

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



FILED

Jul 17, 2024, 1:15 pm

OFFICE OF FAIR HEARINGS

[REDACTED],

PETITIONER,

AHCA Case No.: 24-FH0962

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 May 21, 2024, at 1:05 p.m. Eastern Standard Time (“EST”).

APPEARANCES

For the Petitioner:

[REDACTED]
Petitioner’s Authorized Representative

For the Respondent:

Sandra Durden
Medical Health Care Program Analyst
Fair Hearing Liaison
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 personal care services was incorrect.

PRELIMINARY STATEMENT

All parties and witnesses appeared telephonically. [REDACTED] (“[REDACTED]”), Petitioner’s Authorized Representative and [REDACTED], appeared for the hearing and

provided testimony on behalf of Petitioner. [REDACTED] (“[REDACTED]”), BCBA for the Petitioner appeared as a witness for Petitioner. [REDACTED], (“[REDACTED]”), case manager for the Petitioner appeared as a witness for Petitioner. [REDACTED], (“[REDACTED]”), service provider for the Petitioner appeared as a witness for the Petitioner.

Sandra Durden, Medical Health Care Provider Analyst and Fair Hearing Liaison for the Agency for Health Care Administration (“Agency” or “AHCA”) appeared as a representative for Respondent. Dr. Rakesh Mittal, MD (“Dr. Mittal”) for eQHealth Solutions, Inc., appeared as a witness for the Respondent.

Petitioner did not introduce any documents for evidence.

Respondent introduced a one hundred and eight (108)-page evidence package at the Fair Hearing. The packet is maintained in the Office of Fair Hearings’ case management system as “[REDACTED] FH 05.21.2024 1-93.pdf,” and “[REDACTED] FH 05.21.2024 94-108.pdf.” Absent an objection from Petitioner, the undersigned admitted the evidence packet into evidence as Respondent’s Composite Exhibit 1.

Respondent introduced an eighty (80)-page evidence package at the Fair Hearing. The packet is maintained in the Office of Fair Hearings’ case management system as “24-FH0962 AHCA EVIDENCE PKT.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.

[REDACTED]

In total, the provider requested 1,514 hours during the requested authorization period. The Respondent denied the total hours requested but did authorize 4 hours per day, Monday thru Friday for a total of 524 hours.

5. On March 1, 2024, Respondent issued a Notice of Outcome (“NOO”) denying Petitioner’s request for personal care services. *Id.* at 26-29. 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]
[REDACTED]
[REDACTED] The [REDACTED] works M-F
830a-530p.

Deny requested PCS units. The [REDACTED] is available to provide care on the weekends. Would approve HHA 4 hrs/d M-F to provide assistance with ADLs when [REDACTED] works. The remaining units, for monitoring and supervision, could be provided by non HHA personnel as supervision is not a covered benefit.

Id. at 28.

6. On March 25, 2024, [REDACTED] requested a Fair Hearing to challenge the denial of personal care services. *Id.* at 8. On April 22, 2024, the undersigned scheduled the Fair Hearing for May 21, 2024, at 1:00 p.m. EST, and all parties were duly notified. *Id.*

7. [REDACTED] testified that Petitioner suffers from [REDACTED]
[REDACTED] [REDACTED] states that Petitioner is currently
prescribed [REDACTED]
[REDACTED]

[REDACTED] The school does not want the Petitioner to be present without an RBT or other such individual with the Petitioner. [REDACTED] testified that [REDACTED] has several maladaptive behaviors for which [REDACTED] receives ABA services. [REDACTED] testified that [REDACTED] also receives occupational, speech and physical therapies. [REDACTED] is a single parent and has another child and is having difficulty making ends meet and needs to work a weekend job but cannot do so at this time. [REDACTED] stated that [REDACTED] needs assistance on the weekend to allow [REDACTED] time with [REDACTED] other child and to run errands, food shopping and other such matters. [REDACTED] cannot take the Petitioner out in public areas due to [REDACTED]
[REDACTED].

8. [REDACTED] testified that [REDACTED] had been the Petitioner's BCBA since [REDACTED]. The Petitioner has several maladaptive behaviors and exhibits physically [REDACTED]. The ABA services are being conducted at the school as the school requires an RBT or other such individual to be present with the Petitioner. [REDACTED] testified that the Petitioner does need assistance with [REDACTED] ADLs.

9. [REDACTED] testified that [REDACTED] had prepared the support plan for the Petitioner. The request for services was based upon 8 hours a day seven days a week with 10 hours per day when school was not in session. [REDACTED] stated that the Petitioner [REDACTED]
[REDACTED]
[REDACTED].

10. [REDACTED] testified on behalf of the Petitioner. [REDACTED] felt that 4 hours per day during the week was not enough for [REDACTED] to take care of the Petitioner. [REDACTED] noted that the Petitioner has [REDACTED] and there was a language barrier with the Petitioner.

11. Dr. Mittal testified that the Petitioner was diagnosed with [REDACTED]
[REDACTED] The Petitioner attends school which is scheduled from approximately 9:30 a.m. to 3:30 p.m. daily. The Petitioner does not use any medical devices but does use a communication device. According to the work schedule supplied by [REDACTED] employer, [REDACTED] is scheduled to work from 8:30 a.m. until 5:30 p.m. Monday through Friday. *Id.* at 76. [REDACTED] work does not include weekends. In considering a request for personal care services, only hours actually worked can be considered. [REDACTED] had stated that [REDACTED] needed to work

on the weekend, but at this time [REDACTED] does not actually have weekend employment. [REDACTED] does not have any medical limitations in caring for [REDACTED]. *Id.* at 87. Dr. Mittal testified that personal care services did not include services outside of the home environment and does not include transportation. Also, the maladaptive behaviors would be addressed with the ABA treatment that the Petitioner was receiving. Dr. Mittal testified that using the allotted hours with two hours in the morning and two hours in the afternoon after school, the Petitioner could meet [REDACTED] needs and assistance with the ADLs. Any additional personal care time would exceed the Petitioner's needs. Dr. Mittal also suggested that if school was out of session, (closed or holidays), a supplemental request for additional time for those specific days could be submitted.

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.

17. 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
Bathing	
Full-body Bath: Tub, shower or sponge/bed bath.	Up to 30 minutes. May rotate with partial bath based on recipient’s needs
Partial Bath: A sponge bath includes, at a minimum, bathing of the face, hands, and perineum.	15–20 minutes per partial bath
Dressing	
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
Grooming and Skin Care	
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
Positioning	
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
Transfers	

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
Toileting and Maintaining Continence	
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
Eating	
Taking in food by any method. Extra time may be allowed for preparing a special diet.	30 minutes per meal
Delegated Medical Monitoring and Activities	
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, monitoring vital signs, and measurement of intake/output.	15–30 minutes day for all monitoring tasks performed

PC Policy at pages 3 – 8, and 10.

18. 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.

19. 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.

Id. at 32 - 34.

20. 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.

Id. at 42.

21. Given that Petitioner is twelve (12) years old, 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.

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 definition of medical necessity. The 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.

Id. at 23.

23. The evidence and testimony establish that Respondent denied Petitioner's request for personal care services because Respondent's QIO determined that the requested one thousand five hundred and fourteen (1,514) hours are not medically necessary. Specifically, Respondent denied the services on the basis that they are "in excess of Petitioner's needs." *See supra* ¶ 5,11. However, it was determined that the Petitioner receive authorization for five hundred and twenty-four (524) hours of personal care during the authorization period. *See supra* ¶4,5.

24. 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* ¶ 17. 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* ¶ 22. 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* ¶ 22. 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* ¶ 17. Parents and legal guardians must participate in providing care to the fullest extent possible. *See supra* ¶ 17. Section 5.2 of the PC Policy provides that personal care services cannot be used for babysitting purposes. *See supra* ¶ 18. 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 ¶ 16.

25. The record demonstrates that the requested one thousand five hundred and fourteen (1,514) hours of personal care services are not 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. Mittal provided credible and persuasive testimony that Petitioner needs five hundred and twenty (524) hours of personal care services assistance with ADLs and IADLs. See supra ¶ 4,5,11. As Dr. Mittal testified, Petitioner is [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED] See supra ¶ 11.

26. The PC Policy provides general guidance for the amount of time allocated for ADLs, *supra* ¶ 17. Here, Petitioner has the burden of proof that one thousand five hundred and fourteen (1,514) hours are medically necessary. See supra ¶ 14. Petitioner provided no time estimates to explain the amount of time Petitioner requires for each of [REDACTED] ADLs. 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 amount of 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* ¶ 17. In this case, Petitioner's [REDACTED], [REDACTED] did not provide any evidence that [REDACTED] is unable to provide ADL or IADL care. For example, the record indicates that [REDACTED] has no medical limitations, is not employed on weekends, and is available to provide care for [REDACTED]. *See supra* ¶ 11. Petitioner's parent(s) must participate to the fullest possible extent. The record reflects that Petitioner is able to attend outbound school six (6) hours per day. *See supra* ¶ 11. Based on the foregoing, the record does not demonstrate by a preponderance of the evidence that the requested one thousand five hundred and fourteen (1,514) hours of personal care services are "not in excess of Petitioner's needs."

27. A written prescription was provided by the Petitioner's physician in this case. *RCE 1 at 69*. However, the written prescription is not persuasive because it merely states that Petitioner is diagnosed with [REDACTED] and states "8hrs 7d/week, 10hrs on non-school days or early release/ 6 months." The PC Policy prevents personal care services from being used for companion sitting or babysitting. *See supra* ¶ 18. Moreover, 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.

28. Because Petitioner did not demonstrate that the requested one thousand five hundred and fourteen (1,514) hours of 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 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 the requested one thousand five hundred and fourteen (1,514) hours of personal care services was incorrect.

DECISION

Respondent's denial of one thousand five hundred and fourteen (1,514) hours of personal care services is **AFFIRMED**. Petitioner's appeal based on Respondent's denial in this matter is **DENIED**.

DONE AND ORDERED this 17th day of July 2024, in Tallahassee, Leon County, Florida.


George L. Winslow, Jr.
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2024.07.17 06:36:44
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GEORGE WINSLOW, 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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