner is requesting additional 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.)

16. The Florida Medicaid Statewide 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. *Id.* at 92 – 113. The LTC Policy provides the following with respect to personal care services:

1.1 Description and Program Goal

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

...

1.3.1 Activities of Daily Living (ADLs)

ADLs include:

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

...

1.3.9 Instrumental Activities of Daily Living (IADLs)

When necessary for the recipient to function independently, including:

- Grocery shopping
- Laundry
- Light housework
- Meal preparation
- Money Management
- Personal hygiene
- Transportation
- Using the telephone to take care of essential tasks (examples include paying bills and setting up medical appointments)

...

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.

...

4.2.1.15 Respite Care

The provision of services on a short-term basis due to the absence of, or need to relieve, the enrollee’s natural supports on a planned or an emergency basis.

...

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.

17. 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.

18. 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.

19. The Florida Medicaid Personal Care Services Coverage Policy (November 2016) (“Personal Care Policy”), incorporated by reference in Fla. Admin. Code R. 59G-4.215, governs personal care services available under Florida Medicaid. *Id.* at 77 – 86. The Personal Care Policy provides the following with respect to personal care services:

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.

...

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

...

5.2 Specific Non-Covered Criteria

Florida Medicaid does not reimburse for the following:

- A skill level other than what is prescribed in the physician order and approved plan of care (POC)
- Assistance with homework
- Babysitting
- Care, grooming, or feeding of pets and animals
- Certification of the POC by a physician
- Companion sitting or leisure activities
- Escort services
- Housekeeping (except light housekeeping to make the environment safe), homemaker, and chore services
- Nursing assessments related to the POC
- Professional development training or supervision of home health staff or other home health personnel
- Respite care to facilitate the parent or legal guardian attending to personal matters
- Services funded under section 110 of the Rehabilitation Act of 1973 or under the provisions of the Individuals with Disabilities Educational Act
- 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)
- Services provided in any of the following locations:
 - Hospitals
 - Intermediate care facility for individuals with intellectual disabilities
 - Nursing facilities
 - Prescribed pediatric extended care centers
 - Residential facilities or assisted living facilities when the services duplicate those provided by the facility

- Services rendered prior to the development and approval of the POC
- Travel time to or from the recipient's place of residence
- Yard work, gardening, or home maintenance work

...

Appendix 9.1

Review Criteria for Personal Care Services

First level reviewers evaluate all of the following information to ensure requested services are appropriate. Reviewers will approve the frequency and duration of services that are medically necessary.

If the first level reviewer cannot determine medical necessity, or additional hours are requested, the case will be referred to a physician reviewer for final determination.

1. Service Criteria for First Level Reviewers:

All documentation submitted must substantiate the recipient's specific diagnoses and the coverage criteria specified in section 4.0. Providers must include assessments from both the personal care services provider and the treating physician.

All documentation must substantiate one of the following functional impairments:

a. Minimal functional impairment - One of the following indicators must be satisfied:

- ADLs requiring at least minimum assistance
- Ambulates with assist of person or device
- Transfers requiring at least minimum assistance

b. Moderate functional impairment - Two of the following indicators must be satisfied:

- ADLs requiring at least minimum assistance
- Ambulates with assist of person or device
- Transfers requiring at least minimum assistance

c. Maximum functional impairment - All of the following indicators must be satisfied:

- ADLs requiring total assistance
- Non-ambulatory
- Transfers requiring 1-2 person assist

d. Maximum and persistent functional impairment without available parent or legal guardian support - All of the following indicators must be satisfied:

- ADLs requiring total assistance
- Non-ambulatory
- Transfers requiring 1-2 person assist
- Treating physician must certify that all of the above impairments are present

...

20. Petitioner requested fourteen (14) additional hours of personal care services. *See* ¶ 5. In the NABD dated October 10, 2022, Respondent denied the services. *See supra*. Respondent cited medical necessity as the basis for their decision, specifically to 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. *See supra*. Respondent subsequently partially approved ten (10) additional hours of personal care services, denying the remaining four (4) hours. *See* ¶ 10. Petitioner has burden of proof to show by a preponderance of evidence that the Respondent’s determination was incorrect.

21. Petitioner is currently approved for forty (40) hours of personal care services, and twelve (12) hours of homemaker services, weekly. *See* ¶¶ 4, 8. According to the LTC Policy, personal care services are used to provide medically necessary assistance with ADLs and IADLs, including assistance with preparation of meals, and housekeeping chores which are essential to the health and welfare of the enrollee. *See* ¶ 17. In the instant case, Petitioner’s needs for ADLs are as follows: [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED] Petitioner needs assistance (but not total help). According to [REDACTED] testimony, [REDACTED] provides full-time care for Petitioner as [REDACTED] primary caregiver, and with the additional 10 hours approved, [REDACTED] will be providing the personal care services for Petitioner. *See* ¶ 10. The HCBS Tool was used to assess Petitioner’s personal care service

duration and determined thirty (30) weekly hours of service was medically necessary for Petitioner. See ¶ 11. Subsequently, in response to Petitioner's plan appeal with additional information regarding Petitioner's swallow test, a 701B Form and HCBS Tool were completed on March 9, 2023, which determined forty (40) weekly hours of personal care was medically necessary for Petitioner. See *supra*. The undersigned finds this increased level of care to be individualized, specific, and consistent with Petitioner's [REDACTED]. The record does not show an unmet need in Petitioner's ADLs and IADLs that has not been addressed since the updated 701B Form was completed and the increase in service hours was approved. As such, Petitioner did not establish that the additional four (4) hours of personal care services were not in excess of the patient's needs.

22. Moreover, the medical necessity definitions requires that services be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider. See ¶ 18. According to [REDACTED] testimony, [REDACTED] requests the additional hours to cover the time when [REDACTED] would be out of the home running errands and tending to [REDACTED] own personal needs while Petitioner is home alone. See ¶¶ 9, 10. Petitioner's [REDACTED] is approved to provide personal care service for Petitioner. See ¶ 10. According to Ms. Ingino's testimony, respite care can cover Petitioner's specific needs including [REDACTED]. See ¶ 11. The undersigned understands that [REDACTED] should have time to tend to [REDACTED] personal needs. The undersigned finds that with the additional service hours approved, [REDACTED] can use these hours for the periods of time [REDACTED] is out of the home that would still meet Petitioner's safety and care needs. Alternatively, Petitioner may seek all other viable services,


including respite care services, to [REDACTED] as the primary caregiver. As such, Petitioner did not establish that the additional four (4) hours of personal care services were not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.

23. Upon consideration of the testimony provided, evidence submitted, and applicable policies, the undersigned concludes that Petitioner did not prove by a preponderance of the evidence that the denial of Petitioner's request of the additional four (4) personal care hours was incorrect. In view of all the evidence relevant to the particular needs of Petitioner, Petitioner has not shown that the requested services are not in excess of the Petitioner's needs. Accordingly, Petitioner has not proved by a preponderance of the evidence that Respondent's denial of personal care services was incorrect.

IT IS HEREBY ORDERED AND ADJUDGED THAT:

Respondent's denial of personal care services is **AFFIRMED**. Petitioner's appeal based on Respondent's decision is **DENIED**.

DONE AND ORDERED this 16th day of May, 2023 in Tallahassee, Leon County, Florida.


Kimberly Roche
23-FH0302
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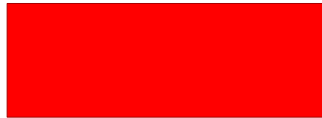
KIMBERLY ROCHE, Hearing Officer
Agency for Health Care Administration
Office of Fair Hearings
2727 Mahan Drive, Mail Stop # 11
Tallahassee, FL 32308-5407

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:



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