



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

FILED
Nov 18, 2020, 8:29 am
OFFICE OF FAIR HEARINGS

[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 Hearing Officer convened a telephonic Medicaid Fair Hearing in the above styled case on October 6, 2020, at [REDACTED] and October 28, 2020, at [REDACTED]

APPEARANCES

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

For the Respondent: Maria Mojica
Compliance Specialist
Sunshine State Health Plan, Inc.

STATEMENT OF ISSUE

The issue is whether Petitioner proved by a preponderance of the evidence that Respondent's denial of an additional 98 hours per week of personal care services was incorrect.

PRELIMINARY STATEMENT

All parties and witnesses appeared telephonically. [REDACTED], Petitioner's Authorized Representative and sister, appeared at the Fair Hearing and provided testimony on Petitioner's behalf.

Maria Mojica, Compliance Specialist for Sunshine State Health Plan, Inc. ("Sunshine"), appeared for the hearing and represented Respondent. Dr. Heather Lutz ("Dr. Lutz"), Medical Director for Sunshine, provided testimony on behalf of the Respondent. The following individuals also appeared on behalf of Respondent but did not provide testimony: Melissa Layne ("Ms. Layne"), Senior Manager for Member Appeals for Sunshine; Diana Santiago-Romero, Care Coordinator for Sunshine; and Marisol Ciccotelli, Supervisor of Case Management for Sunshine.

Lisa Sanchez, Medical/Health Care Program Analyst for the Agency for Health Care Administration ("Agency" or "AHCA"), appeared for observational purposes.

Prior to the hearing, Petitioner sent a 34-page evidence packet to the Office of Fair Hearings and Respondent. The packet included the following documents: an email from [REDACTED], dated October 15, 2020; a document from the [REDACTED]; a Notice of Ad Valorem Taxes and Non-Ad Valorem Assessments; a letter from [REDACTED] ("[REDACTED]"), dated September 24, 2020; an undated letter from [REDACTED] and [REDACTED]; a blank page; Petitioner's Care Logs; the Public View Property Card; an email from [REDACTED], dated October 15, 2020; and Petitioner's insurance documentation. Absent an objection from Respondent, the undersigned admitted Petitioner's 34-page evidence packet as Petitioner's Composite Exhibit 1.

Prior to the hearing, Respondent sent to the Office of Fair Hearings and Petitioner a 121-page evidence packet. The packet included the following documents: the Medicaid Fair Hearing Table of Content; a Medicaid Fair Hearing Summary, dated September 8, 2020; a Notice of Adverse Benefit Determination (“NABD”), dated February 20, 2020; Sunshine’s care plan, signed by the Care Manager on January 21, 2020; the care plan, signed by the Care Manager on September 2, 2020; the Florida Department of Elder Affairs 701B Comprehensive Assessment (“701B”) with an assessment date of January 21, 2020 (the “1/21/20 701B”); the 701B with an assessment date of August 11, 2020 (the “8/11/2020 701B”); an email from Sherona Bryant to Sunshine Appeals, dated April 20, 2020; a 6-page facsimile transmission (“fax”) from [REDACTED] to Petitioner, dated February 13, 2020; Sunshine’s Standard Appeal Acknowledgment, dated April 24, 2020; the Notice of Plan Appeal Resolution (“NPAR”), dated May 19, 2020; the Sunshine Health Policy and Procedure LT.UM.09; and Fla. Admin. Code R. 59G-1.010. Absent an objection from Petitioner, the undersigned admitted Respondent’s 121-page evidence packet into evidence as Respondent’s Composite Exhibit 1.

FINDINGS OF FACT

1. Petitioner is an enrolled member of Sunshine’s LTC plan. *See* Respondent’s Composite Exhibit 1, page 2. Sunshine is a managed care organization contracted by AHCA to provide services to eligible Medicaid recipients in Florida.
2. Petitioner is an adult male who lives in a private residence. *See* Respondent’s Composite Exhibit 1, page 50.
3. The letter from [REDACTED], Advanced Practice Registered Nurse (“APRN”), Family Nurse Practitioner (“FNP”), dated September 24, 2020, states:

Please provide additional hours of Personal Care and Adult Companion Care hours in order to provide around the clock care - 24 hours per day 7 days per week total. Patient is 58 y/o and is mentally and physically unable to care for himself. History and Diagnoses include: Quadriplegia, Epilepsy, Spondylosis without myelopathy, Expressive Aphasia, Seizure Disorder, Contracture of bilateral hands, Contracture of joint (ankle), Pressure Ulcers (additional Dx below)

...

Dx: (M47.816) Spondylosis without myelopathy or radiculopathy, lumbar region (I10) Essential(primary) hypertension (G40.909) Epilepsy, unspecified, not intractable, without status epilepticus (279.82) Long term (current) use of aspirin (N39.0) Urinary tract infection, site not specified (K59.00) Constipation, unspecified

...

(H04.123) Dry eye syndrome of bilateral lacrimal glands (M21.379) Foot drop, unspecified foot (E87.1) Hypo-osmolality and hyponatremia (R33.9) Retention of urine, unspecified (K31.84) Gastroparesis (G40.909) Epilepsy, unspecified, not intractable, without status epilepticus (N39.0) Urinary tract infection, site not specified (F41.9) Anxiety disorder, unspecified (K29.70) Gastritis, unspecified, without bleeding (M24.549) Contracture, unspecified hand (F32.9) Major depressive disorder, single episode, unspecified (R25.2) Cramp and spasm (E22.2) Syndrome of inappropriate secretion of antidiuretic hormone (F41.9) Anxiety disorder, unspecified (M24.574) Contracture, right foot (R19.7) Diarrhea, unspecified (E72.20) Disorder of urea cycle metabolism, unspecified (711) (R52) Pain, unspecified (C44.92) Squamous cell carcinoma of skin, unspecified (DM20.039) Swan-neck deformity of unspecified finger(s) (03.9) Melanoma in situ, unspecified

Petitioner's Composite Exhibit 1, pages 4 and 5.

4. The email from [REDACTED], dated October 15, 2020 states, "I am an RN and I have been the Home Healthcare Nurse for [Petitioner] for the past 4 years. . . . he would like to be able to remain in his home and to that end he requires 24-hour care." See Petitioner's Composite Exhibit 1, page 30.

5. The 8/11/20 701B reflects the following regarding Petitioner's Activities of Daily Living ("ADLs"). Petitioner requires total assistance with bathing, dressing, eating, using the bathroom,

and transferring. See Respondent's Composite Exhibit 1, page 54. Petitioner uses assistive device for walking/mobility. *Id.*

6. Regarding Petitioner's Instrumental Activities of Daily Living ("IADLs"), the 8/11/20 701B reflects that Petitioner needs total assistance (cannot do at all) with heavy chores, light housekeeping, using the telephone, managing money, preparing meals, shopping, managing medication, and shopping. See Respondent's Composite Exhibit 1, page 55. Petitioner uses an assistive device for using transportation. *Id.*

7. Petitioner is currently authorized to receive the following home and community-based services: 7 home delivered meals per week; 28 hours per week of adult companion care services; 35 hours per week of Patient Directed Option ("PDO") personal care services (does not include the hours requested for this hearing); 1 case per month of underpads; 10 packs per month of wipes; 7 hours per week of homemaker services; 10 hours per week of in home respite care. See Respondent's Composite Exhibit 1, page 26. Included in Petitioner's Composite Exhibit 1 are documents entitled, "[Petitioner] Additional Care Logs" for the dates of "7/22" through "9/30."

8. On February 20, 2020, Respondent issued an NABD denying Petitioner's request for an additional 98 hours per week of personal care services. See Respondent's Composite Exhibit 1, pages 4 – 8. The NABD stated the reason for Respondent's determination was "[w]e determined that your requested services are not medically necessary. . . ." *Id.*

9. Petitioner requested an appeal of Respondent's denial of Petitioner's request for an additional 98 hours per week of personal care services. See Respondent's Composite Exhibit 1, page 77. On May 19, 2020, Respondent sent Petitioner an NPAR, denying Petitioner's plan appeal. *Id.* at 83. The NPAR stated as follows:

On April 20, 2020, we received your timely plan appeal request about Sunshine Health's Notice of Adverse Benefit Determination dated March, 25, 2020, Notice of Adverse Benefit Determination Number [REDACTED], partially denying 112 additional hours a week of Personal Care Services (the person who helps bathe and dress you) provided to [Petitioner].

On May 18, 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 98 additional hours a week of Personal Care Services (the person who helps bathe and dress you), effective May 18, 2020.

The reason for our decision was: Based on the assessment of the member's care needs and household and caregiver status, the denial of the extra 98 hours/week of Personal Care Services is upheld as not medically needed. The presently approved home 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.

This decision was made by a Sunshine Health's Medical Director who is Board Certified in Internal Medicine, Geriatric Medicine, and Hospice & Palliative Care.

Respondent's Composite Exhibit 1, page 83.

10. Petitioner requested a Fair Hearing due to the denial of an additional 98 hours per week of personal care services. On September 3, 2020, the undersigned scheduled the Fair Hearing for October 6, 2020, at [REDACTED], and all parties were duly notified. During the October 6, 2020, Fair Hearing, [REDACTED] requested a continuance, which was granted. On October 8, 2020, the undersigned rescheduled the Fair Hearing for October 28, 2020, at [REDACTED], and all parties were duly notified.

11. [REDACTED] is Petitioner's sister. Petitioner resides alone, and his mother is deceased. [REDACTED] believes that Petitioner requires 24-hour care. Petitioner's primary caretakers are [REDACTED], [REDACTED]'s sister, and a home health aide. Petitioner is never left alone, and either [REDACTED], her sister, or Petitioner's home health aide is with him at all times. The home

health aide provides Petitioner's care for 10 hours a day on Fridays, Saturdays, and Sundays, and 5 hours per day on Mondays. [REDACTED] provides care to Petitioner from 5:00 p.m. to 10:00 p.m. on Mondays. On Tuesdays, [REDACTED] provides PDO homemaker services to Petitioner from 9:30 a.m. to 11:30 a.m., and PDO adult companion care services from 11:30 a.m. to 7:30 p.m. On Wednesdays and Thursdays, [REDACTED]'s sister provides PDO adult companion care services to Petitioner from 9:30 a.m. to 7:30 p.m.

12. Dr. Lutz is a Medical Director for Sunshine. Dr. Lutz testified that the additional 98 hours per week of personal care services was denied because Petitioner's current hours are appropriate, and 2 family members are Petitioner's caregivers. Dr. Lutz explained that to prevent caregiver burnout, Sunshine offered adult daycare which was declined; and Sunshine also offered to transition the PDO hours to agency care, which was declined.

13. [REDACTED] testified that nothing was declined, and that "we" did not decline Sunshine's offer to transition PDO hours to agency care.

CONCLUSIONS OF LAW

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

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

16. The burden of proof in this proceeding is governed by Fla. Admin Code R. 59G-1.100(17)(g), which provides as follows:

The burden of proof is on the party asserting the affirmative of an issue, except as otherwise required by statute. The burden of proof is on the Agency or plan,

whichever is applicable, when the issue presented is the suspension, reduction, or termination of a previously authorized service. The burden of proof is on the recipient or enrollee, when the issue presented is the denial or a limited authorization of a service. The party with the burden of proof shall establish its position to the satisfaction of the Hearing Officer by a preponderance of the evidence.

17. Because Petitioner is requesting additional services, so in 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.).

18. The Florida Medicaid policy that applies to the requested services is the Florida Medicaid Statewide Medicaid Managed Care Long-term Care Program Coverage Policy (“March 2017”) (“SMMC LTC Policy”). The Agency’s SMMC LTC Policy has been incorporated, by reference, into Florida Administrative Code Rule 59G-4.192. The SMMC 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.

...

1.3.16 Natural Supports

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

...

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 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.

...

4.2.1.15 Respite Care

The provision of services on a short-term basis due to the absence of, or need to relieve, the enrollee's natural supports on a planned or an emergency basis.

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.

...

6.0 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.

SMMC LTC Policy, pages 1-8.

19. The Florida Medicaid Definitions Policy (August 2017) (“Definitions Policy”), which is incorporated by reference in Fla. Admin. Code R. 59G-1.010, defines “medical necessity” as follows:

2.83 Medically Necessary or Medical Necessity

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

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

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

20. In the instant case, Respondent denied Petitioner’s request for an additional 98 hours per week of personal care services. *See supra* ¶ 8 and 9. As established on the record by the evidence and testimony, Respondent denied Petitioner’s request for an additional 98 hours of personal care services per week, because the documentation submitted in support of Petitioner’s request failed to establish that the requested services were medically necessary. *Id.*

21. Section 4.1 of the SMMC 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* ¶ 18. 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 ¶ 18.

22. The evidence presented in this case does not reflect that Petitioner is in need of an additional 98 additional hours per week of personal care services. Specifically, regarding ADLs, Petitioner uses assistive device for walking/mobility, but requires total assistance with bathing, dressing, eating, using the bathroom, and transferring. See supra ¶ 5. Regarding IADLs, Petitioner uses assistive device for using transportation, but needs total assistance (cannot do at all) with heavy chores, light housekeeping, using the telephone, managing money, preparing meals, shopping, and managing medication. and shopping. See supra ¶ 6. Petitioner lives alone in a private residence, and has multiple medical conditions. See supra ¶ 2 and 3. [REDACTED] believes that Petitioner requires 24-hour care. See supra ¶ 11. However, Petitioner is never left alone, as either [REDACTED], her sister, or Petitioner's home health aide is with Petitioner at all times. See supra ¶ 11. The record reflects that Petitioner's home health aide provides Petitioner's care for 10 hours a day on Fridays, Saturdays, and Sundays, and 5 hours per day on Mondays, while [REDACTED] and her sister provide the following care: [REDACTED] provides care to Petitioner from 5:00 p.m. to 10:00 p.m. on Mondays; on Tuesdays, [REDACTED] provides PDO homemaker services to Petitioner from 9:30 a.m. to 11:30 a.m., and PDO adult companion care services from 11:30 a.m. to 7:30 a.m.; and on Wednesdays and Thursdays, [REDACTED]'s sister provides PDO adult companion care services to Petitioner from 9:30 a.m. to 7:30 p.m. *Id.* Dr. Lutz testified that the additional 98 hours per week of personal care services were denied because Petitioner's current hours are appropriate, and 2 family members are Petitioner's

caregivers. *See supra* ¶ 12. Petitioner did not specify, nor clarify, the specific hours of the day or night for which the Petitioner is seeking the additional 98 hours per week of personal care services. Although Petitioner provided “[Petitioner] Additional Care Logs” for the dates of “7/22” through “9/30,” *supra* ¶ 7, Petitioner offered no substantive testimony on how the denial of the additional personal care services will impact his ability to manage his ADLs and IADLs. As such, Petitioner failed to justify the approval of the 98 additional hours of personal care services weekly. Based upon the evidence presented by both parties, Petitioner failed to establish that the requested personal care services are warranted in this case.

23. Section 1.3.14 of the SMMC LTC Policy 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* ¶ 18. Petitioner is currently authorized to receive the following home and community-based services: 7 home delivered meals per week; 28 hours per week of adult companion care services; 35 hours per week of Patient Directed Option (“PDO”) personal care services (does not include the hours requested for this hearing); 1 case per month of underpads; 10 packs per month of wipes; 7 hours per week of homemaker services; 10 hours per week of in home respite care. *See supra* ¶ 7. Considering the SMMC LTC Policy’s definitions for natural supports, adult companion care services, homemaking services, home delivered meals, and personal care services, *supra* ¶ 18, Petitioner did not demonstrate that his aforementioned needs, *supra* ¶ 3-6, and 22, are not sufficiently met by his currently authorized services. Further, given that Petitioner failed to establish that the requested homemaker services and personal care services are warranted in

this matter, *supra* ¶ 23, the requested adult homemaker and personal care services are “in excess of [Petitioner’s] needs.” *See supra* ¶ 18.

24. The letter from ██████ states, “[p]lease provide additional hours of Personal Care and Adult Companion Care hours in order to provide around the clock care - 24 hours per day 7 days per week total.” *See supra* ¶ 3. The email from ██████ reflects that Petitioner “requires 24-hour care.” *See supra* ¶ 4. However, section 2.83 of the Definitions Policy mandates that “[t]he 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.” *See supra* ¶ 19. Therefore, the letter from ██████ and the email from ██████ do not, in themselves, make the requested personal care services medically necessary. In this case, the record reflects that Petitioner is never left alone, as either ██████, her sister, or Petitioner’s home health aide is with Petitioner at all times. *See supra* ¶ 11.


25. In light of the both parties’ testimony and evidence, the SMMC LTC Policy, the Authorization Requirements Policy, and the Definitions Policy, the undersigned Hearing Officer finds that Petitioner failed to meet his burden of proving the additional 98 hours per week of personal care services are medically necessary. Accordingly, the undersigned Hearing Officer finds that Petitioner failed to prove by a preponderance of the evidence that Respondent’s denial of the requested additional personal care services was incorrect.

DECISION

Respondent’s denial of an additional 98 hours per week of personal care services is **AFFIRMED**.

Petitioner’s appeal based on Respondent’s denial in this matter is **DENIED**.

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

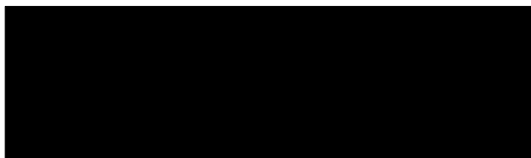
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NOTICE OF A RIGHT TO JUDICIAL REVIEW

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.

COPIES FURNISHED TO:



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