



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

FILED

Dec 22, 2023, 10:30 am

OFFICE OF FAIR HEARINGS

[Redacted]

PETITIONER,

AHCA Case No.: 23-FH2357

vs.

AGENCY FOR HEALTH CARE
ADMINISTRATION,

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned scheduled and convened a telephonic Medicaid Fair Hearing in the above-styled case on October 18, 2023, at 1:00 p.m., Eastern Standard Time (“EST”).

APPEARANCES

For the Petitioner:

[Redacted]

Petitioner’s Authorized Representative

For the Respondent:

Marielisa Amador
Medical Healthcare 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 termination of Petitioner’s Prescribed Pediatric Extended Care (“PPEC”) services was correct.

PRELIMINARY STATEMENT

All parties appeared telephonically. [REDACTED] (“[REDACTED]”), Petitioner’s Authorized Representative, appeared on behalf of Petitioner. [REDACTED], Director of [REDACTED], appeared as witnesses for Petitioner.

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

Prior to the hearing, Respondent sent to the Office of Fair Hearings and Petitioner a one hundred and eighty-three (183)-page evidence packet and a forty-seven (47)-page evidence packet. The one hundred and eighty-three (183)-page evidence packet appears in the Office of Fair Hearings’ document management system as file titles “[REDACTED] FH 10.18.2023 1-99.pdf,” “[REDACTED] FH 10.18.2023 100-169.pdf,” and “[REDACTED] FH 10.18.2023 170-183.pdf.” The forty-seven (47)-page evidence packet appears in the Office of Fair Hearings’ document management system as the file title “23-FH2357 AHCA evidence (Pages 1-47).pdf.” Absent an objection from the Petitioner, the undersigned admitted the one hundred and eighty-three (183)-page evidence packet into evidence as Respondent’s Composite Exhibit 1 (“RCE 1”) and the forty-seven (47)-page evidence packet into evidence as Respondent’s Composite Exhibit 2 (“RCE 2”).

Prior to the hearing, Petitioner sent to the Office of Fair Hearings and Respondent a one (1)-page evidence packet, a fourteen (14)-page evidence packet, a four (4)-page evidence packet, and a seven (7)-page evidence packet. The one (1)-page evidence packet appears in the Office of Fair Hearings’ document management system as file titles “MFH Request EH.pdf.” The

fourteen (14)-page evidence packet appears in the Office of Fair Hearings' document management system as the file title "Petitioner evidence EH.pdf." The four (4)-page evidence packet appears in the Office of Fair Hearings' document management system as the file title "Petitioner evidence 2 EH.pdf." The seven (7)-page evidence packet appears in the Office of Fair Hearings' document management system as the file title as "Post Hearing Evidence.pdf." Absent an objection from the Petitioner, the undersigned admitted into evidence the one (1)-page evidence packet as Petitioner's Composite Exhibit 1 ("PCE 1"), the fourteen (14)-page evidence packet as Petitioner's Composite Exhibit 2 ("PCE 2"), the four (4)-page evidence packet as Petitioner's Composite Exhibit 3 ("PCE 3"), and the seven (7)-page evidence packet as Petitioner's Composite Exhibit 4 ("PCE 4").

FINDINGS OF FACT

1. Petitioner receives Medicaid services on a fee-for-service basis from the Agency. eQHealth is a Quality Improvement Organization contracted by the Agency to review prior authorization requests for services. *See* page 2 of RCE 2.
2. Petitioner is a [REDACTED], at the time of the present hearing. *Id.* at 16. Petitioner is diagnosed with the following: [REDACTED], [REDACTED], [REDACTED], [REDACTED], and [REDACTED]. *Id.* at 17. Petitioner was recently diagnosed with [REDACTED]. *See* page 7 of PCE 4.
3. Petitioner is not ventilator dependent, nor does [REDACTED] use a BiPap/CPAP, or oxygen. *Id.* at 61. Petitioner uses no enteral feeds. *Id.*
4. Petitioner's current medications are as follows: [REDACTED] [REDACTED]. *Id.* at 18. Petitioner's [REDACTED] does not permit

PPEC staff to administer [REDACTED] or other medications. *Id.* at 19. Petitioner was recently prescribed to [REDACTED]. PCE 4 at 7.

5. Petitioner was [REDACTED] *Id.* at 60. According to the Florida Home Health Assessment Tool, dated August 29, 2023, ("FL HH Assessment), Petitioner's overall status as being "[s]table with no heightened risks for serious complications and death (beyond those typical of the recipient's age)." *Id.*

6. Petitioner attends PPEC five (5) days per week. *Id.* at 61. Petitioner is unable to [REDACTED]. *Id.*

Petitioner is [REDACTED]. *Id.* Petitioner's cognitive functioning level requires considerable assistance in routine situations: [REDACTED] is not [REDACTED]

[REDACTED] *Id.* at 62. Petitioner's activities of daily living (ADLs) are not age appropriate, including [REDACTED]. *Id.* at 63 - 64. Petitioner needs total assistance [REDACTED]

[REDACTED]. *Id.* at 63. Petitioner requires [REDACTED]. *Id.* at 64. Petitioner receives [REDACTED], outside of PPEC. See page 3 at PCE 2.

7. Petitioner lives with [REDACTED], who does not work outside the home, and [REDACTED]. *Id.* at 60.

8. Petitioner requested PPEC services for five (5) days per week for the certification period

starting September 3, 2023, through February 29, 2023. *Id.* at 16.

9. On September 13, 2023, eQHealth sent Petitioner a Notice of Outcome (“Notice”) terminating Petitioner’s PPEC services. *Id.* at 28 - 32. The Notice explained that the requested services were terminated because they were not medically necessary and explained 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.

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.

The rationale for our decision is as follows:

PR Principal Reason – Denial:

Submitted information does not support the medical necessity for requested services.

Clinical Rationale for Decision: [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED] and monitoring.

Date of Action is 9/13/2023.

...

Pages 28 - 29 of RCE 1.

10. On September 20, 2023, Petitioner requested a Fair Hearing due to Respondent’s termination of Petitioner’s PPEC services. On September 28, 2023, the undersigned issued an Order Scheduling Fair Hearing and Prehearing Instructions, setting the hearing for October 18,

2023, at 1:00 p.m. EST. All parties were duly notified. *Id.* at 7 - 13. Petitioner received administrative approval, or continuation of benefits, pending the outcome of the Fair Hearing. *Id.* at 21.

11. Dr. Kunis' testimony established that Petitioner's request for PPEC services were terminated because [REDACTED] does not meet the criteria for medical necessity, as set forth by AHCA and Medicaid rules. Dr. Kunis explained that a review of Petitioner's medical information reflects that Petitioner is [REDACTED]

[REDACTED] and [REDACTED] medical records show [REDACTED] receives no medications at PPEC. Dr. Kunis noted that physical, occupational, and speech therapies are important for Petitioner, but that [REDACTED] may receive those therapies outside of PPEC. Dr. Kunis also noted that changing Petitioner's [REDACTED] can be done by any adult and does not require skilled nursing. Dr. Kunis concluded that Petitioner's nursing needs consist of monitoring and supervision, therefore, Petitioner lacks sufficient skilled nursing needs to warrant PPEC care.

12. [REDACTED] testified that Petitioner, [REDACTED], always needs assistance and care. [REDACTED] testified that [REDACTED] needs [REDACTED]. [REDACTED] testified that [REDACTED] is required to [REDACTED] and the PPEC nurses assist with [REDACTED]. [REDACTED] further testified that [REDACTED] providers have recommended that [REDACTED] continue to attend PPEC. [REDACTED] testified that [REDACTED] is unable to get [REDACTED] into a different day care or school setting because [REDACTED] must wait until [REDACTED] is [REDACTED]

[REDACTED].

13. [REDACTED] testified that Petitioner is totally dependent on others for [REDACTED] ADLs. [REDACTED] testified that Petitioner requires [REDACTED]. [REDACTED] explained that the nurses at PPEC monitor Petitioner to intake food and liquid, to ensure that [REDACTED]; and to reassure Petitioner when [REDACTED] becomes [REDACTED], particularly after [REDACTED]. [REDACTED] further explained that when Petitioner leaves PPEC, Petitioner is returned to [REDACTED] in a clean and tidy state, which is an important human factor.

CONCLUSIONS OF LAW

14. 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. This order is the final administrative decision of AHCA under section 409.285(2)(a).

15. This hearing was held as a *de novo* proceeding pursuant to Fla. Admin. Code R.59G-1.100(17)(b), which states "[e]ach fair hearing shall be a de novo, evidentiary proceeding, and shall be conducted in a manner that meets the requirements of this rule."

16. 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.

17. In the instant case, Respondent terminated Petitioner's PPEC services. As such, Fla.

Admin. Code R. 59G-1.100(17)(g) assigns the burden of proof to Respondent. 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.)

18. The Florida Medicaid Prescribed Pediatric Extended Care Services Policy (February 2018) (“PPEC Policy”), incorporated by reference in Fla. Admin. Code R. 59G- 4.260, governs PPEC services available under Florida Medicaid. The PPEC Policy provides the following:

- **Description**

Florida Medicaid prescribed pediatric extended care (PPEC) services provide skilled nursing supervision and therapeutic interventions in a non-residential setting to medically dependent or technologically dependent recipients.

....

- **1.3.7 Medically Necessary/Medical Necessity**

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

....

- **2.2 Who Can Receive**

Florida Medicaid recipients under the age of 21 years requiring medically necessary PPEC services and who:

- Require continuous therapeutic interventions or skilled nursing supervision, as described in section 400.902, F.S. and in Rule 59A- 13.007, F.A.C.
- Are determined medically stable by a physician and who are not a threat to self or others

Some services may be subject to additional coverage criteria as specified in section

....

- **4.0 Coverage Information**

- **4.1 General Criteria**

Florida Medicaid covers 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 covers PPEC services provided in accordance with section 400.902, F.S., the applicable Florida Medicaid fee schedule, or

as specified in this policy, on a full or partial day basis. Services must include the following at a minimum:

- Caregiver training
- Developmental therapies
- An appropriate escort for travel to and from the PPEC when Florida Medicaid nonemergency transportation is provided
- Medical services
- Nursing services
- Personal care services
- Psychosocial services
- Respiratory therapy services

The PPEC day begins when the recipient arrives at the PPEC or is picked up for escorted transportation to the PPEC.

The PPEC day ends when the recipient departs from the PPEC for the day or is returned home by escorted transportation from the PPEC.

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.

5.0 Exclusion

5.1 General Non-Covered Criteria

Services related to this policy are not covered 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

5.2 Specific Non-Covered Criteria

Florida Medicaid does not cover the following as part of this service benefit:

- A full day and a partial day of PPEC services on the same date of service, for the same recipient

- Early intervention services when billed separately
- Food or formulas
- Supportive or contracted services as defined in section 400.902, F.S.
- Transportation services

Some services may be reimbursed through another Florida Medicaid-covered service. Please refer to the service-specific coverage policy for more information.

....

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.

7.2 Specific Criteria

Providers must obtain authorization from AHCA, or its designee, every 180 days or more frequently if there is a change in the recipient’s condition requiring an alteration in services.

Providers must submit a discharge request to AHCA, or its designee, to terminate a recipient’s services. The discharge request must include both of the following:

- Last date services were provided to the recipient
- Number of units of service used during the current authorization period (through the discharge date)

PPEC Services Coverage Policy at pages 1 - 4.

19. Section Rule 59A-13.007(4)(a), F.A.C. states the following:

(4) Each child admitted for service to a PPEC center must meet at least the following criteria:

(a) Infants and children considered for admission to the PPEC center will be those who are medically or technologically dependent. . . .

...

Further, section 400.902, F.S described “medically dependent or technologically dependent child” as follows:

[A] child who because of a medical condition requires continuous therapeutic interventions or skilled nursing supervision which must be prescribed by a licensed physician and administered by, or under the direct supervision of, a licensed registered nurse.

20. Rule 59G-4.290 defines skilled nursing as follows:

(3) Skilled Services Criteria.

- a) To be classified as requiring skilled nursing or skilled rehabilitative services in the community or in a nursing facility, the recipient must require the type of medical, nursing or rehabilitative services specified in this subsection.
- b) Skilled Nursing. To be classified as skilled nursing service, the service must meet all of the following conditions:
 - 1. Ordered by and remain under the supervision of a physician;
 - 2. Sufficiently medically complex to require supervision, assessment, planning, or intervention by a registered nurse.
 - 3. Required to be performed by, or under the direct supervision of, a registered nurse or other health care professionals for safe and effect performance;
 - 4. Required on a daily basis;
 - 5. Reasonable and necessary to the treatment of a specified documented illness or injury; and,
 - 6. Consistent with the nature and severity of the individual's condition or the disease state or stage.
- c) Examples of services that qualify as skilled nursing services:
 - 1. Intravenous medication or fluids.
 - 2. Intramuscular or subcutaneous injection and hypodermoclysis when:
 - a. Administered by licensed nursing personnel at least 5 times weekly, excluding daily insulin administration; and,
 - b. Observation is necessary to assess the recipient's response to treatment or to identify adverse reactions.
 - 3. Management and monitoring medication regime on a daily basis:
 - a. For drugs whose dosage requirements may rapidly change;
 - b. For drugs prone to cause adverse reactions, severe side effects or unfavorable reactions; and,
 - c. For residents with unstable reactions.
 - 4. Levin tube and gastrostomy feedings; excluding feedings performed by residents, family members, or friends.
 - 5. Administration of medical gases, aerosolized medication or oxygen which is started, monitored and regulated by professional staff.
 - 6. Naso-pharyngeal and tracheotomy aspiration, excluding tracheotomy care in self-care residents.
 - 7. Insertion, replacement, and sterile irrigation of catheters when:
 - a. Medically necessary or required for reasons other than to maintain satisfactory catheter functioning and dryness;
 - b. The medical need is documented by the physician;

- c. Continuous irrigation, frequent insertion, special care or observation is required because of bleeding, infection, obstruction, or heavy sediment formations; and,
 - d. Care of a recently inserted supra-pubic catheter, inserted within 2-4 weeks, is required.
8. Colostomy and ileostomy care:
 - a. When medically necessary and required during early postoperative period;
 - b. During the period of initial self-care training, or
 - c. when complications are present and documented in the medical record.
 9. Treatment of decubitus ulcers when:
 - a. Deep or wide without necrotic center;
 - b. Deep or wide with layers of necrotic tissue, or
 - c. Infected and draining.
 10. Treatment of widespread infected or draining skin disorders.
 11. Application of dressings involving prescription medication and aseptic techniques when documented as required on a daily basis. Excludes simple dressings involving non-infected cases, simple skin breaks, and healed postoperative incisions.
 12. Heat treatments prescribed by a physician as daily treatment for a specific condition.
 13. Rehabilitation nursing procedures required on a daily basis as necessary to restore functioning, including teaching and adaptive aspects of nursing.

21. Since the Petitioner is under twenty-one years old, the Early and Periodic Screening, Diagnosis, and Treatment ("EPSDT") requirements apply to the request for PPEC services. See supra ¶ 18.

22. 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 published definition of medical necessity. 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.

Definitions Policy at page 7.

23. The Florida Medicaid Authorization Requirements Policy (June 2016) (“Authorization Requirements Policy”), incorporated by reference in Fla. Admin. Code R. 59G-1.053, provides general requirements for providers to obtain authorization to render Florida Medicaid services. It states the following:

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.

Florida Medicaid Authorization Requirements Policy, pages 1-3.

24. In the instant case, Respondent terminated Petitioner's PPEC services for the certification period of September 3, 2023, through February 29, 2024. See supra ¶ 9. As established on the record by the testimony and evidence, eQHealth terminated Petitioner's PPEC services, because the PPEC services were not medically necessary. See supra ¶ 9.

25. Florida Medicaid covers PPEC services that: are determined medically necessary; do not duplicate another service; and meet the criteria as specified in the PPEC Policy. *See supra* ¶ 18. PPEC provides “skilled nursing supervision and therapeutic interventions in a non-residential setting to medically dependent or technologically dependent recipients.” *See supra* ¶ 18.

26. In this case, there was no testimony or evidence that Petitioner requires “skilled nursing supervision and therapeutic interventions” at a PPEC facility. The documentation regarding Petitioner’s medical status, *supra* ¶ 2 – 6, reflects that Petitioner does not meet the definition of a "medically dependent or technologically dependent child" as Petitioner is not "a child who because of a medical condition requires continuous therapeutic interventions or skilled nursing supervision which must be prescribed by a licensed physician and administered by, or under the direct supervision of, a licensed registered nurse." *See supra* ¶ 19. Specifically, Petitioner is not ventilator dependent, nor does [REDACTED] use a Bi-Pap, C-Pap, oxygen, or tracheotomy. *See supra* ¶ 3. Petitioner does not have gastrostomy tube or nasogastric tube. *See supra* ¶ 3. Petitioner has [REDACTED]. *See supra* ¶ 5. Petitioner’s overall condition is presently “[s]table with no heightened risks for serious complications and death.” *See supra* ¶ 5. Petitioner has no scheduled medications at PPEC. *See supra* ¶ 4. Petitioner’s nursing needs consist of monitoring and supervision. *See supra* ¶ 4, 13.

27. Section 2.83 of the Definitions Policy mandates that to be medically necessary, “[t]he medical or allied care, goods, or services furnished or ordered must - [b]e 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;" and "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 ¶ 22. Based upon the aforementioned facts and evidence, supra ¶ 26, Respondent has demonstrated that the PPEC services at issue are not "individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment," and are "in excess of the patient's needs." Thus, Respondent has established that the requested PPEC services are not medically necessary, as defined in Fla. Admin. Code R. 59G- 1.010, and required by section 1.3.7 of the PPEC Policy. Looking at all the evidence relevant to the particular needs of Petitioner, the PPEC services at issue are not necessary to correct or ameliorate a defect or a physical and mental illness or condition.

28. At the Fair Hearing, [REDACTED] further testified that [REDACTED] providers have recommended that Petitioner continue to attend PPEC. See supra ¶ 12. 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 ¶ 22.

29. In light of the parties' testimony, Petitioner's Composite Exhibit 1, Petitioner's Composite Exhibit 2, Petitioner's Composite Exhibit 3, Petitioner's Composite Exhibit 4, Respondent's Composite Exhibit 1, Respondent's Composite Exhibit 2, the PPEC Policy, the Authorization Requirements Policy, and the Definitions Policy, Respondent has proved by a preponderance of the evidence that Respondent's termination of Petitioner's PPEC services was correct.

Respondent's termination of Petitioner's PPEC services is **AFFIRMED**. Petitioner's appeal based on Respondent's termination of Petitioner's PPEC services is hereby **DENIED**.

DONE and **ORDERED** this 22nd day of December 2023, in Tallahassee, Leon County, Florida.



Debbie K. Winicki
23-FH2357
2023.12.22 09:01:00
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DEBBIE WINICKI, Hearing Officer
Agency for Health Care Administration
Office of Fair Hearings
2727 Mahan Drive, Mail Stop # 11
Tallahassee, FL 32308

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]

AHCA Medicaid Hearing Unit
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