



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

FILED

Jul 29, 2020, 2:00 pm

OFFICE OF FAIR HEARINGS

[REDACTED]

PETITIONER,

AHCA Case No.: 20-FH [REDACTED]

Plan ID No.: [REDACTED]

vs.

COVENTRY HEALTHCARE OF FLORIDA, INC.
D/B/A AETNA BETTER HEALTH OF FLORIDA, INC.,

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic Fair Hearing on June 29, 2020,
at [REDACTED]

APPEARANCES

For the Petitioner: [REDACTED]
Petitioner's Authorized Representative

For the Respondent: Deborah Wingo
Director of Long Term Care
Coventry Healthcare of Florida, Inc.
d/b/a Aetna Better Health of Florida, Inc.

STATEMENT OF ISSUE

The issue is whether Petitioner proved by a preponderance of the evidence that Respondent's denial of an additional twenty-five (25) hours of Patient Directed Option ("PDO") personal care services from [REDACTED] 2020, through [REDACTED] 2020, was incorrect.

PRELIMINARY STATEMENT

All parties and witnesses appeared telephonically. [REDACTED] (“[REDACTED]”), Petitioner’s Authorized Representative and daughter, appeared as a witness for Petitioner.

Debra Wingo (“Ms. Wingo”), Director of Long Term Care for Coventry Healthcare Of Florida, Inc. d/b/a Aetna Better Health Of Florida, Inc. (“Aetna”), appeared on behalf of Respondent. The following persons also appeared as witnesses for Respondent but did not testify: Damaris Segura, Grievance and Appeals Manager; Lucille Comrie, Program Manager for Public Partnerships; and Dr. Ikpeazu, Medical Director. Maria Capaluna, Manager for Long Term Care, and Lindsay Sullivan, Contract Manager, appeared as observers for Respondent.

Doris Rivera, Medical Health Care Program Analyst for the Agency for Health Care Administration (“Agency” or “AHCA”), appeared for observational purposes.

Prior to the hearing, Petitioner submitted a fifteen (15) page evidence packet to the Office of Fair Hearings and Respondent. The packet included the following documents: email, dated June 13, 2020; fax cover page, dated June 12, 2020; Notice of Adverse Benefit Determination (“NABD”), dated March 27, 2020; letter from [REDACTED], dated April 17, 2019; letter from [REDACTED], dated June 12, 2020 (two copies); letter from [REDACTED], dated [REDACTED] 2020; letter from [REDACTED] dated January 31, 2020; and [REDACTED] Discharge Instructions, Orders and Medications, dated [REDACTED] 2020. Absent an objection from Respondent, the undersigned admitted the 15 page evidence packet into evidence as Petitioner’s Exhibit 1.

Prior to the hearing, Petitioner submitted a 1 page e-mail to the Office of Fair Hearings. The email provided Petitioner's summary of the case. Absent an objection from Respondent, the undersigned admitted the 1 page e-mail into evidence as Petitioner's Exhibit 2.

Prior to the hearing, Respondent sent to the Office of Fair Hearings and Petitioner a two hundred and sixty-six (266)-page evidence packet. The packet included the following documents: Medicaid Fair Hearing & Appeal Document Checklist; an Acknowledgement of Third Party Medicaid Fair Hearing Request, dated May 27, 2020; an NABD, dated March 27, 2020; a letter from Respondent, dated May 1, 2020; a Notice of Plan Appeal Resolution ("NPAR"), dated May 7, 2020; a Comprehensive LTSS Plan of Care ("Plan of Care"), with an effective date of October 14, 2019; a Florida Department of Elder Affairs 701B Comprehensive Assessment ("701B Assessment"), dated October 14, 2019; a blank page; Caregiver Supplemental Assessment, dated October 14, 2019; a thirty-one page Employer of Record Packet, signed October 11, 2016; Participant Directed Option ("PDO") Participant guidelines; a thirty-seven (37)-page Direct Service Worker Enrollment packet; Aetna's 2020 Medicaid Member Handbook; the Florida Medicaid Statewide Managed Care Long-term Care Program Coverage Policy (March 2017) ("LTC Policy"); and the Florida Medicaid Home Health Visit Services Coverage Policy (November 2016). Absent an objection from Petitioner, the undersigned admitted Respondent's 266 page evidence packet into evidence as Respondent's Composite Exhibit 1.

Prior to hearing, Respondent sent to the Office of Fair Hearings and Petitioner a fourteen (14)-page evidence packet containing the following document: Florida Medicaid Personal Care Services Coverage Policy ("PC Policy"). Absent an objection from the Petitioner, the undersigned admitted Respondent's 14 page evidence packet into evidence as Respondent's Exhibit 2.

Prior to hearing, Respondent sent to the Office of Fair Hearings and Petitioner a two-page evidence packet containing the following document: Summary of Case. Absent an objection from the Petitioner, the undersigned admitted Respondent's two-page evidence packet into evidence as Respondent's Exhibit 3.

FINDINGS OF FACT

1. Petitioner is an enrolled member of Aetna's Long-term Care ("LTC") plan. See Respondent's Composite Exhibit 1, page 38. United is a managed care organization contracted by AHCA to provide services to eligible Medicaid recipients in Florida.
2. Petitioner is a [REDACTED] year-old female with dementia, anxiety and depression, dizziness, osteoporosis, and heart problems. *Id.* at 49 - 50. Petitioner lives with her daughter, [REDACTED], who is her only natural support. *Id.* at 44. [REDACTED], as Petitioner's Direct Service Worker ("DSW"), regularly performs the routine of private life for Petitioner, including shared meals and holidays with family. *Id.* at 88.
3. Regarding Petitioner's Activities of Daily Living ("ADLs"), Petitioner needs assistance (but not total help) with bathing, dressing, eating, using the bathroom, transferring, and walking/mobility. *Id.* at 47.
4. Regarding Petitioner's Instrumental Activities of Daily Living ("IADLs"), Petitioner needs total assistance (cannot do at all) with heavy chores, light housekeeping, managing money, preparing meals, shopping, and using transportation. *Id.* at 48. Petitioner needs assistance (but not total help) with using the telephone, and managing medication. *Id.*
5. On March 27, 2020, Respondent issued an NABD denying Petitioner's request for an additional twenty-five (25) hours of personal care services rendered from March 16, 2020,

through March 20, 2020. *Id.* at 11 – 14. The NABD stated the reason for Respondent’s determination as follows:

X Other Authority

The facts that we used to make our decision are:

You have asked Aetna Better Health to pay for services that were already done but never asked for, so the services were never approved (authorized). We cannot approve this request. The services must be approved by the health plan before the service is provided.

Id. at 12.

6. On April 29, 2020, Petitioner requested a plan appeal. *Id.* at 21. On May 7, 2020, Respondent sent Petitioner an NPAR denying Petitioner’s plan appeal. *Id.* at 30 - 32. The NPAR stated as follows:

On April 29, 2020 we received your timely plan appeal request regarding Aetna Better Health of Florida’s Notice of Adverse Benefit Determination dated March 26, 2020, NABD Number [REDACTED], denying 25 additional hours of Personal Care Services from 03/16/2020-03/20/2020 provided to [Petitioner].

On May 6, 2020, after consideration of the information you provided to Aetna Better Health of Florida in support of your plan appeal, Aetna Better Health of Florida hereby denies your plan appeal. As a result, [Petitioner] will not receive 25 additional hours of Personal Care Services from 03/16/2020 - 03/20/2020, effective 5/7/2020.

Dr. David Gilchrist, D.O., Chief Medical Officer, Florida Board certified in Emergency Medicine and Internal Medicine reviewed your appeal. Aetna Better Health of Florida has reviewed your appeal for coverage of previously supplied services. Services were never approved or authorized. We cannot approve this appeal. The services must be approve[d] through the health plan before the services are provided. You should discuss treatment options with your doctor. Decisions about the care you will have are between you and your doctor. We made this decision using clinical records and the Aetna Better Health of Florida Medicaid Member Handbook.

Id. at 30.

7. On May 14, 2020, Petitioner requested a Fair Hearing due to the denial of the requested twenty (25) hours of personal care services. On June 12, 2020, the undersigned scheduled the Fair Hearing for June 29, 2020, at 9:00 a.m. EST, and all parties were duly notified.

8. The PDO Consent Form, which was initialed and signed by Petitioner on October 11, 2016, provides in pertinent part:

7. I will make sure that my direct service worker(s) does not work more hours than approved on the Participant/Direct Service Worker Agreement.

Id. at 65.

9. The PDO Employer of Record Agreement, which was signed by Petitioner on October 11, 2016, provides in pertinent part:

Employer of Record (EOR) Requirements and Responsibilities:

...

4. Collaborate with your case manager to develop your individual service plan based on your medical, social, functional and educational needs and goals.

...

12. Contact your case manager to request a new assessment or to change your plan or care as your needs and goals change.

Id. at 67 – 68.

10. Petitioner’s Plan of Care, dated May 29, 2020, includes three (3) hours per week of homemaker services, five (5) hours per week of adult companion care services, and seventeen (17) hours per week of personal care services. *Id.* at 38. On March 31, 2020, Aetna added ten (10) hours per week of temporary personal care services, which were set to terminate on June 28, 2020. *Id.* at 42. The temporary personal care services are related to COVID-19. *Id.*

11. Pursuant to Petitioner’s Discharge Instructions, Orders and Medications from [REDACTED] [REDACTED] dated [REDACTED] 2020, Petitioner was discharged from the hospital with “Home Health” services. See Petitioner’s Composite Exhibit 1 at page 11. As Ms. Wingo testified,

the home health services were provided by [REDACTED] and supplemented the services provided by Aetna upon Petitioner's release from the hospital.

12. [REDACTED] testified that, on [REDACTED] 2020, the hospital told her to pick-up the Petitioner on Sunday, [REDACTED] 2020. [REDACTED] testified that Petitioner's day care provider advised that Petitioner would need a release from her physician before returning to day care. On [REDACTED] 2020, Petitioner saw her physician, who advised Petitioner to "stay home from day care for a few more days." [REDACTED] testified that she discussed obtaining authorization for PDO personal care services with Petitioner's case manager on [REDACTED] 2020. [REDACTED] asserted that she did not have time, prior to Petitioner's release from the hospital or immediately after, to seek authorization. [REDACTED] argued that she should be compensated for PDO personal care services rendered on March 16, 2020, through March 20, 2020.

13. Ms. Wingo testified that the PDO personal care services at issue were not requested by Petitioner or approved by Aetna before they were rendered by [REDACTED]. During the period of March 16 - 20, 2020, Petitioner was receiving 3 hours of homemaker, 5 hours of companion care, and 17 hours per week of personal care services. Further, although the Petitioner did not attend adult daycare during this time frame, she was discharged from the hospital with supplemental home care services provided by [REDACTED].

14. Ms. Wingo argued that Aetna should not pay for the natural support provided by [REDACTED] from on March 16, 2020, through March 20, 2020. Ms. Wingo testified that [REDACTED] did not request authorization for the personal care services at issue until Friday,

March 20, 2020. Petitioner's long term care plan was reassessed by Petitioner's case manager on March 23, 2020, and no changes to the care plan were determined to be warranted.

15. Ms. Wingo argued that long term care services are intended to supplement natural supports and are not intended to be provided for the convenience of the member, caregiver, or provider. She asserted that all PDO long term care services must be pre-authorized by the plan before the services are rendered. She asserted that, in this case the case, the services were not pre-authorized because Petitioner's case manager was not notified until March 20, 2020, and a re-assessment of Petitioner's needs was not made until March 23, 2020.

CONCLUSIONS OF LAW

16. 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).

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

18. Because Petitioner is requesting new services, Fla. Admin. Code R. 59G-1.100(17)(g) 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.)

19. The Florida Medicaid policy that applies to the requested services is the LTC Policy. The Agency’s LTC Policy has been incorporated, by reference, into Fla. Admin. Code R. 59G-4.192. The LTC Policy provides as follows:

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 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 (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

...

1.3.5 701-B Comprehensive Assessment

An individualized, complete assessment of an individual’s medical, developmental, behavioral, social, financial, and environmental status. The assessment is conducted by a trained individual employed by the Department of Elder Affairs Comprehensive Assessment and Review for Long-Term Care Services (CARES) program or the LTC plan, to determine eligibility for the LTC program based on the need for a nursing facility level of care.

...

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
- Medication management
- Money management
- Personal hygiene
- Transportation
- Using the telephone to take care of essential tasks (examples include paying bills and setting up medical appointments)

...

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.

...

2.2 Who Can Receive

Florida Medicaid recipients requiring medically necessary LTC services who are enrolled in a LTC plan and have a nursing facility level of care determined by the CARES program. Some services may be subject to additional coverage criteria as specified in section 4.0.

...

4.0 Coverage Information

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.

...

4.2.1.1. 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.

...

4.2.1.9 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.

...

4.2.2 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.

5.2 exclusion for specific non-covered services rendered prior to the development and approval of the POC

...

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.

...

7.0 Authorization

LTC services must be authorized by the enrollee's LTC plan prior to delivery of services.

LTC Policy at pages 1 - 9.

20. The PC Policy, which is incorporated by reference in Fla. Admin. Code R. 59G-4.215, 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.

...

1.3.6 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.

...

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

PC Policy at pages 3 - 5.

21. The Florida Medicaid Definitions Policy (August 2017) (“Definitions Policy”), which is incorporated by reference in Fla. Admin. Code R. 59G-1.010, contains 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. It 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.

22. The Aetna PDO guidelines provide as follows:

Your Managed Care Plan will offer you the Participant Direction Option (PDO). The PDO is available to you if you have at least one of the following services on your care plan:

- Adult companion care
- Attendant Nursing care
- Homemaker services
- Intermittent and skilled nursing
- Personal care.

The PDO allows you to self-direct your services. This means you get to choose who will provide your services and how and when your services are provided. You are responsible for hiring, training, and supervising your direct service workers.

...

PDO Responsibilities

Your Responsibilities

- Contacting your case manager if you have questions or need help;

...

- Completing all required paperwork and submitting it in a timely manner;

...

- Making sure that your direct service worker does not work more hours than approved on your Participant. Direct Services Worker Agreement. If you feel that you need more services than what you are approved to receive, contact your case manager;

...

Public Partnerships, LLC Responsibilities

Public Partnerships, LLC helped you take care of many of your employer responsibilities, including:

...

- Making sure that your direct service worker is not paid for providing more hours that approved on your Participant/Direct Service Worker Agreement.

...

Respondent's Composite Exhibit 1 at pages 98, 102 - 3.

23. The Aetna Direct Service Worker Enrollment Packet includes a Direct Service Worker Employment Information & Attestation Form, which provides:

Direct Service Worker Responsibilities

As the Direct Service Worker I understand my responsibilities are as follows:

...

8. Will communicate any change in the participant's condition, including an admission to a health facility if the participant is unable to do so.

Id. at 135.

24. In the instant case, the Petitioner requested twenty-five (25) additional hours of PDO personal care services for the time period of March 16, 2020, through March 20, 2020. *See supra* ¶ 5 and 6. As established on the record by the evidence and testimony, Respondent denied Petitioner's request for 25 additional hours because the documentation submitted in support of Petitioner's request failed to establish that the requested personal care services were authorized before they were provided. *Id.*

25. The testimony and evidence presented in this case reflects that Respondent's denial of 25 additional hours of personal care services was warranted. The LTC Policy requires that long term care services must be authorized prior to delivery. *See supra* ¶ 19 and Respondent's Composite Exhibit 1 at 207 – 211. The Aetna PDO guidelines require the recipient to make sure that the direct service worker does not work more hours than approved on the Participant Direct Services Worker Agreement and that, if the recipient feels they need more services than what they are approved to receive, they should contact their case manager first. *See supra* ¶ 8 and 22. The DSW responsibilities require ██████████ to communicate any change in the participant's condition, including an admission to a health facility, if the participant is unable to do so. *See supra* ¶ 2, 9 and 23.

26. In the instant case, ██████████ did not deny that she failed to obtain authorization before rendering 25 hours of PDO personal care services on March 16, through March 20, 2020. *See supra* ¶ 9. Rather, ██████████ contends that she did not have time to seek prior authorization. *See supra* ¶ 9. She testified that she provided the personal care services at issue because Petitioner was unable to return to day care. She further testified that she did not contact Petitioner case manager's supervisor about obtaining authorization until Thursday, March 19,

2020. See supra ¶ 9. Accordingly, [REDACTED] did not demonstrate that the requested 25 additional hours of PDO personal care services provided on March 16, 2020, through March 20, 2020, were authorized before they were rendered.

27. In light of the both parties' testimony, Respondent's Composite Exhibit 1, the SMMC LTC Policy, the PDO Manual, the PC Policy, and the Definitions Policy, the undersigned Hearing Officer finds that Petitioner did not meet her burden of proving that an additional twenty-five (25) hours per week of PDO personal care services were authorized for the time period of March 16 – 20, 2020.

28. Accordingly, the undersigned Hearing Officer finds that Petitioner did not prove by a preponderance of the evidence that Respondent's denial of twenty-five (25) additional hours of personal care services from the time period [REDACTED] 2020, through [REDACTED] 2020, was incorrect.

DECISION

Respondent's denial of an additional twenty-five (25) hours of personal care services from March 16, 2020, through March 20, 2020, is **AFFIRMED**. Petitioner's appeal based on Respondent's denial in this matter is **DENIED**.

DONE AND ORDERED this 29th day of July, 2020, in Tallahassee, Leon County, Florida.



Laura Gallagher
20-FH [REDACTED]
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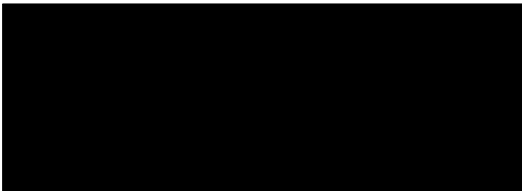
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NOTICE OF A RIGHT TO JUDICIAL REVIEW

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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