



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

FILED

Nov 18, 2020, 8:07 am
OFFICE OF FAIR HEARINGS

[REDACTED]

PETITIONER,

AHCA Case No.: 20-FH [REDACTED]
Plan ID No.: [REDACTED]

vs.

SUNSHINE STATE HEALTH PLAN, INC.,

RESPONDENT.

_____ /

[REDACTED]

PETITIONER,

AHCA Case No.: 20-FH [REDACTED]
Plan ID No.: [REDACTED]

vs.

SUNSHINE STATE HEALTH PLAN, INC.,

RESPONDENT.

_____ /

[REDACTED]

PETITIONER,

AHCA Case No.: 20-FH [REDACTED]
Plan ID No.: [REDACTED]

vs.

SUNSHINE STATE HEALTH PLAN, INC.,

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic Fair Hearing on the instant case on September 15, 2020, at [REDACTED], and October 1, 2020, at [REDACTED]

APPEARANCES

For the Petitioner: [REDACTED]
Counsel for Petitioner

For the Respondent: Paige Comparato
Counsel for Respondent
Sunshine State Health Plan, Inc.

STATEMENT OF ISSUE

The first issue (AHCA Case Number 20-FH [REDACTED]) is whether Respondent proved by a preponderance of the evidence that Respondent’s decision to reduce Petitioner’s personal care services from fifty-six (56) to twenty (20) hours weekly was correct.

The second issue (AHCA Case Number 20-FH [REDACTED]) is whether Respondent proved by a preponderance of the evidence that Respondent’s decision to reduce Petitioner’s homemaker services from fourteen (14) hours weekly to seven (7) hours weekly was correct.

The third issue (AHCA Case Number 20-FH [REDACTED]) is whether Respondent proved by a preponderance of the evidence that Respondent’s decision to reduce Petitioner’s adult companion care services from twenty-one (21) to thirteen (13) hours weekly was correct.

PRELIMINARY STATEMENT

All parties and witnesses appeared telephonically. [REDACTED] Counsel for Petitioner, [REDACTED], represented Petitioner at the hearing. [REDACTED] (“[REDACTED]”), Petitioner’s mother and caregiver, appeared at the Fair Hearing and provided testimony on Petitioner’s behalf. [REDACTED] (“[REDACTED]”), a registered nurse and Petitioner’s aunt, testified on behalf of Petitioner. [REDACTED], a friend of family and Petitioner’s Participant Direction Option (“PDO”) representative, provided testimony on behalf of Petitioner. [REDACTED], a friend of Petitioner’s family, provided testimony on behalf of

Petitioner. [REDACTED], an advocate investigator for [REDACTED], appeared as an observer for Petitioner.

Paige Comparato appeared as Counsel for Respondent. Dr. John Carter, Long Term Care Medical Director for Sunshine State Health Plan, Inc. ("Sunshine"), appeared as a witness for Respondent. Vonsheila Murray, Care Coordinator for Sunshine, appeared as a witness for Respondent. The following individuals appeared as witnesses for Sunshine, but did not testify: Jennifer Corbett, Manager of Case Management for Sunshine; Andrea Hoffman, Care Coordinator for Sunshine; Tammy Swann, Director of case Management for Sunshine; Alsheneeka Williams, Care Coordinator Supervisor for Sunshine; and Mellissa Lane, Senior Manager for Member Appeals for Sunshine.

Sheila Gonzalez, Medical Health Care Program Analyst, Registered Nurse Specialist for the Agency for Health Care Administration ("Agency" or "AHCA"), appeared for observational purposes.

Prior to the hearing, Petitioner sent to the Office of Fair Hearings and Respondent a two-hundred and fifty-five (255)-page evidence packet. The evidence packet contains the following documents: email from [REDACTED], dated September 8, 2020; Petitioner's Witness and Exhibit List, dated September 5, 2020; Exhibit 1 cover page; letter from [REDACTED] ("[REDACTED]"), dated [REDACTED], 2020; letter from [REDACTED], dated [REDACTED], 2020; letter from [REDACTED], dated [REDACTED], 2019; letter from [REDACTED], dated [REDACTED], 2019; letter of medical necessity, dated June 1, 2016; Exhibit 2 cover page; letter from [REDACTED], dated [REDACTED] 2020; letter from [REDACTED], dated [REDACTED], 2020; Exhibit 3 cover page; authorization, dated March 2, 2019; authorization letter, dated March 5, 2018; authorization letter, dated May

22, 2017; authorization letter dated December 2, 2016; authorization letter dated March 14, 2014; Exhibit 4 cover page; Florida Department of Elder Affairs 701B Comprehensive Assessment, dated July 10, 2020 (“July 701B Assessment”); Florida Department of Elder Affairs 701B Assessment, dated June 18, 2020 (“June 710B Assessment”); email from [REDACTED], dated September 8, 2020; Florida Department of Elder Affairs 701B Assessment, dated December 15, 2019; Florida Department of Elder Affairs 701B Assessment, dated September 16, 2019; Florida Department of Elder Affairs 701B Assessment, dated June 18, 2019; Sunshine Health blank questionnaire; Fax cover page from [REDACTED], dated [REDACTED], 2019; Florida Department of Elder Affairs 701B Assessment, dated April 3, 2019; Sunshine Health blank questionnaire; Florida Department of Elder Affairs 701B Assessment, dated September 4, 2018; Sunshine blank questionnaire; Florida Department of Elder Affairs 701B assessment, dated July 25, 2018; Sunshine blank questionnaire; Florida Department of Elder Affairs 701B Assessment, dated February 9, 2018; Sunshine blank questionnaire; Florida Department of Elder Affairs 701B Assessment, dated September 22, 2017; blank questionnaire; Florida Department of Elder Affairs 710B Assessment, dated August 11, 2014; and blank questionnaire. Absent an objection from Respondent, the undersigned admitted the evidence packet into the record as Petitioner’s Composite Exhibit 1.

Prior to the hearing, Petitioner sent to the Office of Fair Hearings and Respondent a six (6)-page evidence packet. The evidence packet contains the following documents: email from [REDACTED], dated September 8, 2020; Petitioner’s Supplemental Exhibit List, dated September 8, 2020; Exhibit 5 cover page; and letter from [REDACTED], dated [REDACTED], 2020. Absent an

objection from Respondent, the undersigned admitted the evidence packet into the record as Petitioner's Composite Exhibit 2.

Prior to the hearing, Respondent sent to the Office of Fair Hearings and Petitioner a one hundred and thirteen (113)-page evidence packet. The evidence packet contains the following documents: the Medicaid Fair Hearing Table of Content; Medicaid Fair Hearing Summary, dated August 11, 2020; Notice of Adverse Benefit Determination ("NABD"), dated June 24, 2020; Long Term Care Person-Centered Care Plan ("Care Plan"), signed June 18, 2020; Long Term Care Person-Centered Care Plan, signed July 24, 2020; the June 701B Assessment; the July 701B Assessment; email from [REDACTED], dated June 30, 2020; Standard Appeal Acknowledgment, dated July 6, 2020; Notice of Plan Appeal Resolution ("NPAR"), dated July 14, 2020; the Sunshine Health Policy and Procedure LT.UM.09; and Florida Administrative Code Rule ("Fla. Admin. Code R.") 59G-1.010(166). Absent an objection from Petitioner, the undersigned admitted the evidence packet into evidence as Respondent's Composite Exhibit 1.

FINDINGS OF FACT

1. Petitioner is an enrolled member of Sunshine. See Respondent's Composite Exhibit 1 at page 24. Sunshine is a managed care organization contracted by the Agency to provide services to eligible Medicaid recipients in Florida.
2. Petitioner is 41-years old. *Id.* Petitioner has a history of anoxic brain injury and the following diagnoses: depression, Alzheimer's, dementia, and Obsessive Compulsive Disorder ("OCD"). *Id.* at 20 and 26. Petitioner receives quarterly Botox injections from her neurologist to help with muscle weakness and stiffness. *Id.* at 25. Additional health concerns include dysarthria with irregular movements, spasticity, hyperreflexia, and altered gait. *Id.*

3. In a letter dated [REDACTED] 2019, Petitioner's rehabilitation physician, [REDACTED], who is also the [REDACTED]

[REDACTED], stated:

I have been [Petitioner's] rehabilitation physician since 2011. She has anoxic brain injury, resulting in cognitive and physical impairments. She also has mood difficulties, such as anger, irritability, mental inflexibility, and memory deficits. As a result of her anoxia, she also has difficulty making new relationships and does not interact well with people she doesn't know. Her mother has been her primary care giver since her injury. Knowing [Petitioner] well, I do not recommend that she receives supervision from anyone else other than her immediate family, such as her mother or her aunt.

Petitioner's Composite Exhibit 1 at page 17.

4. In a letter dated [REDACTED], 2019, [REDACTED], [REDACTED] [REDACTED], wrote a letter to the Agency stating:

[Petitioner] is a longtime patient of mine, who unfortunately suffered a traumatic brain injury secondary to a post anoxic encephalopathy that occurred as a complication of a C-section. This patient unfortunately has post-residual effects from her traumatic injury. These residual effects include dysarthria with irregular movements, spasticity, as well as hyperreflexia. She has a slightly altered gait. She also has problems with cognitive impairment. Her most recent Mini-Mental Status Exam shows a score of 23/30. A year ago, she had a 24/30. She has remained below 25 for all the times that the patient has been evaluated. Other symptom[s] that the patient has is she has some problems with memory lapses. She has a history of wandering off. She also exhibits symptoms of excessive compulsive disorder. Unfortunately, these problems caused the problem for her to be a good caregiver for herself and for her two children at this time[. T]he patient still is not able to safely care for herself in all situations as well as these two young children. This patient's mother has been her guardian and been her main caregiver for the past several years. I do not believe this patient could be able to live independently on her own or able to safely care for herself, for her children, and since this condition has been chronic ongoing, it is unlikely to change in the future. The patient's mother has done a good job in caring for both the patient and assisting in caring with her children. I believe this is the best situation for this patient and I believe the mother should be able to continue to be considered as the main caregiver for this patient with multiple reasons that the patient, like I said, can become easily frustrated and agitated and the mother has been dealing with this for the past several years. The patient is familiar with the mother as the caregiver

and her children were also familiar with the grandmother as the caregiver. In this situation I do not necessarily feel outside care would be of any significant benefit.

Petitioner's Composite Exhibit 1 at page 12 .

5. In a letter dated [REDACTED], 2020, [REDACTED] stated as follows:

[Petitioner] is a patient in my practice who unfortunately suffered an anoxic brain injury while in the process of having a C-section. She subsequently developed a post anoxic encephalopathy, which caused her to sustain residual defects. These defects resulted in the patient having both physical and mental sequela including decreased cognitive function, some physical impairment, and emotional distress. The patient now shows signs of obsessive-compulsive behavior. She also has episodes where the patient wanders off. She has problems with short term memory. . . .

[Petitioner] is followed here regularly. Her condition has not significantly improved in the past several years. She has some functional capacity, however, the patient is not able to function on a consistent level and she is not able to fully care for herself. She is not able to adequately care for her children alone. At times, she requires 24-hour care. . . .

Due to this patient's emotional liability and confrontational behavior with unfamiliar people and difficulty developing a good rapport, I believe that it is in the patient's best medical interest that she should have her mother continue as her main caregiver, full-time as well as being her legal guardian.

It is my medical opinion that this patient's mother would be the best source for care for her patient and provide the best medical outcome. Again, with the multitude of problems noted above, the patient should not have reduced care giving for hours from her mother. . . [D]ue to the above mentioned conditions, this patient at times requires 24-hour care. She has some cognitive impairment, and behavioral issues, which at times could put her in possible harmful situations, it is my medical opinion that she requires 24 hour care/monitoring for her safety.

Petitioner's Composite Exhibit 1 at page 8.

6. Regarding Activities of Daily Living ("ADLs"), Petitioner needs no assistance with eating, using the bathroom, transferring, and walking or mobility. *Id.* at 31 and 49. The testimony and evidence reflect that Petitioner needs some supervision or prompt when bathing and dressing. *Id.* at 49 and 68. Petitioner's Care Plan indicates that "she can self feed, dress herself with

assistance/supervision.” Respondent’s Composite Exhibit 1 at page 14. At the Fair Hearing, [REDACTED] and [REDACTED] clarified that Petitioner is able to dress herself; however, she needs assistance with undergarments, fasteners, and buttons, and she needs assistance picking out appropriate clothing. With respect to bathing, at the Fair Hearing, [REDACTED] and [REDACTED] clarified that Petitioner is able to bathe on her own; however, some supervision or prompt is needed to ensure, for example, that Petitioner rinses and uses bath products appropriately.

7. Regarding Instrumental Activities of Daily Living (“IADLs”), Petitioner needs total assistance (cannot do at all) with heavy chores, managing money, preparing meals, and using transportation. Petitioner’s Composite Exhibit 1 at pages 50 and 69. Petitioner needs assistance (but not total help) with light housekeeping, shopping, and managing medication. *Id.* Petitioner requires supervision when using the telephone. *Id.* Petitioner always has assistance with her IADLs. *Id.* At the Fair Hearing, [REDACTED] clarified that Petitioner is able to answer the telephone but is unable to make outgoing calls without assistance.

8. Petitioner requires supervision due her to cognitive decline, OCD behavior, and risk of wandering off. *Id.* at 36, 54, and 73. Petitioner is forgetful or easily confused “[n]early every day.” *Id.* Petitioner gets lost or wanders off and gets easily agitated or disruptive “more than half the days” in a month. *Id.* Petitioner threatens or is verbally hostile “several days” a month. *Id.* Petitioner experiences anger, irritability, mental inflexibility and mood deficits. *Id.*

9. Petitioner participates in the PDO Program. [REDACTED] is Petitioner’s Direct Service Worker (“DSW”) and her primary caregiver. [REDACTED] does not work outside the home. Petitioner’s Composite Exhibit 1 at pages 41, 59, and 78. [REDACTED] testified that Sunshine recently changed its PDO policy and will not pay a DSW more than a total of forty (40)-hours per

week. [REDACTED] testified that she quit her job as a domestic and international flight attendant to care for Petitioner after her injury over fifteen years ago. She argued that forty-hours (40) hours per week is not financially viable and that she may be required to return to work. She asserted that, if she returns to work, Petitioner will require round-the-clock paid care, because [REDACTED] will have to be on-call with the airline even when she is not at work. She further asserted at the Fair Hearing that she is unwilling to continue to provide unpaid “natural support” services to Petitioner.

10. Petitioner resides with [REDACTED] and Petitioner’s fifteen-year-old, twin sons. *Id.* at 28, 46, and 65. Petitioner does not interact well with people she does not know and, [REDACTED] has not allowed paid home health aides into the home to assist with Petitioner’s care. *Id.* at 36, 54, and 73, and Respondent’s Composite Exhibit 1 at 14. [REDACTED] testified that she is looking for another paid DSW worker to assist with Petitioner’s care.

11. In Petitioner’s Florida Department of Elder Affairs 701B Comprehensive Assessments dated from September 22, 2017, through July 10, 2020, [REDACTED] indicated that she provides one hundred and sixty eight (168) hours per week of care to Petitioner, and she experienced no mental or emotional strain in doing so during that timeframe. *See* Petitioner’s Composite Exhibit 1 at pages 42, 60, 79, 98, 117, 124, 157, 178, 197, 217, and 238. In the same 701B Assessments, [REDACTED] indicated that she is “very confident” she will have the ability to continue to provide care for Petitioner and that she is not in financial, emotional or physical crisis. *Id.* [REDACTED] testified that the Florida Department of Elder Affairs 701B Comprehensive Assessments completed prior to July 2020, were accurate relative to the amount of strain she experienced in

caring for Petitioner in the past; however, she asserted that she is experiencing a significant financial strain since the hours were reduced.

12. On June 24, 2020, Respondent issued an NABD reducing Petitioner's personal care services, homemaker services, and adult companion care services. Respondent's Composite Exhibit 1 at page 4. The NABD stated the reason for Respondent's actions as follows:

We determined that your requested services are **not medically necessary** because the services do not meet either of the reason(s) checked below: (See Rule)

...

Meet all of the following criteria for all extended state plan services used for the purposes of maintenance therapy and all other home and community-based services:

1. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs;
2. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available statewide; and
3. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider;

And one of the following:

1. Enable the enrollee to maintain or regain functional capacity; or
2. Enable an enrollee receiving long-term services and supports to have access to the benefits of community living, to achieve person-centered goals, and live and work in the setting of their choice.

...

The facts that we used to make our decision are: Sunshine Health has looked at the member's present care needs and provided home services. The member's present care plan includes:

- 56 hours per week of Personal Care Services
- 14 hours per week of Homemaker Services
- 21 hours per week of Companion Care Services

Based on the assessment of the member's care needs and household and caregiver status, Sunshine Health will reduce Personal Care Services from 56 hour per week to 20 hours per week, a reduction of 36 hours per week of Personal Care Services. Sunshine Health will reduce Homemaker Services from 14 hours per week to 7 hours per week, a reduction of 7 hours per week of

Homemaker Services. Sunshine Health will reduce Companion Care Services from 21 hours per week to 13 hours per week, a reduction of 8 hours per week of companion care Services. The updated care plan approved by Sunshine Health will include:

- 20 hours per week of Personal Care Services
- 7 hours per week of Homemaker Services
- 13 hours per week of Companion Care Services

This decision was made with Sunshine Health Policy LT.UM.09 Long Term Care Ancillary Services Criteria.

Id. at 4 - 6.

13. At hearing, Ms. Murray testified that Petitioner's hours were reduced after a routine review in June 2020, and a determination that based on Petitioner's medical conditions, medical history, and living arrangements, Petitioner was receiving more hours than she needed.

14. Petitioner requested a plan appeal on June 30, 2020, and received an NPAR dated July 14, 2020, upholding Sunshine's decision to reduce Petitioner's personal care services, homemaker services, and companion care services. *Id.* at 69, 75 - 77. The NPAR explained as follows:

On June 30, 2020 we received your timely plan appeal request about Sunshine Health's Notice of Adverse Benefit Determination dated July 4, 2020, Notice of Adverse Benefit Determination Number [REDACTED] REDUCING 56 hours per week of Homemaker Services (the person who helps bathe and dress you), 14 hours per week of Homemaker Services (the person who cleans you) and 21 hours per week of Companion Care Services (the person who helps and watched over you, provided to [Petitioner]).

On June 13, 2020, after consideration of the information you provided to Sunshine Health in support of your plan appeal, Sunshine Health hereby DENIES your plan appeal. As a result, [Petitioner] will not receive 56 hours per week of Personal Care Services (the person who helps bathe and dress you), 14 hours per week of Homemaker Services (the person who cleans for you) and 21 hours per week of Companion Care Services (the person who helps and watches over you), effective July 13, 2020.

The reason for our decision was: Based on the assessment of the member's care needs and household and caregiver status, the reduction of Personal Care Services from 56 hours/week to 20 hours/week is upheld, and the reduction of Homemaker Services from 14 hours/week to 7 hours/week is upheld, and the

reduction of Companion Care Services from 21 hours per week to 13 hours per week is upheld. The presently approved services are enough to meet the member's care needs. This decision was made with Sunshine Health Policy LT.UM.09 Long Term Care Ancillary Service Criteria.

Id. at 75 - 77.

15. On July 7, 2020, [REDACTED] provided a letter stating as follows:

I have been [Petitioner's] rehabilitation physician since 2011. She has anoxic brain injury, resulted in cognitive and physical impairments. She also has mood difficulties, such as anger, irritability, mental inflexibility, and memory loss. As a result of her anoxia, she also has difficulty making new relationships and does not interact well with people she doesn't know. Her mother has been her primary care giver since her injury. Knowing [Petitioner] well, I do not recommend that she receives supervision from anyone else other than her immediate family, such as her mother or aunt. Patient requires 24 hour supervision for safety. This is medically necessary.

Petitioner's Composite Exhibit 2 at page 6.

16. Petitioner is currently approved to receive 20 hours of personal care services weekly, 13 hours of companion care services weekly, and 7 hours of homemaker services weekly.

Respondent's Composite Exhibit 1 at page 75.

17. Dr. Carter is a Long Term Care Medical Director for Sunshine. He is board certified in internal medicine, geriatric medicine, hospice medicine, and palliative care. Dr. Carter testified that Petitioner's June 701B Assessment and July 701B Assessment describe Petitioner's medical conditions and functional difficulties. He asserted that it was the opinion of the Medical Director who initially reviewed the case that Petitioner's previously approved hours are excessive based on her medical needs and home environment. Dr. Carter testified that he also reviewed Petitioner's case and agrees with the reduction of hours.

18. Dr. Carter testified that personal care services are primarily "hands on" services to assist with such activities as bathing, dressing, using the bathroom, and mobility. Dr. Carter argued that

Petitioner is quite independent with all her ADLs and that the reduction will enable 2.5 to 3 hours per day for assistance with ADLs. Dr. Carter argued that this amount of personal care is “more than adequate” to meet Petitioner’s “hands on” care needs.

19. Dr. Carter testified that homemaker services are intended to encompass meal preparation, laundry, and light housekeeping relative to the Petitioner’s specific needs, versus the needs of the household. Dr. Carter asserted that [REDACTED] is performing activities such as light housekeeping, grocery shopping, and preparing meals for the household. Dr. Carter argued that 7 hours weekly is more than adequate to meet Petitioner’s individual homemaker needs given that she lives with her family and has the natural support of her mother who does not work.

20. Dr. Carter testified that companion care services are not intended to be “hands on” services; rather, they are intended to provide supervision or companionship. Dr. Carter asserted that the approved 13 hours weekly give Petitioner 1.5 – 2 hours per day of supervision. He asserted that Petitioner lives with her caregiver, [REDACTED], who provides natural support and has expressed no concerns in the past about being able to continue to care for Petitioner.

21. Ms. Murray testified that she has been a care coordinator with Sunshine for 2 years and Petitioner’s care coordinator for approximately 9 months. Ms. Murray conducted Petitioner’s June and July 701B Assessments via teleconference due to COVID-19 concerns. *Id.* at 33 and 51. Ms. Murray asserted that, based on her experience and observations, the reductions are warranted because Petitioner can complete her ADLs independently or with some assistance. She asserted that Petitioner’s home is well kept and that Petitioner does not require many hours of homemaker services because she lives with her family.

22. ██████ testified that she has observed Petitioner's condition worsening over time. ██████ asserted that Petitioner is at risk of wandering from home and getting lost in the community, and she must be supervised 24/7 for her safety.

23. ██████ is a family friend who has been Petitioner's PDO representative for approximately 8 years. ██████ observed that Petitioner's condition is declining and her OCD symptoms have worsened over time.

24. ██████ testified that she was Petitioner's case worker at Florida Department of Children and Families between the years of 2006 to 2011 and is now a friend of the family. She stated that she sees Petitioner about once per week. ██████ testified that she used to take Petitioner on outings in the community, but she no longer does so because Petitioner has regressed and become less agreeable.

CONCLUSIONS OF LAW

25. 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 the Agency under section 409.285(2)(a).

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

27. Because Respondent is reducing previously approved services, Fla. Admin Code R. 59-1.100(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.)

28. The LTC Policy, incorporated by reference in Fla. Admin. Code R. 59G-4.192, governs Long-Term Care services available under Florida Medicaid. The LTC Policy provides the following with respect to personal care, adult companion care, and homemaker services:

1.1 Description and Program Goal

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

...

1.3.1 Activities of Daily Living (ADLs)

ADLs include:

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

...

1.3.9 Instrumental Activities of Daily Living (IADLs)

When necessary for the recipient to function independently, including:

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

...

1.3.16 Natural Supports

Unpaid supports that are provided voluntarily to the individual in lieu of home and community-based services and supports.

...

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

...

4.2.1.1. 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.

...

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.

LTC Policy at pages 1 - 8.

29. The LTC Policy also addresses medical necessity:

1.3.14 Medically Necessary or Medical Necessity

For the purposes of this policy, the service must meet either of the following criteria:

- (a) Nursing facility services and mixed services must meet the medical necessity criteria defined in Rule 59G-1.010, F.A.C.

(b) All other LTC supportive services must meet all of the following:

- Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs
- Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available statewide
- Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider

And, one of the following:

- Enable the enrollee to maintain or regain functional capacity; or
- Enable the enrollee to have access to the benefits of community living, to achieve person-centered goals, and to live and work in the setting of his or her choice.

LTC Policy at pages 2 – 3.

30. The Florida Medicaid Authorization Requirements Policy, June 2016, ("Authorizations Policy") states in pertinent part, as follows:

1.1 Description

This policy contains general requirements for providers to obtain authorization to render Florida Medicaid services, when applicable.

1.1.1 Florida Medicaid Policies

This policy is intended for use by all providers that render services to eligible Florida Medicaid recipients through the fee-for-service delivery system, unless otherwise specified. It must be used in conjunction with Florida Medicaid's general policies (as defined in section 1.3) and any applicable service-specific and claim reimbursement policies with which providers must comply.

...

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.

1.3.2 Claim Reimbursement Policy

A policy document that provides instructions on how to bill for services.

1.3.3 Coverage and Limitations Handbook or Coverage Policy

A policy document that contains coverage information about a Florida Medicaid service.

1.3.4 General Policies

A collective term for Florida Medicaid policy documents found in Rule Chapter 59G-1 containing information that applies to all providers (unless otherwise specified) rendering services to recipients.

1.3.5 Medically Necessary/Medical Necessity

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

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).

2.4.3 Modifications

Providers must submit a modification request to the QIO to update the authorization when the recipient requires a different level of service (amount, frequency, duration, or scope) than is currently authorized. Providers must submit additional information documenting the need for the change, including an updated physician's order and plan of care (as applicable) with the request.

Authorizations Policy, pages 1 and 3.

31. The Florida Medicaid Definitions Policy (August 2019) ("Definitions Policy"), incorporated by reference in Fla. Admin. Code R. 59G-1.010, defines "Medically Necessary" or "Medical Necessity" as follows:

The medical or allied care, goods, or services furnished or ordered must meet the following conditions:

- Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate pain

- Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs
- Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational
- Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available statewide
- Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider

The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services does not, in itself, make such care, goods or services medically necessary or a medical necessity or a covered service.

32. Respondent relied upon the LTC Ancillary Service Criteria to make its Medical Necessity determination. See Respondent's Composite Exhibit 1, pages 82-112. The LTC Ancillary Service Criteria states as follows regarding Adult Companion Care services:

1. Determinants for Services

When considering the level of support the member requires and which of the ancillary services may support the member's cognitive, functional, environmental, and social needs, several elements are to be considered. The review for the medical necessity of the ancillary services includes consideration of the member's support needed due to ADL deficits, living situation, and supervision needs.

- a) Activities of Daily Living (ADL's)/Instrumental Activities of Daily Living (IADL's)
- Independent where member is able to provide the task without support, with or without assistive devices
 - Minimal functional impairment where the ADL's require one of the following:
 - Supervision
 - At least minimum assistance
 - Member ambulates with assistance of a person or a device
 - Member transfers require at least minimum assistance
 - Moderate functional impairment where two of the follow apply
 - Member has ADLs requiring at least minimal assistance
 - Member ambulates with assistance of a person or device
 - Member transfers require at least minimum assistance

- Maximum and persistent functional impairment without available caregiver support where all of the following exist:
 - Member has ADLs requiring total assistance
 - Member is non-ambulatory
 - Member transfers require one (1) to two (2) person assist
 - Member's treating physician has certified that member meets Maximum functional impairment.

b) Living situation consideration

- Lives alone.
- Lives with family (with consideration of the number of days and hours that family members are not available to assist the member). Lives with non-family (with consideration of the number of days and hours that nonfamily members are not available to assist the member).

c) Supervision needs, including:

- Wandering risk: Member has already been found to leave their home unsafely and/or is unable to find their way back.
- Confused/disoriented and at risk to themselves: Member is confused and/or disoriented to the point that they are unable to perform functional activities, and if they do are at risk of harm to themselves.
- Member has a cognitive impairment that prevents them from knowing when or how to carry out personal care tasks and caregivers are not able to provide the services. The member is incapable of learning despite efforts to train in the care tasks. The member has memory deficits, which prevent them from managing care tasks.
- Member is unable to call for help, even with a personal emergency response unit. Member's medical status will not permit the member to all for help, even with assistance of a personal emergency response unit.

d) Available Supports

- No assistance needed or Always has assistance
- Has assistance most of the time
- Rarely has assistance
- Never has assistance

Services in Place

- Provided by Sunshine Health
- Provided by other Provider insurance

Respondent's Composite Exhibit 1, pages 86 – 87.

33. Appendix 9.1 of the Florida Medicaid Personal care Services Coverage Policy (November 2016) (“PC Policy”) provides review criteria for personal care services. Specifically, the criteria include a chart that first level reviewers use to determine whether the amount of requested personal care services requested will be approved. The chart contains the following pertinent personal care tasks:

Bathing:

...

Partial Bath: A sponge bath includes, at 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

...

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

...

Eating:

Talking in food by any method. Extra time may be allowed for preparing a special diet – 30 minutes per meal.

Personal Care Services

34. In the instant case, Respondent reduced Petitioner’s personal care services from fifty-six (56) hours per week to twenty (20) hours per week. See supra ¶ 12 - 14. As established on the record by the evidence and testimony, Respondent reduced Petitioner’s personal care services, because the documentation submitted in support of Petitioner’s request failed to establish that the requested services were medically necessary. See supra ¶ 12 and 14.

35. Section 4.1 of the LTC Policy provides that Florida Medicaid LTC plans cover services that: are medically necessary, as defined in the SMMC LTC Policy; do not duplicate another service;

and meet the criteria as specified in the SMMC LTC Policy. *See supra* ¶ 28. Section 4.2.2.6 of the SMMC LTC Policy reflects that personal care services are “[t]o 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.” *See supra* ¶ 28.

36. The evidence presented reflects that Respondent’s reduction of personal care services is warranted under the circumstances of this case. Personal care services are generally considered to be “hands on” services to assist with such activities as bathing, dressing, using the bathroom, and mobility. *See supra* ¶ 18 and 28. Specifically, regarding ADLs, the testimony and evidence reflect that Petitioner needs some supervision or prompt when bathing and dressing. *See supra* ¶ 6. The testimony of [REDACTED] and [REDACTED] at hearing clarified that Petitioner is able to dress herself; however, she needs some assistance with undergarments, fasteners, and buttons, and she needs assistance picking out clothing. *See supra* ¶ 6. Petitioner needs no assistance with other ADLs such as eating, using the bathroom, transferring, and walking or mobility. *See supra* ¶ 6. Petitioner’s Care Plan confirms that “she can self feed [and] dress herself with assistance/supervision.” *See supra* ¶ 6. The testimony of [REDACTED] and [REDACTED] also confirmed that Petitioner is able to bathe on her own; however, some supervision or prompt is needed. *See supra* ¶ 6. In sum, as Dr. Carter concluded in his testimony at the Fair Hearing, Petitioner is “quite independent” with her ADLs. *See supra* ¶ 6. The reduction in personal care services enables 2.5 to 3 hours per day for assistance with Petitioner’s ADLs. As discussed *supra* ¶ 33, Appendix 9.1 of the PC Policy contains time duration guidelines for personal care services. Fifteen to twenty (15 – 20) minutes are allowed for a partial bath, fifteen (15) minutes are allowed

for assistance with dressing, and fifteen (15) minutes are allowed for assistance with grooming. The reduction in personal care services is consistent with these criteria, and as Dr. Carter concluded, this amount of personal care is “more than adequate” to meet Petitioner’s “hands on” care needs.

37. Though no documentary evidence was submitted on the issue, at hearing ██████████ argued that she is experiencing a significant financial strain and that the currently approved hours are insufficient to remain financially viable. She testified that if the reductions are not overturned, she will have to obtain work outside the home. *See supra* ¶ 11. However, the evidence indicates that even if Petitioner’s hours are not reduced, ██████████ can only be paid for 40 hours per week as a DSW in the PDO program. *See supra* ¶ 9. Therefore, it does not appear that a reversal would resolve her described financial issue. If ██████████ decides to work outside the home, pursuant to section 2.4.3 of the Authorizations Policy, ██████████ can submit a “modification request” to Respondent “to update the authorization when the recipient requires a different level of service (amount, frequency, duration, or scope) than is currently authorized.” *See supra* ¶ 30. Based on the record in this case, an approval of an excess amount of personal care services hours to address ██████████’s financial concerns would be in conflict with the requirement that the services “[b]e furnished in a manner not primarily intended for the convenience of the recipient, the recipient’s caretaker, or the provider.” Based upon the evidence presented by both parties, Respondent established that a reduction of personal care services was warranted in this matter.

38. Additionally, the Definitions Policy requires that the 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." See supra ¶ 31. Considering the LTC Policy's definitions for personal care services, supra ¶ 35, Respondent demonstrated that Petitioner's aforementioned needs, supra ¶ 2 – 4, 10, and 20, are sufficiently met by her currently authorized personal care services. Given that Respondent established that the reduction of personal care services is warranted in this matter, supra ¶ 21, the requested 56 hours per week of personal care services is "in excess of [Petitioner's] needs." See supra ¶ 15.

39. In light of the both parties' testimony, the evidence submitted, and the applicable policies, the undersigned finds that Respondent met its burden of proving that the 36 hours of personal care services reduced (a reduction from 56 hours per week to 20 hours per week) are not medically necessary for Petitioner.

40. Accordingly, the undersigned Hearing Officer concludes that Respondent proved by a preponderance of the evidence that Respondent's reduction of personal care services was correct.

Homemaker Services

41. In the instant case, Respondent reduced Petitioner's homemaker services from fourteen (14) hours per week to seven (7) hours per week. As established on the record by the evidence and testimony, Respondent reduced the homemaker services because 7 hours per week are "adequate to meet the member's care needs." See supra ¶12 - 14.

42. Section 4.1 of the LTC Policy provides that Florida Medicaid LTC plans cover services that: (a) are determined medically necessary, as defined in the SMMC LTC Policy; (b) do not duplicate another service; and (c) meet the criteria as specified in the SMMC LTC Policy. See supra ¶ 28.

43. The testimony and evidence presented in this case reflect that Respondent's reduction of homemaker services was warranted under the circumstances of this case. Specifically, Petitioner's homemaker services failed to satisfy the medical necessity criteria which requires that the requested services 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." See supra ¶ 29.

44. As stated in the LTC Policy, homemaker services provide for general household activities and routine household care by a trained homemaker, "*when the individual regularly responsible for these activities is temporarily absent or unable to manage these activities*" [emphasis added]. See supra ¶ 28. The record reflects that Petitioner lives with her primary caregiver, [REDACTED], who does not work outside the home, and her family members. See supra ¶ 10. [REDACTED] cares for the household members, supra ¶ 4, and also provides assistance to the Petitioner relative to Petitioner's light housekeeping, shopping, and meal preparation needs, as well as medication. See supra ¶ 7. Petitioner needs total assistance (cannot do at all) with heavy chores, managing money, and using transportation and the telephone. See supra ¶ 7. Further, Petitioner always has assistance with her IADLs. See supra ¶ 7.

45. Dr. Carter testified that he reviewed Petitioner's medical history and current medical needs. See supra ¶ 14. Dr. Carter argued that a reduction in homemaker services is medically appropriate because Petitioner lives with her primary caregiver, [REDACTED], who is already performing activities such as light housekeeping, grocery shopping, and preparing meals for the household. See supra ¶ 19. Dr. Carter testified that, in his professional opinion, Petitioner only

requires 7 hours of homemaker services, rather than the 14 hours that were previously approved in this case. *See supra* ¶ 17 and 19.

46. In light of the fact that [REDACTED] already performs light housekeeping, meal preparation, and grocery shopping for the household, *supra* ¶ 4, 10 and 19, and Petitioner's 701B Assessments, discussed *supra* ¶ 7 and 44, Dr. Carter's testimony that 7 hours of homemaker services would be more than sufficient for Petitioner is credible. *See supra* ¶ 19. As provided above, homemaker services are intended for situations where the individual regularly responsible for those activities is temporarily absent or unable to manage these activities, which at present, appears to not be the case here. Based on the foregoing, Respondent has demonstrated that Petitioner's current level of homemaker services are in excess of the Petitioner's needs. As such, Respondent has shown that 14 hours per week of homemaker services are not medically necessary.

47. Therefore, upon consideration of the testimony provided, evidence submitted, and applicable policies, the undersigned finds that Respondent met its burden of proving that the 7 hours of homemaker services reduced (reduction from 14 hours per week to 7 hours per week) are not medically necessary for Petitioner.

48. Accordingly, the undersigned Hearing Officer concludes that Respondent proved by a preponderance of the evidence that Respondent's reduction of homemaker services was correct.

Companion Care Services

49. Respondent reduced Petitioner's companion care services from twenty-one (21) hours weekly to thirteen (13) hours weekly. *See supra* ¶ 12 and 14. Respondent's rationale for reducing the services was that Petitioner's request failed to meet the requirements of medical necessity;

specifically, Respondent stated that the presently approved services are enough to meet the member's care needs. See supra ¶ 12 - 14.

50. As provided in the LTC Policy, the purpose of adult companion care services is to provide "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." See supra ¶ 28. Companion care is designed to prevent social isolation or to provide supervision to protect the enrollee's safety. See supra ¶ 28.

51. Petitioner is a 41-year-old female who resides with her family members. See supra ¶ 10. Petitioner has a history of anoxic brain injury, and she has been diagnosed with depression, Alzheimer's, dementia, and OCD. See supra ¶ 2. Petitioner has mood difficulties, such as anger, irritability, mental inflexibility, and memory loss. See supra ¶ 3, 8, and 23 - 24. Petitioner's physicians reported that she has cognitive impairment and memory deficits. See supra ¶ 3 - 5. Specifically, Petitioner's most recent Mini-Mental Status Exam shows a score of 23/30, which is one point worse than her score a year ago, when she had a 24/30. She has remained below 25 for every evaluation. See supra ¶ 4. The record evidence and testimony establishes that Petitioner has a history of wandering off and getting lost. See supra ¶ 5, 8 and 22.

52. Respondent argued that the Adult Companion Care services, at issue, were no longer medically necessary based on the 701-B Comprehensive Assessments, the natural support provided by ██████████, Petitioner's LTC services, and the LTC Ancillary Criteria. See supra ¶ 12, 14, 17, and 20. Petitioner is forgetful or easily confused "[n]early every day." See supra ¶ 8. Petitioner gets lost or wanders off and gets easily agitated or disruptive "more than half the days" in a month. See supra ¶ 8. Petitioner threatens or is verbally hostile "several days" a month. See

supra ¶ 8. Petitioner needs some level of supervision due to her cognitive decline, history of wandering, and OCD behavior as well as her anger, irritability, mental inflexibility and mood deficits.

53. Based on the record, Respondent reduced Petitioner's Companion Care services for not meeting section 1.3.14 of the LTC Policy which requires that "LTC supportive services must . . . [b]e individualized, specific, consistent with symptoms or diagnosis of illness or injury and not be in excess of the patient's needs." See supra ¶ 12 - 14, 20 and 29.

54. The record indicates that 21 hours per week of Adult Companion Care services are in excess of the Petitioner's needs. Dr. Carter asserted that Petitioner's caregiver, [REDACTED], does not work outside of the home, lives with the Petitioner, and she has provided natural support to Petitioner in the past. See supra ¶ 17 and 20. In addition, Dr. Carter testified that companion care services are not intended to be "hands on" services; rather, they are intended to provide supervision. See supra ¶ 20. Dr. Carter asserted that the approved 13 hours weekly give Petitioner 1.5 – 2 hours per day of supervision, which is sufficient to meet her needs. See supra ¶ 20.

55. [REDACTED] testified that she is no longer willing to provide natural supports for Petitioner. See supra ¶ 9. Section 1.3.16 of the LTC Policy provides that natural supports are "[u]npaid supports that are provided voluntarily to the individual in lieu of home and community-based services and supports." See supra ¶ 28. [REDACTED] has been Petitioner's primary caregiver for over fifteen years. See supra 2. Petitioner resides in the home with [REDACTED]. See supra ¶ 2. [REDACTED] does not work outside the home. See supra ¶ 2. Since September 2017, [REDACTED] has provided one hundred and sixty-eight (168) hours per week of care for

Petitioner, and she experienced no mental or emotional strain in doing so. *See supra* ¶ 11. Since September 2017, ██████████ indicated that she is “very confident” in her ability to continue to provide care for Petitioner. *See supra* ¶ 11. Thus, although ██████████ testified that she is unwilling to provide natural support, the greater weight of record evidence supports that ██████████ has been willing and able to provide natural supports for Petitioner. ██████████ testified on cross-examination that when Petitioner’s hours were reduced, she continued to provide care for Petitioner. In light of these facts, ██████████’s assertion that she is no longer willing to provide natural support is not credible.

56. Though no documentary evidence was submitted on the issue, ██████████ argued at hearing that the currently approved hours are insufficient to remain financially viable. She testified that if the reductions are not overturned, she will have to obtain work outside the home. *See supra* ¶ 11. However, the evidence indicates that even if Petitioner’s hours are not reduced, ██████████ can only be paid for 40 hours per week as a DSW in the PDO program. *See supra* ¶ 9. Therefore, it does not appear that a reversal would solve her described financial issue. If ██████████ decides to work outside the home, pursuant to section 2.4.3 of the Authorizations Policy, ██████████ can submit a “modification request” to Respondent “to update the authorization when the recipient requires a different level of service (amount, frequency, duration, or scope) than is currently authorized.” *See supra* ¶ 30. Furthermore, to be medically necessary, services must “[b]e furnished in a manner not primarily intended for the convenience of the recipient, the recipient’s caretaker, or the provider.” Based upon the evidence presented by both parties, Respondent established that a reduction of companion care services was warranted in this matter.

57. In addition, although [REDACTED] and Dr. Futchero recommended twenty-four hours of supervision or “monitoring,” supra ¶ 4 and 5, their recommendations alone do not make such services medically necessary. Their recommendations do not include a statement as to the specific type(s) of LTC services Petitioner needs, what the appropriate mix of LTC services would be, or how many hours per week Petitioner needs for each type of service. The recommendations also do not mention what natural supports are available. Based on the testimony and record evidence, Respondent demonstrated that Adult Companion Care services at issue (21 hours per week) are in excess of Petitioner’s needs.

58. Therefore, upon consideration of the testimony provided, evidence submitted, and applicable policies, the undersigned finds that Respondent met its burden of proving that 21 hours per week are not medically necessary for Petitioner.

59. Accordingly, the undersigned Hearing Officer concludes that Respondent proved by a preponderance of the evidence that Respondent’s reduction of companion care services was correct.


IT IS THEREFORE ORDERED AND ADJUDGED THAT:

Respondent’s reduction of personal care service is **AFFIRMED**. Petitioner’s appeal based on Respondent’s reduction is **DENIED**.

Respondent’s reduction of homemaker care services is **AFFIRMED**. Petitioner’s appeal based on Respondent’s reduction is **DENIED**.

Respondent’s reduction of companion care services is **AFFIRMED**. Petitioner’s appeal based on Respondent’s reduction is **DENIED**.

DONE and ORDERED this 18th day of November, 2020, in Tallahassee, Leon County, Florida.

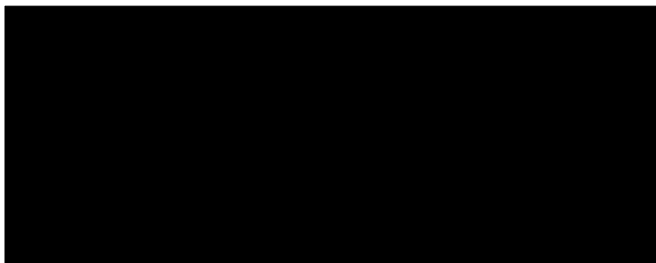

Laura Gallagher
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NOTICE OF A RIGHT TO JUDICIAL REVIEW

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 CHEADQUARTERS 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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