

PRELIMINARY STATEMENT

All parties and witnesses appeared for the Fair Hearing telephonically. Petitioner appeared for the Fair Hearing to provide testimony. [REDACTED] (“[REDACTED]”) appeared as a witness for Petitioner.

Angela Royster, Greivance and Appeals Coordinator for Simply Health Care Plans, Inc. d/b/a Clear Health Alliance (“Simply Healthcare”), appeared as a representative for Respondent. The following persons appeared as witnesses for Respondent: Roberta Frank, Nurse Appeals Associate for Simply Healthcare; Susie Poli (“Ms. Poli”), UM Manager for Simply Healthcare; Dr. Marc Kaprow (“Dr. Kaprow”), Doctor of Osteopathic Medicine and Medical Director for Simply Healthcare; Dr. Marni Nicholas (“Dr. Nicholas”), Medical Director for Simply Healthcare.

Doris Rivera, Medical Health Care Program Analyst and Fair Hearing Liaison for the Agency for Health Care Administration (“Agency” or “AHCA”), appeared as an observer.

Petitioner’s Authorized Representative did not introduce any exhibits at the Fair Hearing. Respondent introduced an evidence packet containing two hundred (200) pages, which was admitted into evidence as Respondent’s Composite Exhibit 1. Respondent’s Composite Exhibit 1 included the following: Table of Contents; Sequence of Events; Fax cover sheet (dated February 13, 2020); LTC Service Request Form (dated February 12, 2020); Prescription from [REDACTED] (dated [REDACTED] 2020); Florida Department of Elder Affairs: 701B Comprehensive Assessment (dated February 12, 2020); Medication List – [REDACTED]; Simply Comprehensive Plan of Care (dated February 12, 2020); LTC Recommendation (dated February 17, 2020); Notice of Adverse Benefit Determination (“NABD”) (dated February 18, 2020); Case Manager Monthly Contact Visit notes (dated February 21, 2020); Member Appeal

Acknowledgement letter (dated February 26, 2020); Case Manager Quarterly Visit notes (dated March 9, 2020); Advanced Directives (dated March 9, 2020); Member Centric Goals (dated March 9, 2020); Natural Disaster Plan (dated March 9, 2020); Contingency Plan for HCBS Services (dated March 9, 2020); Comprehensive Plan of Care (dated March 9, 2020); Plan of Care Summary (dated March 9, 2020); Member Standard Appeal Extension letter (dated March 16, 2020); FUSE Other Health Insurance (OHI) Verification (dated March 16, 2020); Notice of Plan Appeal Resolution (“NPAR”) (dated March 23, 2020); Member Appeal Notes (dates: February 26, 2020 to March 23, 2020); Case Manager Monthly Contact Visit notes (dated April 22, 2020); Updated NPAR (dated May 7, 2020); Florida Medicaid Statewide Medicaid Managed Care Long-term Care Program Coverage Policy (“LTC Policy”) (March 2017); Simply Healthcare Plans – Home Health Aide (HHA) Services SMMC (2018); Center for Medicare & Medicaid Services – Coordination of Benefits; Center for Medicare & Medicaid Services – Medicare and Home Health Care (October 2017); and Medicare.gov – Home Health Services Coverage (printed May 19, 2020).

FINDINGS OF FACT

1. Petitioner is an enrolled member of Simply Healthcare’s Long-Term Care (“LTC”) Program. Simply Healthcare is a Medicaid Managed Care organization contracted by the Agency to provide services to eligible Medicaid recipients in the State of Florida.
2. On February 13, 2020, Petitioner requested the following service: T1503 – Administration of medication, other than oral and/or injectable, by a health care agency/professional, per visit – (2 hours per month). See Respondent’s Composite Exhibit 1, page 3.
3. On February 18, 2020, Simply Healthcare issued an NABD denying Petitioner’s request for two (2) hours per month of Medication Administration services. *Id.* at 41-43. The NABD states:

Simply Healthcare has reviewed your request for MEDICATION ADMINISTRATION – 2 HOURS PER MONTH, which we received on 02/12/2020. After our review, this service has been:

Denied as of 02/17/2020.

We made our decision because:
(Check all boxes that apply)

Other Authority

The facts that we used to make our decision are: Our records show that you have a primary health insurance carrier that is not Simply Healthcare. Simply Healthcare is your secondary insurance carrier. This means that Simply Healthcare will not review your medical request but instead will pay based upon the claims given after your primary insurance carrier has paid. This means an authorization is not needed and will not be given by Simply Healthcare for this request. Please give all medical review requests to your primary insurance carrier. A peer to peer reconsideration may be requested by your physician/health care provider within 2 days of the adverse determination.

Id. at 41-43.

4. On March 23, 2020, Simply Healthcare issued an NPAR denying Petitioner’s plan appeal

Id. at 107-108. The NPAR states as follows:

Per review of your appeal you have an active OHI. Medicare is your (primary health insurance). Please give all medical review requests to your (primary health insurance carrier). Simply Healthcare will pay based upon the claims given after (Medicaid) has paid. The case will be closed accordingly. Your care was looked at by a Nurse for Simply.

Id. at 107-108.

5. On May 7, 2020, Simply Healthcare issued an updated NPAR denying Petitioner’s plan appeal for reasons previously stated, *supra* ¶ 4. *Id.* at 121.

6. Petitioner is a seventy-eight (78) year old female who lives in the community with her daughter. *Id.* at 8. Petitioner’s daughter refuses to assist with Activities of Daily Living (“ADLs”)

and Instrumental Activities of Daily Living (“IADLs”). *Id.* Petitioner requires assistance with medication administration. *Id.* Petitioner is unable to administer medication on her own. *Id.*

7. Simply Healthcare’s Case Manager recommended services to prevent overdoses and/or poor medication management. *Id.* at 8.

8. ██████████ prescribed RN/LPN services for medication management. *Id.* at 9.

9. Petitioner experiences the following medical conditions: Rectum Prolapse; Acid Reflux; Arthritis; Diabetes; Dizziness; Gallbladder (removal); bowel and bladder incontinence; Blindness; and fractured hip. *Id.* at 6. Petitioner is partially bedbound. *Id.* at 7.

10. Petitioner requires total assistance (cannot do at all) with managing medication. *Id.* at 15.

11. Petitioner currently receives the following services: Adult Companion Care services (32 hours per week); Homemaker services (4 hours per week); Home-Delivered Meals (7 meals per week); Personal Care services (4 hours per week); and Medical Supplies (1 box per month of Adult Pull-ups). *Id.* at 7.

12. Petitioner has nineteen (19) prescription medications. *Id.* at 29.

13. LTC service code, T1503, is listed under Medication Administration services. *Id.* at 152.

14. On May 6, 2020, Petitioner timely requested a Fair Hearing to contest Respondent’s denial of Medication Administration services.

15. Petitioner is blind in the left eye and is currently going blind in the right eye. Petitioner testified that she needs someone to manage and organize her medication in a container on a biweekly basis. Petitioner has not been able to take her medication in the past four weeks. Due to her blindness, Petitioner cannot manage and administer her prescription medications. Petitioner’s daughter will not assist the Petitioner with ADLs, IADLs, or any care for Petitioner.

Petitioner acknowledges that she receives Medicare (Humana HMO), but testified that Humana HMO will not provide these services any longer. Petitioner testified that Medicare did not provide her with an explanation why she stopped receiving Medication Administration services. Petitioner testified that she may have received a letter from Humana HMO giving an explanation, but she stated all of her paperwork is unorganized with Medicare documentation being mixed in with Medicaid documentation.

16. [REDACTED] testified that Humana HMO, Petitioner's Medicare insurance, was providing Medication Administration services, but Humana HMO has abruptly stopped providing these services. [REDACTED] is unaware why the Humana HMO provider, who rendered the Medication Administration services, stopped coming to the Petitioner's home to render services. [REDACTED] testified that Petitioner has not taken her medication for the past four weeks because she does not have anyone in the home to assist her with management and administration of her medication. [REDACTED] believes that Petitioner may have not taken her medication in the past four months.

17. Ms. Poli is the Utilization Management Manager for Simply Healthcare. Respondent did not make a medical necessity determination regarding Petitioner's request. Respondent's decision was based on third-party liability of Petitioner's other health insurance provider, Medicare. Ms. Poli testified that Respondent's decision is based on the fact that Petitioner has Medicare, Medicare has provided Medication Administration services to the Petitioner in the past, and Medicare should continue providing such services. Respondent is unaware why the Petitioner stopped receiving Medication Administration services through Medicare. Ms. Poli confirmed with Petitioner's Primary Care Physician (PCP) that Humana HMO provided

Medication Administration services to the Petitioner in the past. Ms. Poli argued that Medicaid is the payer of last resort and Medicaid recipients also enrolled in Medicare must seek services from Medicare before seeking services from Medicaid.

CONCLUSIONS OF LAW

18. The Agency's Office of Fair Hearings has jurisdiction over the subject matter of this proceeding and the parties pursuant to Florida Statutes ("Fla. Stat.") § 409.285(2) (2019). This order is the final administrative decision of AHCA under Fla. Stat. § 409.285(2)(a).

19. Pursuant to Fla. Admin. Code R. 59G-1.100(17)(b), this hearing was held as a *de novo* proceeding.

20. 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.

21. Because Petitioner requested a new service, the burden of proof is on the Petitioner. *See* Fla. Admin. Code R. 59G-1.100(17)(g). The standard of proof in an administrative hearing is a preponderance of the evidence. *Id.* The preponderance of the evidence standard requires proof by "the greater weight of the evidence" (Black's Law Dictionary at 1201, 7th Ed.).

22. The LTC Policy, incorporated by reference in Fla. Admin. Code R. 59G-4.192, governs LTC services available to eligible Medicaid recipients in the State of Florida. *See* Respondent's Composite Exhibit 1, pages 129-150.

23. The 701B Comprehensive Assessment is, “an individualized, complete assessment of an individual’s medical, developmental, behavioral, social, financial, and environmental status. . . . to determine eligibility for the LTC program based on the need for a nursing facility level of care.” § 1.3.5 of the LTC Policy.

24. Natural Supports are, “[u]npaid supports that are provided voluntarily to the individual in lieu of home and community-based services and supports.” § 1.3.16 of the LTC Policy.

25. The LTC Policy states the following:

4.1 General Criteria

Florida Medicaid covers services that meet all of the following:

- Are determined medically necessary;
- Do not duplicate another service; and
- Meet the criteria as specified in the 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 restrictive setting

4.2.1 Home and Community-Based Supportive Services

The LTC program benefit includes coverage of the following home and community-based supportive services:

4.2.1.1 Adult Companion Care

The provision of non-medical care, supervision when necessary to protect the health, safety, and well-being of the enrollee, or social enrichment of a functionally impaired enrollee. This includes assistance or supervision with meal preparation, laundry, and light housekeeping tasks incidental to the care and supervision of the enrollee.

4.2.1.8 Home Delivered Meals

The provision of nutritionally sound meals delivered to an enrollee’s home when an enrollee has difficulty shopping for, or preparing food, without assistance. All meals must provide a minimum of 33 1/3% of the current

Dietary Reference Intake. The meals must meet the current Dietary Guidelines for Americans, the United States Department of Agriculture My Pyramid Food Intake Pattern and reflect the predominant statewide demographic.

4.2.1.9 Homemaker Services

The provision of general household activities (such as meal preparation) and routine household care (including laundry and pest control) by a trained homemaker, when the individual regularly responsible for these activities is temporarily absent or unable to manage these activities.

4.2.1.10 Medication Administration

The provision of services in accordance with section 429.256, F.S.

4.2.2 Mixed Services

Mixed services may exceed State Plan limits on those services in accordance with this policy. The Long-term Care benefit includes coverage of the following mixed services:

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.

...

8.0 Appendix

Statewide Medicaid Managed Care Long-term Care Provider Qualifications

LTC Plan Benefit:	Medication Administration
Qualified Service Provider Types:	RN, LPN
Minimum Provider Qualifications:	Licensed per Chapter 464, F.S.

...

Statewide Medicaid Managed Care Long-term Care Program Procedure Codes for Home and Community-Based Supportive Services

Procedure Code: T1503
Modifier 1: HN
Description: Medication administration, administration of medication, other than oral and/or injectable by BSN

Procedure Code: T1503
Modifier 1: TD

Description: Medication administration, administration of medication, other than oral and/or injectable by RN

Procedure Code: T1503

Modifier 1: TE

Description: Medication administration, administration of medication, other than oral and/or injectable by LPN

Respondent's Composite Exhibit 1, pages 129-150.

26. Fla. Stat. § 429.256 (2019) provides the following regarding Medication Administration services, *supra* ¶ 25, provided under the LTC Policy:

429.256 Assistance with self-administration of medication.—

- (3) Assistance with self-administration of medication includes:
- a) Taking the medication, in its previously dispensed, properly labeled container, including an insulin syringe that is prefilled with the proper dosage by a pharmacist and an insulin pen that is prefilled by the manufacturer, from where it is stored, and bringing it to the resident.
 - b) In the presence of the resident, reading the label, opening the container, removing a prescribed amount of medication from the container, and closing the container.
 - c) Placing an oral dosage in the resident's hand or placing the dosage in another container and helping the resident by lifting the container to his or her mouth.
 - d) Applying topical medications.
 - e) Returning the medication container to proper storage.
 - f) Keeping a record of when a resident receives assistance with self-administration under this section.
 - g) Assisting with the use of a nebulizer, including removing the cap of a nebulizer, opening the unit dose of nebulizer solution, and pouring the prescribed premeasured dose of medication into the dispensing cup of the nebulizer.
 - h) Using a glucometer to perform blood-glucose level checks.
 - i) Assisting with putting on and taking off antiembolism stockings.
 - j) Assisting with applying and removing an oxygen cannula but not with titrating the prescribed oxygen settings.
 - k) Assisting with the use of a continuous positive airway pressure device but not with titrating the prescribed setting of the device.
 - l) Assisting with measuring vital signs.
 - m) Assisting with colostomy bags.

- (4) Assistance with self-administration does not include:
 - a) Mixing, compounding, converting, or calculating medication doses, except for measuring a prescribed amount of liquid medication or breaking a scored tablet or crushing a tablet as prescribed.
 - b) The preparation of syringes for injection or the administration of medications by any injectable route.
 - c) Administration of medications by way of a tube inserted in a cavity of the body.
 - d) Administration of parenteral preparations.
 - e) Irrigations or debriding agents used in the treatment of a skin condition.
 - f) Rectal, urethral, or vaginal preparations.
 - g) Medications ordered by the physician or health care professional with prescriptive authority to be given "as needed," unless the order is written with specific parameters that preclude independent judgment on the part of the unlicensed person, and at the request of a competent resident.
 - h) Medications for which the time of administration, the amount, the strength of dosage, the method of administration, or the reason for administration requires judgment or discretion on the part of the unlicensed person.

27. Fla. Admin. Code R. 59G-1.052 provides the legal obligations of third-parties to pay part, or all, of the expenditures for medical assistance furnished under the Florida Medicaid program.

It provides the following:

59G-1.052 Third-Party Liability Requirements.

...

(3) Definitions.

- a) Dually Eligible Recipient. As defined in rule 59G-1.010, Florida Administrative Code (F.A.C.).
- b) Rate. As defined in rule 59G-1.010, F.A.C.

(4) Third-Party Liability Vendor. The Agency for Health Care Administration (AHCA) contracts with a TPL vendor to identify, manage, and recover funds and overpayments paid on behalf of recipients when a third-party is, or was, responsible. The TPL vendor also administers Florida Medicaid's third-party liability recovery programs for casualty, estate, trust, and annuities on behalf of deceased Medicaid recipients.

Information regarding AHCA's TPL vendor can be found on the AHCA Web site at <http://www.ahca.myflorida.com/Admin/>

(5) Third-Party Liability Notices.

- a) Notices regarding any third-party benefit, including trust, annuity, or estate probate actions, must be submitted in accordance with sections 409.910, 409.9101, Florida Statutes (F.S.), to the appropriate address located on the AHCA Web site at <http://www.ahca.myflorida.com/Admin/>
- b) Notice provided to any other AHCA office, or delivered to any other address, is not effective to fulfill the notice requirements.

(6) Exhausting Third-Party Resources.

- a) **Florida Medicaid is the payer of last resort. Providers must exhaust all TPL sources of payment, such as Medicare, TRICARE, private health insurance, AARP plans, or automobile coverage prior to submitting or resubmitting a claim for reimbursement to Florida Medicaid.**
- b) The following programs are exceptions to Florida Medicaid being the payer of last resort:
 - 1. Federal funds for the Individuals with Disabilities Education Act, Part B or C.
 - 2. Indian Health Services, according to 42 CFR 136.61.
 - 3. Programs funded through state and county funds, including:
 - a. Acquired Immune Deficiency Syndrome (AIDS) drug assistance programs.
 - b. County health departments.
 - c. Department of Health indigent drug programs.
 - d. Substance abuse, mental health, and developmental disabilities programs operated by the Department of Children and Families and the Agency for Persons with Disabilities.
 - e. Victim's compensation funds.
 - f. Vocational rehabilitation programs.

(7) Refusal of Services. Providers may not refuse to furnish a covered Florida Medicaid service to a recipient solely because of the presence of other insurance, including Medicare, in accordance with 42 CFR 447.20(b).

(8) Reimbursement for Services Provided to Recipients with TPL.

- a) Florida Medicaid reimburses the difference between the Florida Medicaid rate and the third-party payment, minus any applicable Florida Medicaid copayment or coinsurance, unless otherwise specified in this rule.
- b) **Florida Medicaid does not reimburse for services when:**
 - 1. The amount of any third-party payment(s) (including Medicare) is equal to, or exceeds, the Florida Medicaid rate for the service.
 - 2. **The provider's TPL claim is denied for failing to obtain the appropriate authorization from the third-party. Services approved by Medicare do not require Florida Medicaid prior authorization.**

(Emphasis added).

28. The Florida Medicaid Definitions Policy (August 2017) (“Definitions Policy”), incorporated by reference in Fla. Admin. Code R. 59G-1.010, provides definitions of commonly used terms that are applicable to all sections of Rule Division 59G, Florida Administrative Code (F.A.C.), unless specifically stated otherwise in a service-specific coverage policy or rule. The Definitions Policy defines commonly used terms as follows:

2.21 Centers for Medicare and Medicaid Services (CMS)

Federal agency within the United States Department of Health and Human Services (DHHS) that administers the Medicare program and works in partnership with state governments to administer Medicaid, the Children’s Health Insurance Program (CHIP), and health insurance portability standards.

2.39 Dually Eligible Recipient

Any person who is eligible to receive benefits under the Florida Title XIX Medicaid program, and the federal Title XVIII Medicare program.

2.85 Medicare

Medical assistance program authorized by Title XVIII of the federal Social Security Act, 42 U.S.C. section 1395 et seq., and regulations thereunder.

29. The CMS Medicare & Home Health Care booklet provides the following:

The home health agency must give you a written notice called an “Advance Beneficiary Notice of Noncoverage” (ABN) before giving you a home health service or supply that Medicare probably won’t pay for because of any of these:

- The care isn’t medically reasonable and necessary.
- The care is only nonskilled, personal care, like help with bathing or dressing.
- You aren’t homebound.
- You don’t need skilled care on an intermittent basis.

When you get an ABN because Medicare isn’t expected to pay for a medical service or supply, the notice should describe the service and/or supply, and explain why Medicare probably won’t pay. The ABN gives clear directions for getting an official decision from Medicare about payment for home health services and supplies and for filing an appeal if Medicare won’t pay.

In general, to get an official decision on payment, you should do

these:

- Keep getting the home health services and/or supplies if you think you need them. The home health agency must tell you how much they'll cost. Talk to your doctor and family about this decision.
- Understand you may have to pay the home health agency for these services and/or supplies.
- Ask the home health agency to send your claim to Medicare so that Medicare will make a decision about payment. You have the right to have the home health agency bill Medicare for your care.

The home health agency must also give you the ABN or a "Home Health Change of Care Notice" (HHCCN) when they reduce or stop providing home health services or supplies:

- For business-related reasons
- Because your doctor has changed or hasn't renewed your orders

If a home health agency reduces or stops providing certain services or supplies, you may have the option to keep getting them. The ABN or HHCCN will explain what service or supply is going to be reduced or stopped and give you instructions on what you can do if you want to keep getting the service or supply.

...

Appeal—An appeal is the action you can take if you disagree with a coverage or payment decision made by Medicare, your Medicare health plan, or your Medicare Prescription Drug Plan. You can appeal if Medicare or your plan denies one of these:

- Your request for a health care service, supply, item, or prescription drug that you think you should be able to get
- Your request for payment for a health care service, supply, item, or prescription drug you already got
- Your request to change the amount you must pay for a health care service, supply, item or prescription drug

You can also appeal if Medicare or your plan stops providing or paying for all or part of a health care service, supply, item, or prescription drug you think you still need.

Respondent's Composite Exhibit 1, pages 160-178

30. Petitioner is a 78-year-old blind female who is partially bedbound. *See supra* ¶ 6 and 9.

Petitioner argued that her request for services, *supra* ¶ 2, should be approved based upon her medical diagnosis (blindness), and her inability to manage and administer her nineteen (19)

prescribed medications, *supra* ¶ 12, on her own. *See supra* ¶ 15. Petitioner requires total assistance (cannot do at all) with managing medication. *See supra* ¶ 10. In addition, Petitioner asserted the signed prescription of [REDACTED] for medication management. *See supra* ¶ 8. Respondent argued that given that Petitioner is also enrolled into Medicare, Petitioner's other health insurance (Humana HMO) is responsible for providing medication management services and medication administration services. *See supra* ¶ 17. Respondent did not make a medical necessity determination for Petitioner's request. *See supra* ¶ 17.

31. To be covered by the Florida Medicaid program, a service such as Medication Administration services, must not duplicate another service. *See supra* ¶ 25. Both parties are in agreement that Petitioner was receiving Medication Administration services through Medicare prior to requesting Medication Administration services through Respondent. Petitioner testified that she stopped receiving Medication Administration services through the Medicare provider. *See supra* ¶ 15. However, although Petitioner asserted that the Medicare provider stopped visiting her home to render Medication Administration services, and Respondent conceded that Petitioner has stopped receiving such services, *supra* ¶¶ 15-17, Petitioner did not submit an Advance Beneficiary Notice of Noncoverage (ABN) indicating that adverse action has been taken against her regarding Medication Administration services. Petitioner did not present sufficient evidence to demonstrate that she is no longer approved to receive Medication Administration services through Medicare. Petitioner did not present any documentation, such as a ABN or HGCCN, or policies from her Medicare plan or provider indicating that the previously approved Medicare Medication Administration services were terminated, suspended, or reduced, or that Medication Administration services are otherwise no longer approved through Medicare.

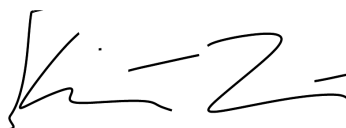
Likewise, Respondent provided no testimony or evidence to indicate that Medication Administration services were no longer approved through Medicare and that Medicare has terminated, suspended, or reduced the approved Medication Administration services. See supra ¶ 16-17. Petitioner testified that she may have received a letter from Humana HMO regarding her services, but submitted no such documentation into the record. *Supra* ¶ 15. Therefore, Petitioner has not proved by a preponderance of the evidence that the requested Medication Administration services under Medicaid are not duplicative of the approved Medication Administration services under Medicare. In light of insufficient testimony and evidence, Petitioner did not demonstrate that the requested services are not a duplication of services. Thus, the Petitioner has not met this criterion for coverage under the LTC Policy.

32. Accordingly, upon consideration of Respondent's Composite Exhibit 1, both parties' sworn testimony, and applicable rules and regulations, the undersigned Hearing Officer concludes that Petitioner has not proved by a preponderance of the evidence that Respondent's denial of Petitioner's request for Medication Administration services was incorrect.

DECISION

Respondent's denial of Petitioner's request for Medication Administration services is **AFFIRMED**. Petitioner's request for relief is hereby is **DENIED**.

DONE and ORDERED this 13th day of July, 2020, in Tallahassee, Leon County, Florida.



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KRISTOPHER LEÓN, Hearing Officer
Agency for Health Care Administration
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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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