STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

ALEJANDRO ABARCA AND ANA PAULINO, AS PARENTS AND NATURAL GUARDIANS OF IAN ABARCA, A MINOR,

Petitioners,

vs. Case No. 17-5571N

FLORIDA BIRTH-RELATED NEUROLOGICAL INJURY COMPENSATION ASSOCIATION,

Respondent,

and

OSCEOLA REGIONAL MEDICAL CENTER,

Intervenor.
_____/

FINAL ORDER

Pursuant to notice, a final hearing was conducted by Zoom Conference on September 1, 2020, before Administrative Law Judge (ALJ) Todd P. Resavage of the Division of Administrative Hearings (DOAH).

APPEARANCES

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## STATEMENT OF THE ISSUES

For the purpose of determining compensability, whether the injury claimed is a birth-related neurological injury and whether obstetrical services were delivered by a participating physician in the course of labor, delivery, or resuscitation in the immediate post-delivery period in the hospital; and whether notice was accorded to the patient, as contemplated by section 766.316, Florida Statutes, or whether the failure to give notice was excused because the patient had an emergency medical condition, as defined in section 395.002(8), Florida Statutes, or the giving of notice was not practicable.

## PRELIMINARY STATEMENT

On October 2, 2017, Petitioners filed a *pro se* Petition for Benefits Pursuant to Florida Statute Section 766.301 et seq. (Petition) with DOAH for a determination of compensability under the Florida Birth-Related Neurological Injury Compensation Plan (Plan).

The Petition named Michael R. DeNardis, D.O. (Dr. DeNardis), as the physician who provided obstetrical services during the birth of Ian Abarca (Ian) on September 28, 2016, at Osceola Regional Medical Center (ORMC) in Kissimmee, Florida.

On October 19, 2017, DOAH mailed a copy of the Petition to Respondent, the Florida Birth-Related Neurological Injury Compensation Association

(NICA), as well as Dr. DeNardis and ORMC by certified mail. The certified receipts indicate the same was served on Dr. DeNardis on October 20, 2017, and ORMC on October 23, 2017. Respondent was served on or before November 16, 2017.

On November 2, 2017, ORMC filed a Motion to Intervene that was granted on November 14, 2017. On December 11, 2017, Respondent moved for additional time in which to respond to the Petition. On December 19, 2017, that Motion was granted.

On January 24, 2018, Respondent filed its Response to the Petition, suggesting that the subject claim was not compensable because Ian had not suffered a birth-related neurological injury, and requested a final hearing to address said issue. On January 25, 2018, an Order requiring the parties to advise as to the need for a final hearing was entered. After several unsuccessful attempts to receive communication from Petitioners, on May 25, 2018, a telephonic status conference was held. Petitioners chose not to attend same. On May 31, 2018, Intervenor and Respondent provided dates for a final hearing to occur in December 2018.

On June 22, 2018, Intervenor filed an Application for Discovery, which was granted on June 25, 2018. Several days later, Intervenor propounded written discovery on Petitioners, including interrogatories, and then requested dates for the deposition of Petitioners and a medical examination of Ian. On September 6, 2018, Intervenor filed a Motion to Appear and Show Cause and Motion to Compel Petitioners' Depositions, Answers to Interrogatories, and Production of the Minor for Independent Medical Examination.

On September 12, 2018, counsel for Petitioners filed an appearance and requested additional time to respond to Intervenor's discovery. On September 18, 2018, an Order granting Intervenor's Motion, in part, and denying Petitioners' request for additional time was entered where the undersigned required the Petitioners to "properly respond or object to all outstanding discovery within thirty (30) days."

On October 18, 2018, Petitioners served Answers to Intervenors Interrogatories. On November 13, 2018, Intervenor filed its notice of taking the depositions of Petitioners. On December 21, 2018, Petitioners served Amended Answers to ORMC's Interrogatories. On January 16, 2019, Petitioners appeared for depositions and provided testimony. The next day, on January 17, 2019, Petitioners filed an Amended Petition "under protest." On January 31, 2019, Intervenor filed a Motion to Compel Discovery and Motion for Sanctions, which was amended on February 13, 2019.

On February 14, 2019, a telephonic hearing on Intervenor's Amended Motion to Compel Discovery and Motion for Sanctions was held. On February 18, 2019, an Order Accepting the Amended Petition and an Order on Intervenor's Motion to Compel Discovery and Motion for Sanctions related to written discovery were entered.

On April 26, 2019, Ian presented to a Compulsory Medical Examination (CME) with Maria Gieron, M.D., Intervenor's pediatric neurology expert. On May 6, 2019, Dr. Laufey Siguardardottir, M.D., provided deposition testimony on behalf of Respondent.

On June 14, 2019, this matter was first scheduled for final hearing to occur on October 2 and 3, 2019, pursuant to a Notice of Hearing. However, the final hearing was continued secondary to outstanding discovery and the

unavailability of counsel. After several additional continuances, the final hearing was rescheduled via Zoom Conference to occur on September 1, 2020.

On August 28, 2020, the parties' Joint Pre-Hearing Stipulation was filed. The final hearing proceeded, as scheduled, on September 1, 2020. At the final hearing, the parties moved, without objection, for the admission of the following exhibits: Joint Exhibit Numbers 1 through 11; Respondent's Exhibit Numbers 1 through 6; and Intervenor's Exhibit Numbers 1 through 21, and 23 through 25. Said exhibits were admitted.

The parties further mutually agreed to the admission of the stipulated facts as set forth in Paragraph 5 of the parties' Joint Pre-Hearing Stipulation. Testimony was received from Dr. Sigurdardottir. In lieu of presenting additional live testimony, the parties stipulated and mutually agreed to the presentation of their respective cases solely by the admission of the aforementioned exhibits, which included transcripts of witness depositions, and the presentation of a closing argument.

Upon the conclusion of the final hearing, the parties stipulated to the submission of proposed final orders within 30 days of the filing of the transcript and to the issuance of the undersigned's Final Order on or before 60 days from the filing of the transcript. The transcript was filed on September 23, 2020. Respondent and Intervenor timely filed proposed final orders, which have been considered in the preparation of this Final Order.

## FINDINGS OF FACT

Pursuant to the parties' Joint Pre-Hearing Stipulation, the Findings of Fact set forth verbatim in paragraphs 1 through 5 are stipulated to by the parties.

1. Ian was born alive on September 28, 2016.

2. Ian was a single gestation, weighing 2,620 grams at birth.

3. Ian was born at ORMC, which was and is a NICA participant.

4. Dr. DeNardis, the delivering physician, was a NICA participant at the time of birth.

5. Resident physicians, Nnenna J. Maduforo, D.O., and Samantha Bunting, D.O., who assisted in the delivery, were exempt from the NICA assessment, pursuant to section 766.314(4)(a).

Compensability:

6. Petitioner, Ana Paulino, presented to ORMC at 37 to 38 weeks gestational age with complaints of numbness of the right arm and face and a headache and was admitted for hypertension. She was placed on a fetal heart rate monitor, which failed to detect heart tones. Ian was then delivered by emergent Cesarean section after a placental abruption.

7. Ian was severely depressed at birth. At one minute of life, Ian's Apgar score was 0.[1] The Apgar score was also 0 at 5 and 10 minutes with resuscitative efforts. By 15 minutes, his Apgar score was 2 out of 10.

8. Ian required cardiorespiratory resuscitation, including positive pressure ventilation, chest compressions, and intravenous epinephrine. A heart rate of 80 bpm was noted at 15 minutes of life. Initial blood sugar measurements were undetectable.

9. He was quickly transferred from the operating room to the neonatal intensive care unit (NICU). The attending neonatologist, Ronald B. Holtzman, M.D.'s plan was to transfer Ian to Nemours Children's Hospital (Nemours) for ongoing hypothermia treatment. At the time of the transfer, Dr. Holtzman's Clinical Note stated, in pertinent part, as follows:

> Hypoxic-Ischemic Encephalopathy [(HIE)]: this infant was delivered by emergency cesarean section

[1] An Apgar Score is a numerical expression of the condition of the newborn and reflects the sum total of points gained on an assessment of heart rate, respiratory effort, muscle tone, reflex irritability, and color. *See Bennett v. St. Vincent's Med. Ctr., Inc.*, 71 So 3d 828, 848 n.2 (Fla. 2011).

> following an apparent abruption placenta and fetal bradycardia. He may have been bradycardic for as long as 25 minutes before he responded to high dose epinephrine. He has no spontaneous respirations or movements, absent tone and reflexes. Assessment: severe HIE sufficiently severe to meet criteria for hypothermia treatment. Infant is at risk for brain injury, as well as multi-system organ injury.

10. Ian arrived at Nemours' NICU later in the evening on September 28, 2016. As documented on the History and Physical, Ian's diagnosis included hypoxic ischemic encephalopathy (HIE) with the plan for neurology consultation.

11. The initial neurology consultation was performed by Matthias Zinn, M.D., on September 29, 2016. The History of Present Illness documented "[a] head ultrasound shows possible early swelling in the basal ganglia. He is noted to be very tremulous." Upon arrival, Ian was placed on video electroencephalography (EEG) monitoring that demonstrated seizure activity. Dr. Zinn's assessment was severe HIE with multifocal seizures.

12. On October 3, 2016, an MRI of Ian's brain was performed at Nemours. The impression of that study included "Symmetrical areas of restricted diffusion involving bilateral thalami, corpus callosum, dorsal brainstem as well as the cortex/subcortical white matter of bilateral posterior parietal and occipital lobes, in keeping with changes related to hypoxic ischemic injury."

13. On October 10, 2016, Dr. Siguardardottir, who is board certified in child neurology and pediatrics, evaluated Ian at Nemours as an attending pediatric neurology specialist. At that time, she recommended decreasing anti-seizure medication. Dr. Siguardardottir discussed the "very abnormal" MRI results from the October 3, 2016, MRI with Petitioners and documented her diagnosis of severe HIE and neonatal seizures.

14. On October 16, 2016, another neonatologist, Yahdira Pardo Rodriguez, M.D., documented as follows:

> Follow up EEG [wa]s completed [on] 10/14 and revealed "The background activity is significant for the presence of dysmaturity, primarily in the form of excessive discontinuity, indicating a widespread area of cortical or subcortical dysfunction as may be present in the setting of a severe nonspecific encephalopathy. No clinical, electrographic or electroclinical seizures are present during this study. In comparison to prior studies, there is decreasing interburst intervals during discontinuity of the background activity."

15. Following his discharge, Ian began seeing Pilar Gonzales, M.D., a pediatrician, on November 9, 2016. Dr. Gonzales diagnosed, among other things, microcephaly and referred Ian to physical therapy (PT), occupational therapy, and speech therapy. Ian was enrolled in outpatient PT through Nemours with the goals of treatment to have the ability to sit independently in six months, lie prone for up to two hours daily, roll prone to supine and vice versa, and to hold his head midline while prone.

16. On June 2, 2017, after completing eight sessions, Ian was discharged from PT. The progress note, completed by Amber Yampolsky, physical therapist, documented that Ms. Paulino was "pleased with how well Ian is doing and very thankful." It was noted that he had met his goals with respect to rolling supine to and from prone independently; sitting independently while holding toys; and reaching for toys elevated off the surface in prone. Ms. Yampolsky's assessment provided as follows:

> Ian is demonstrating appropriate emerging skills for transitions in/out of side sitting, belly crawling, and quadruped. His ankle dorsiflexors are still stiff/tight but it is improving. He is demonstrating age appropriate stationary and locomotion gross motor skills based on Peabody standardized testing. Since his emerging skills are also appropriate, it is felt that patient no longer requires further PT treatment. Given his birth history, he will require continuing monitoring by

> family and his pediatrician and if any issues or concerns arise, he should be re-evaluated in PT.

17. During his newborn hospital course testing, it was suspected that Ian exhibited bilateral sensorineural hearing loss (SNHL). On December 30, 2016, Ian was diagnosed with mild SNHL in both ears. At four months old, on February 6, 2017, he was fitted for hearing aids.

18. On October 23, 2018, Chelsea McNee, Au.D., a pediatric audiologist with Nemours, conducted a follow-up auditory examination. She documented that, as of that date, Ian had "[m]oderate to moderately-severe hearing loss from 500-4000 Hz in right ear and mild to moderate hearing loss from 500-4000 Hz in left ear." She recommended, inter alia, that he wear both hearing aids during all waking hours and to continue auditory verbal therapy.

19. As noted above, Ian was referred for a speech and language evaluation by Dr. Gonzales. The first evaluation was conducted by Kelly Komisaruk, a speech language pathologist (SLP), on December 8, 2016, when Ian was approximately two and a half months old. At that time, Ms. Komisaruk's evaluation summary documented that, Ian "is developing well at this time regarding language and feedings skill," and recommended repeat testing in six months to one year.

20. On June 21, 2018, when Ian was approximately 20 months old, he began speech language and pathology treatment with Elizabeth Hernandez-DeJesus, SLP. In her summary findings, Ms. Hernandez-DeJesus documented, in pertinent part, as follows:

> Evaluation findings: Ian is a 20 month old male with a communication delay secondary to bilateral sensorineural hearing loss. When compared to same aged peers who have typical hearing, Ian presents with: auditory perception deficits, receptive language skills that are mildly delayed, expressive language skills that are moderately delayed. . . .

> Functional Limitation: Ian had difficulty with Communication/Self Direction/Interpersonal Skills due to auditory perception deficits, poor comprehension, limited expressive skills, and limited phonemic repertoire.

21. At the time of the evaluation, Ms. Hernandez-DeJesus established short and long-term goals designed to address his auditory, receptive language, and expressive language skills. A review of the PT records reveals that he had made little improvement. Indeed, as of September 10, 2019, Ms. Hernandez-DeJesus documented that Ian had not met the goals she had established 15 months prior.

Retained Experts:

22. Respondent retained Ronald Willis, M.D., a board certified obstetrician and gynecologist specializing in maternal-fetal medicine, to review Ian's medical records and opine as to whether he has sustained an injury to his brain in the course of labor, delivery, or in the immediate post-delivery period due to oxygen deprivation or mechanical injury. On or about November 13, 2017, Dr. Willis completed his records review and authored a report that included his findings and opinions. The summary section of his report provides as follows:

> In summary, the mother had a placental abruption at 37 to 38 weeks gestational age. The baby was severely depressed at birth with Apgar scores of 0/0/0. The newborn hospital course was complicated by multi-system organ failures. MRI was consistent with HIE.
>
> It does not appear the mother was in labor at time of placental abruption. This was based on no reported complaint of abdominal pain and the Labor and Delivery Summary stating there was "no labor." I was not able to find a cervical exam for the mother on admission. This would not be unexpected based on the history of fetal bradycardia in Triage and being rushed for emergency delivery.

> Placental abruption occurred prior to onset of labor. Although some oxygen deprivation likely occurred prior to delivery, the oxygen deprivation continued during delivery and continuing into the post delivery period. The oxygen deprivation resulted in brain injury. I am not able to comment about the severity of the injury.

23. Dr. Willis was deposed on February 19, 2019, and testified that the findings and opinions contained in his report were accurate. Specifically, he opined that there was an injury to Ian's brain associated with oxygen deprivation that occurred during the course of delivery or resuscitation of the infant during the immediate post-delivery period; and that the same occurred in a hospital. Dr. Willis further opined that Ian weighed over 2,500 grams at the time of birth and that the brain injury was not due to any genetic abnormality.

24. When questioned regarding the degree that Ian was depressed at birth, the following exchange occurred:

> Q. All right. So the baby's born and then we do resuscitation measures, including positive pressure – pressure ventilation, chest compression, epinephrine, right?
>
> A. Correct.
>
> Q. So would it be fair to say in layman's terms that this child was born basically dead and they resuscitated the child back to life?
>
> A. Yes. The baby was born with no heartbeat and was resuscitated back to life, yes.
>
> Q. And if the baby was not resuscitated back to life this baby would have been pronounced dead, right?
>
> A. Yes; in all likelihood, that's correct.
>
> * * *

> Q. Apgar scores were 0 upon birth, right?
>
> A. Correct.
>
> Q. And that's at birth or a minute post birth, 0, 0, 0, 2?
>
> A. That would be at 1 minute, 5 minutes, and 10 minutes; and then at 15 minutes, the baby had a heartbeat.
>
> * * *
>
> Q. Well, they brought the baby back to life at 15 minutes with all kinds of resuscitation measures, right?
>
> A. Right. So during that time period, I mean, there is no – there is no detectable heart rate, but they are doing resuscitation, so there is blood flow circulating during that time. But the initial heart rate was – the spontaneous heart rate was detected at 15 minutes.

25. The undersigned finds that Dr. Willis possesses significant education, training, and expertise and is well-qualified and credentialed to render the above-noted opinions. The undersigned finds his opinions as stated above to be credible.

26. Following Ian's discharge from Nemours, Dr. Siguardardottir continued to follow him on an outpatient basis on several occasions from November 14, 2016, through November 2, 2017. On his last visit, Dr. Siguardardottir documented her findings, in part, as follows:

> Ian Paulino is a 13-month-old, ex-27-week infant with severe HIE and neonatal seizures who presents for follow up. All has been well and he is developing well. He is off the PHB and the caretakers have not seen any recent seizure like events. He is now crawling and pulling to stand. He

was discharged from PT here at NCH, but is now not receiving any therapy.

* * *

. . . The patient did have significant neurologic abnormalities throughout his stay. A brain MRI showed severe abnormalities, including a subacute extra-axial hematoma in the right occipital regions and restricted diffusion. An EEG did show seizure activity. Follow up MRI did show significant improvement in diffusion restriction.

* * *

Hearing testing was attempted but he failed and has now been diagnosed with hearing loss and uses hearing aids, something that is likely to be a permanent need.

* * *

Examination: Ian is a beautiful, non-dysmorphic boy, but his head circumference is small. His anterior fontanelle is very small, and there is some overriding of sutures. . . .

* * *

Neurologic Examination: Mental Status: The patient is awake and alert and does exhibit visual fixation and full tracking. He seems to hold his head at midline, with no tendency to lay with it over to the right or the left.

Cranial Nerves: He has intact oculocephalic reflexes and a good suck and swallow. He does not look to sounds from stratus translation device. Motor exam reveals normal axial muscle tone. There is no slip through on vertical suspension. He can grab for toys and rolls over and sits unassisted. He can crawl and even pull to stand. DTRs are normal.

> Assessment and Plan: Here, we have a youngster with an emergent birth after a placental abruption, leading to severe hypoxic ischemic encephalopathy (HIE). At this time, he seems to be developing well. I will ask mom to call Early Steps for an evaluation, although it is not clear that he will qualify for services.

27. Subsequent to her role as a treating physician for Ian, Respondent retained Dr. Sigurdardottir to review the available medical records, conduct a neurological examination, and opine as to whether Ian met the criteria for a birth-related neurological injury. Dr. Sigurdardottir conducted her examination of Ian on January 10, 2018, when he was approximately 15 months old. Dr. Sigurdardottir's report begins with a summary of the subject pregnancy and birth, then provides the following developmental history:

> Ian had delays in gross motor milestones but showed good progress and was discharged from NCH PT in June 2007 at age 9 months. Discharge describes him as follows: "Ian is demonstrating appropriate emerging skills for transitions in/out of side sitting, belly crawling, and quadruped. His ankle dorsiflexors are still stiff/tight but it is improving. He is demonstrating age appropriate stationary and locomotion gross motor skills based on Peabody standardized testing. Since his emerging skills are also appropriate, it is felt that patient no longer requires further PT treatment." He currently walks unassisted (skill developed at 14 months of age). He can finger feed himself and drinks from bottle. He has one word "NaNa," will shake his head for no and open palms for yes. He will not follow verbal commands but looks to voice and is interested in his siblings. He was evaluated with Bayley Scales of infant and toddler development [sic] (3rd edition) at age 4 months in NICU developmental clinic and found to have emerging skills with total raw scores 4-5 in areas of cognitive, receptive communication, expressive communication, fine motor and gross motor domains. Apart from developmental concerns

> patient has been diagnosed with sensorineural hearing loss and currently wears and benefits from hearing aids.

28. Dr. Sigurdardottir's report memorialized the neurological examination as follows:

> Mental Status: The patient is awake and alert and does not exhibit visual fixation and full tracking. He does have verbalization but is mostly roaming exam room. He does look to voice. His hearing aids were not in place. No repetitive behavior, no following of verbal commands other than to give high five, wave bye bye and clap.
>
> Cranial Nerves: He has intact oculocephalic reflexes and conjugate voluntary eye movements, no nystagmus. Motor exam reveals normal axial muscle tone. There is no slip through on vertical suspension. He can grab for toys and manipulate them in age appropriate manner and does prefer to grab toys with left. Gait is unsteady at times and he does trip frequently. DTRs are normal.

29. Dr. Sigurdardottir's report included the following summary:

> Summary: Patient is a 15 month old with history of being born at 37 weeks after sudden placental abruption, loss of fetal heart tones requiring a hyperacute cesarean section. Severe birth asphyxia was well documented, requiring full cardiorespiratory resuscitation, completion of cooling protocol and patient exhibited multisystem organ failure and neonatal seizures as a consequence. The patient had early delays in development but has been discharged from therapy and currently has only mild delays in expressive language. I cannot establish a substantial mental or motor disability at this time.
>
> Result as to question 1: Ian is not found to have substantial delays in motor and mental abilities.

> Result as to question 2: In review of available documents, there is evidence of impairment consistent with a neurologic injury to the brain or spinal cord acquired due to oxygen deprivation or mechanical injury. It seems unclear if the mother was in active labor at the time of placental abruption but it is clear that the event was progressing after the mother presented to ORMC with complaints of abdominal pain. I would consider this event a birth related event.
>
> Result as to question 3: The prognosis for full motor and mental recovery is fair and the life expectancy is full.
>
> In light of evidence presented I believe Ian does not fulfill criteria of a substantial mental and physical impairment at this time. Therefore I do not feel that Ian should be included in the NICA program. I am available for any additional questions, or to review additional medical records if needed.

30. Based on the above-quoted findings and opinions, Respondent's Response to the Petition suggested that, based on its review of the claim, Ian had not suffered a "birth-related neurological injury," as defined in section 766.302(2), and, therefore, the claim was not compensable under the Plan.

31. Dr. Sigurdardottir was deposed on May 6, 2019, and testified that the findings and opinions contained in her report were accurate at the time of the examination. She testified that she had not examined Ian subsequent to the examination and possessed no additional knowledge of his condition. Accordingly, she opined, to a reasonable degree of medical probability that, at the time of the examination, Ian had not sustained a permanent and substantial mental or physical impairment. She further opined that there was no evidence that Ian's injuries were sustained due to any genetic or congenital abnormality.

32. When questioned concerning her opinion that Ian did not fulfill the criteria of a permanent and substantial physical impairment, Dr. Sigurdardottir was asked to define those terms. The following exchange transpired:

> Q. What is your definition of a physical impairment?
>
> A. So a physical impairment is inability to do the age appropriate fine and gross motor skills.
>
> * * *
>
> Q. How about hearing loss, is that a physical impairment?
>
> A. That is considered a physical impairment, yes.
>
> * * *
>
> Q. How about when we were talking about before that hearing loss is a physical impairment?
>
> A. Yeah, it just would not bring you in to a substantial physical impairment or motor impairment.
>
> * * *
>
> Q. Okay. Why do you believe that hearing loss is not substantial?
>
> A. It's – a substantial physical impairment renders – in my opinion, renders the person totally unable to take care of their physical needs. And I do not believe hearing impairment or total hearing loss renders one unable to take care of themselves.

33. Subsequent to her deposition, Dr. Sigurdardottir was provided with additional medical treatment records, as well as two videos of Ian. At final hearing, based on her review of the additional information and the passage of

time, Dr. Sigurdardottir opined that Ian does, in fact, have a permanent and substantial mental impairment.

34. At hearing, Dr. Sigurdardottir defined "mental impairment" as intellectual disability, which includes verbal, nonverbal, and adaptive functioning. Clinically, she explained that she uses the terms "mild," "moderate," "severe," and "profound" when describing the range of intellectual disabilities. She further testified that the term "substantial" in this context would fall on the spectrum from severe and into the profound. She also defined "substantial" as "significantly great."

35. Dr. Sigurdardottir testified that the records demonstrate that the trajectory of Ian's language acquisition is poor. Additionally, she opined that Ian possesses autistic features, which were "possibly slightly emerging" at the time of her IME, and have now become "very clear based on the record."

36. Her opinion, however, remained consistent with her prior testimony regarding physical impairment. She continued to opine that Ian does not have a permanent and substantial physical impairment. At hearing, she defined "physical impairment" as follows:

> So, a physical impairment is when you do not have control of or ability to use your muscles in, sort of, the activities of daily living and that that compromises your ability to take care of yourself in an age-dependent kind of manner. Obviously, when you are small, you do less for yourself than later on.

37. She further agreed that a physical impairment is the inability to do age-appropriate fine and gross motor skills; however, the inability would need to be severe.

38. Ian is not substantially physically impaired, in her opinion, because: 1) he has been observed manipulating toys in an age-appropriate manner; 2) he was discharged from PT at Nemours; 3) his performance, at 31 months, on the Peabody Motor Skills Test (a standardized assessment of motor

abilities), concluded that he was average in his movements and stationary abilities; 4) his performance on the Ages and Stages questionnaire (which addresses fine and gross motor skills, personal/social skills, and communication) that was provided by his primary care physician concluded that his gross motor function was "actually just fine" and his fine motor skills were right below average; and 5) the video of his examination by Dr. Gieron, demonstrates that his gross and fine motor skills are not an issue.

39. Dr. Sigurdardottir conceded that Ian's hearing loss is a physical impairment that is permanent; however, she opined that she does not consider the hearing loss (standing alone) to satisfy the criteria for a substantial physical impairment.

40. The undersigned finds that Dr. Sigurdardottir possesses significant education, training, and expertise and is well-qualified and credentialed to render the above-noted opinions. The undersigned finds her opinions as stated above to be credible.

41. Intervenor retained Dr. Gieron, who is board certified in psychiatry and neurology (with a special competence in pediatric neurology), to conduct an independent medical examination of Ian and opine as to whether his medical/neurological impairment was consistent with injury to the brain or spinal cord acquired due to oxygen deprivation or mechanical injury; and to establish if he suffers from a permanent and substantial mental and physical impairment.

42. After reviewing pertinent medical records, Dr. Gieron conducted the examination on April 26, 2019, when Ian was approximately 31 months old. Based on the records reviewed, information obtained from Mr. Abarca, and her observations, Dr. Gieron noted the following developmental history:

> Physical development:
>
> Walks, runs, climbs on chair, jumps, throws/catches the ball and runs after it. Unable to walk upstairs

> alternating feet, does not help in dressing/undressing, or feeding self.
>
> Language and speech:
>
> Says single words like "mom" and "dad," no phrases, doesn't follow directions, is not understandable, does not ask questions, but communicates with hands touching the parents.
>
> Fine motor skills:
>
> Builds tower of 9 cubes, scribbles, plays with cars "dragging" them on the floor, but doesn't imitate vertical, horizontal, or circular lines, drinks from a cup.
>
> Social/emotional:
>
> Interacts with siblings playing with them with cars and ball, doesn't eat with utensils, grabs food with hands and puts to his mouth in large quantities. Cannot tell when he needs a diaper change. Plays video games on iPhone, watches TV and plays with cars and ball. Shows emotions and easily gets angry.
>
> Cognitive:
>
> Does not understand the concept of one item or thing, does not follow one step directions.
>
> Overall, the father feels that Ian is slow in his development and does not progress any more.

43. With respect to the neurological examination, which Dr. Gieron noted was "difficult to perform due to language barrier and behavior," she documented the following:

> Alert, on-the go in examining room. He didn't make eye contact with the examiner.

> His vision was functional, pupils were equal and reactive to light. Facial sensation normal, facial movements were symmetrical and full. Hearing could not be tested, but when the hearing aids were removed, he responded to a rattle sound. The tongue movements were normal.
>
> On musculoskeletal/motor examination: muscle bulk was normal, tone was decreased at the shoulder girdle. His strength based on observation of function was normal. He was able to climb a chair, walk and run.
>
> Coordination:
>
> He was unable to point to small objects, push a button with one finger, scribble circular lines, or copy straight lines.
>
> Deep tendon reflexes were 3+ biceps, 3+ patellar, 2+ ankles.
>
> Sensation was normal to touch.
>
> During the period of examination, there were occasions when he would put his hands in front of him with palms down and look at them (reportedly common behavior reported by the father).

44. In summary, Dr. Gieron opined that Ian was "found to have a physical and mental impairment, which with reasonable degree of medical probability, is substantial and permanent." She also opined that "[t]he birth medical records provide substantial evidence of impairment consistent with injury to the brain acquired during oxygen deprivation caused by placental abruption."

45. Dr. Gieron was deposed on December 13, 2019. Consistent with her report, Dr. Gieron testified that it is her opinion within a reasonable degree of medical probability that Ian has permanent and substantial mental and physical impairments. Dr. Gieron provided the following definition of the phrase substantial impairment:

> Well, substantial means that the patient cannot perform the activities of daily living without support, that needs various resources to be able to –to have normal life, which often includes therapies or may include some devices. That's what I'm – that's what I mean by substantial.

46. In support of the opinion that Ian is substantially and permanently physically impaired, she opined that he "doesn't do things that are age appropriate," such as: 1) walking stairs with alternating feet; 2) walking normally; 3) pushing a button with one finger; 4) draw a single straight line or circle; and 5) walk backwards upon command. Additionally, she opined that Ian has not made substantial progress in his physical development subsequent to the examination performed by Dr. Sigurdardottir. Moreover, she opined that, based on the history as provided by Petitioners, Ian does not use his hands to do small things such as holding utensils to feed himself, crayons, or push buttons.

47. Dr. Gieron opined that Ian's physical skills range from that of an 18 month to 24 month-old child. She found that he was at least two standard deviations below the normal upon examination. Finally, with respect to his physical condition, Dr. Gieron testified, that he "very likely would not progress beyond the present level."

48. Dr. Gieron's opinion that Ian is substantially and permanently mentally impaired is primarily supported by his markedly delayed language and speech development. She also testified that he is significantly delayed in social interactions and adaptive development.

49. Dr. Gieron concurred with the opinions of Dr. Willis and Dr. Sigurdardottir that Ian suffered a permanent injury to the brain from lack of oxygen during birth, and that the placental abruption was the cause of Ian's lack of oxygenation prior to birth.

50. Due to the evidentiary presentation, the undersigned was unable to observe Ian at the final hearing. In considering whether Ian is substantially

and permanently physically impaired, the undersigned finds persuasive the video recording of Dr. Gieron's examination. The video evidence clearly demonstrates Ian performing various tasks to which Dr. Gieron either did not observe or testified that he could not perform. Specifically, Ian is observed walking backwards, walking in a normal manner, and utilizing his fingers.

51. The video establishes that Ian failed to follow or complete most of Dr. Gieron's requested tasks while she was performing the official examination; however, it is far from clear that Ian lacks the physical ability to perform the requested physical tasks. Indeed, Ian was observed stacking numerous urine sample cups in a vertical column; positioning and climbing upon and balancing on an office chair with rollers; walking normally; running; turning on and off the light switch; moving chairs independently; mock playing with a computer keyboard and mouse; and opening and closing the examination door (upon command). Although difficult to determine precisely, it also appears that Ian also used his father's cell phone by opening the screen with one finger.

52. The undersigned finds that Dr. Gieron possesses significant education, training, and expertise and is well-qualified and credentialed to render the above-noted testimony. Her opinion that Ian suffered an injury to his brain caused by oxygen deprivation or mechanical injury occurring in the course of delivery, or resuscitation in the immediate post-delivery period in a hospital is credited. Additionally, her ultimate opinion that Ian has sustained a substantial and permanent mental impairment is also credited. The undersigned finds, however, her opinion that Ian sustained a substantial and permanent physical impairment to be less persuasive.

Family testimony:

53. Petitioner, Ana Paulino, was deposed on January 16, 2019, when Ian was approximately 28 months old. Ms. Paulino testified that, in her opinion, Ian has a substantial mental impairment. She testified that he does not comprehend when things are said to him and that he is unable to

communicate orally. At the time of the deposition, Ms. Paulino testified that Ian only spoke one word, "Mommy." According to Ms. Paulino, Ian is able to communicate with her and the other members of the family by using his hands. She explained that "[he] touches me or gets near me and he touches me, he slaps my thigh."

54. With respect to his physical condition, Ms. Paulino testified that Ian does have hearing loss that she believes to be permanent. Although she testified that he does not have motor skill issues concerning picking things up and putting food to his mouth, he does not feed himself with utensils. She testified that she feeds Ian everything. When asked if he is able to feed himself with his fingers or hands, she replied "[i]t's possible and it may not be possible." She testified that Ian likes to play with a ball and cars. He is able to throw, catch, and run after a ball.

55. Petitioner, Alejandro Abarca, was deposed on January 16, 2019. He has been informed that Ian has permanent hearing loss; however, he does not believe it is a substantial injury. With respect to his physical condition, Mr. Abarca testified that "[p]hysical, he's good. He can run. He doing everything. You know, he play with me and everything." He also testifies that he plays with the phone.

56. Mr. Abarca explained that Ian drinks on his own from a sippy cup; however, he needs assistance feeding. Mr. Abarca testified that he and Ms. Paulino are scared that he may choke and, therefore, mash his solid food and feed him slowly.

57. Concerning his mental condition, Mr. Abarca testified that Ian is "slow" in oral communication, which was his primary developmental concern. While Mr. Abarca testified that Ian plays with the phone, he was unsure how much he understands. Ian is able to communicate his needs with his hands by touching. For example if he wants milk, Ian will touch the person's leg and point to the refrigerator.

Notice[2]:

58. On September 8, 2016, Ms. Paulino presented to the emergency room at ORMC. The medical records from that visit include an ORMC document entitled "Acknowledgement of Patient's Receipt of Birth Related Neurological Injury Compensation Plan Brochure (NICA)." This form provided the following:

> 1. I acknowledge that I have received the Florida Birth Related Neurological Injury Compensation Plan brochure.
>
> 2. I acknowledge and understand that I may contact the Florida Birth Related Neurological Injury Compensation Association about the details of the plan at 1-800-398-2129.

59. Immediately below the above-quoted language are lines for "Print Name," "Date," and "Signature." The undersigned finds that the signature is that of Ms. Paulino. Although Ms. Paulino testified at her deposition that the signature was not hers, the undersigned finds her testimony not credible on this issue.

60. Ms. Paulino's signature on the NICA Form and additional documents dated September 8, 2016, were witnessed by Irene Aviles, an ORMC registrar. Ms. Aviles's job was "to collect the demographic information, along with the insurance information, emergency contact, and proceed with the collecting signatures [for] the documentation." During Ms. Aviles's deposition on June 19, 2020, she testified definitively that she was present when Ms. Paulino signed the NICA Form and that the signature belonged to

[2] Paragraph 2 of the parties Joint Pre-Hearing Stipulation provides that "[i]t is Petitioners' position that the notice requirements of section 766.316, Florida Statues were not satisfied." In Paragraph 7, the parties represent that "whether notice of NICA participation was given or excused, pursuant to section 766.315, Florida Statutes," is an issue of fact that remains to be litigated. Although Petitioners did not submit a proposed final order and Respondent, in its proposed final order, "takes no position on the factual issue of notice," in compliance with section 766.309(1)(d), the undersigned shall address the issue.

Ms. Paulino, because Ms. Aviles confirmed her own handwriting existed on the NICA Form and other documents bearing Ms. Paulino's signatures from her emergency department visit to ORMC on September 8, 2016.

61. While Ms. Aviles did not have an independent recollection of watching Ms. Paulino sign or initial the documents, she testified about her encounter with Ms. Paulino based on her routine practice: i.e., the NICA Form is handed to a pregnant patient after providing that patient a copy of the NICA brochure and explaining what the information is about; every pregnant patient would receive a copy of the NICA brochure and NICA Form; only the patient would sign that form and other admission documents; and if the patient refused to sign, Ms. Aviles would have documented "patient refused to sign" before she scanned any and all printed documents handed to the patient for incorporation into that patient's electronic medical chart.

62. Ms. Aviles also credibly testified that it was her routine practice to advise the patient of ORMC's participation in the Plan while discussing the brochure and obtaining the obstetric patient's signature. The "NICA brochure" is provided by Respondent and is entitled "Peace of Mind for an Unexpected Problem," and is provided in several languages including Spanish. Ms. Aviles, who is fluent in English and Spanish, testified that she would have provided her explanation to Ms. Paulino in Spanish, and probably provided her with the Spanish NICA brochure.

63. Intervenor further presented the testimony of its forensic document examiner expert, Laurie Hoeltzel, PhDc., via deposition and written declaration made under penalty of perjury. Ms. Hoeltzel testified that she was retained by counsel for Intervenor to examine the NICA Form dated September 8, 2016, to determine whether or not the handwritten signature on that document was written by Ms. Paulino. In addition to reviewing the NICA Form, Ms. Hoeltzel reviewed 14 other documents containing the signatures of Ms. Paulino from September 2016 through October 2019, including the signatures that Ms. Paulino testified were her own at

deposition and other documents Ms. Paulino's counsel obtained and forwarded in discovery. Ms. Hoeltzel also reviewed parts of Ms. Paulino's deposition transcript from January 2019 and the signatures contained within her answers to ORMC's interrogatories from October and December 2018.

64. After taking microscopic measurements of Ms. Paulino's signatures and applying her education, training, and experience as a forensic document examiner, it was Ms. Hoeltzel's deposition testimony that every signature was consistent with one another. Ms. Hoeltzel further testified that, within a reasonable degree of forensic document examining probability, it is highly probable Ms. Paulino authored the signature on the NICA Form.

65. The undersigned finds, based upon the totality of credible evidence, that it is more likely than not that Ms. Paulino was provided a Spanish NICA brochure during her visit to ORMC on September 8, 2016. The undersigned further finds that, on that date, Ms. Paulino was advised of ORMC's participation in the Plan.

## CONCLUSIONS OF LAW

66. DOAH has jurisdiction over the parties to and the subject matter of these proceedings. §§ 766.301-766.316, Fla. Stat.

67. The Plan was established by the Legislature "for the purpose of providing compensation, irrespective of fault, for birth-related neurological injury claims" relating to births occurring on or after January 1, 1989. § 766.303(1), Fla. Stat.

68. Section 766.301(2) provides that it is "the intent of the Legislature to provide compensation, on a no-fault basis, for a limited class of catastrophic injuries that result in unusually high costs for custodial care and rehabilitation."

69. The injured infant, her or his personal representative, parents, dependents, and next of kin may seek compensation under the Plan by filing a claim for compensation with DOAH. §§ 766.302(3), 766.303(2),

and 766.305(1), Fla. Stat. NICA, which administers the Plan, has "45 days from the date of service of a complete claim . . . in which to file a response to the petition and to submit relevant written information relating to the issue of whether the injury is a birth-related neurological injury." § 766.305(4), Fla. Stat.

70. If Respondent determines that the injury alleged is a claim that is a compensable birth-related neurological injury, it may award compensation to the claimant, provided that the award is approved by the ALJ to whom the claim has been assigned. § 766.305(7), Fla. Stat. If, on the other hand, the claim is disputed, as here, the dispute must be resolved by the assigned ALJ in accordance with the provisions of chapter 120, Florida Statutes. §§ 766.304, 766.309, and 766.31, Fla. Stat.

71. In its present posture, the undersigned is required to make the following threshold determinations based upon the available evidence:

> (a) Whether the injury claimed is a birth-related neurological injury. If the claimant has demonstrated, to the satisfaction of the administrative law judge, that the infant has sustained a brain or spinal cord injury caused by oxygen deprivation or mechanical injury and that the infant was thereby rendered permanently and substantially mentally and physically impaired, a rebuttable presumption shall arise that the injury is a birth-related neurological injury as defined in s. 766.303(2).
>
> (b) Whether obstetrical services were delivered by a participating physician in the course of labor, delivery, or resuscitation in the immediate postdelivery period in a hospital; or by a certified nurse midwife in a teaching hospital supervised by a participating physician in the course of labor, delivery, or resuscitation in the immediate postdelivery period in a hospital.

* * *

> (d) Whether, if raised by the claimant or other party, the factual determinations regarding the notice requirements in s. 766.316 are satisfied. The administrative law judge has the exclusive jurisdiction to make these factual determinations.

§ 766.309(1), Fla. Stat.

72. An award may be sustained only if the ALJ concludes that the "infant has sustained a birth-related neurological injury. . . ." § 766.31(1), Fla. Stat. The term "birth-related neurological injury" is defined in section 766.302(2) as follows:

> "Birth-related neurological injury" means injury to the brain or spinal cord of a live infant weighing at least 2,500 grams for a single gestation or, in the case of a multiple gestation, a live infant weighing at least 2,000 grams at birth caused by oxygen deprivation or mechanical injury occurring in the course of labor, delivery, or resuscitation in the immediate postdelivery period in a hospital, which renders the infant permanently and substantially mentally and physically impaired. This definition shall apply to live births only and shall not include disability or death caused by genetic or congenital abnormality.

73. The phrase "substantial mental impairment" is neither defined by statute nor present rule. In *Florida Birth-Related Neurological Injury Compensation Association v. Florida Division of Administration Hearings*, 686 So. 2d 1349 (Fla. 1997) [hereinafter *Birnie*], the court was asked to resolve the certified question as to whether, under the Plan, an infant must suffer both substantial mental and physical impairment, or can the definition be construed to require only substantial impairment, mental and/or physical. In resolving the question, the *Birnie* court explained that "[w]here, as here, the legislature has not defined the words used in a phrase, the language

should usually be given its plain and ordinary meaning." *Birnie*, at 1354, citing *Southeastern Fisheries Ass'n , Inc. v. Dep't Nat. Res.*, 453 So. 2d 1351 (Fla. 1984). "Nevertheless, consideration must be accorded not only to the literal and usual meaning of the words, but also to their meaning and effect on the objectives and purposes of the statute's enactment." *Id*.

74. The *Birnie* court concluded that the NICA statute is written in the conjunctive and requires a permanent and substantial impairment to both the physical and mental elements. *Id*. at 1356. The *Birnie* court did not establish a definition or test for the determination of "substantial mental impairment," but found that the underlying decision by the ALJ must be supported by competent and substantial evidence.

75. In *Adventist Health System/Sunbelt, Inc. v. Florida Birth-Related Neurological Injury*, 865 So. 2d 561 (5th DCA 2004) [hereinafter *Shoaf*], the Fifth District Court of Appeals likewise rejected setting forth a formulaic approach to the resolution of the term "substantial mental impairment." Addressing the argument that *Birnie* had created a definition, the *Shoaf* court countered:

> It is apparent, however, that the *Birnie* court did not define or redefine "substantial mental impairment." They simply said that the decision of the ALJ was supported by competent substantial evidence. All this language in *Birnie* suggests is that, under NICA, the identification of a substantial mental impairment may include not only significant cognitive deficiencies but can include, in a proper case, additional circumstances such as significant barriers to learning and social development.

*Shoaf*, at 567.

76. The *Shoaf* court again reiterated that, as the Legislature did not define the terms used in the test for NICA qualification, these terms are to be

given their ordinary meanings. *Id*. at 568. Indeed, the *Shoaf* court further directed that:

> The legislature left the application of the terms they used to the administrative law judges designated by statute to hear these claims and to apply the expertise they develop in carrying out this task to determine from the evidence adduced in each case whether these for NICA is met.
>
> * * *
>
> In cases such as the one before us, the ALJ, as fact finder, brings his own background, training, experience and expertise to the task of weighing and evaluating very sophisticated evidence. The child's advocate likewise brings his own communication and strategic skills to the fact-finding process; and finally, the evidence in each case will vary in its power to persuade. This will be especially true in cases where the opinions of experts are concerned.

*Id.*, at 568-69.

77. Finally, the *Shoaf* court, in concluding that the underlying decision by the ALJ was supported by competent substantial evidence, advised that the term "substantial mental impairment" is broad enough to encompass more than just damage to cognitive capacity and more than merely the inability to translate cognitive capabilities into adequate learning in a normal manner or impairment of social and vocational development. *Id*., at 569.

78. Here, Petitioners are not seeking compensation under the Plan, but instead are seeking to establish the right to sue in a court of law, and, therefore, are not claimants. *Bennett v. St. Vincent's Med. Ctr.*, 71 So. 3d 828, 844 (Fla. 2011). As the proponent that Petitioners' claim is compensable, Intervenor carries the burden of proof.

79. The undersigned concludes that sufficient evidence was presented, or otherwise stipulated or admitted by the parties to establish that Ian was born

a live infant on September 28, 2016, at ORMC, a "hospital" as defined by section 766.302; that Ian was a single gestation, weighing over 2,500 grams at birth; and that he suffered an injury to his brain caused by oxygen deprivation occurring in the course of labor, delivery, or resuscitation in the immediate post-delivery period.

80. The undersigned further concludes that sufficient evidence was presented, or otherwise stipulated or admitted by the parties to establish that during the course of labor, delivery, or resuscitation in the immediate post-delivery period, obstetrical services for Ms. Paulino were delivered by Dr. DeNardis, a NICA participating physician at the time of birth; and that resident physicians, Nnenna J. Maduforo, D.O., and Samantha Bunting, D.O., who assisted in the delivery, were exempt from the NICA assessment, pursuant to section 766.314(4)(a).

81. The undersigned further concludes that the injury to Ian's brain rendered him permanently and substantially mentally impaired. No evidence was presented to suggest that Ian's injury was caused by genetic or congenital abnormality or due to infection.

82. Although the phrase "substantial physical impairment" under the Plan is neither defined by statute nor present rule, in *Matteini v. Florida Birth-Related Neurological*, 946 So. 2d 1092 (Fla. 5th DCA 2006), the court provided some limited guidance. In that case, the court noted that, "[u]nder the Plan, a 'physical impairment' relates to the infant's impairment of his 'motor abnormalities' or 'physical functions,' . . ." *Id.* at 1095.

83. The parties to this proceeding presented one or more experts to support their respective position as to whether Ian is permanently and substantially physically impaired. All of the experts presented were well-qualified, credentialed, and possessed extensive and significant training and experience in their respective discipline or area of expertise. Having thoroughly reviewed and weighed the considered expert opinions and evidence, including Dr. Gieron's videotaped examination of Ian, the

undersigned concludes that the better evidence supports the conclusion that Ian's injury at issue, based on the Findings of Fact above, did not render him substantially physically impaired. Although Ian's hearing loss is concluded to be permanent, the undersigned concludes that Intervenor failed to meet its burden of presenting sufficient evidence to establish that Ian's physical impairment(s) are substantial.

84. During the course of this litigation, the issue was raised as to whether the notice requirements set forth in section 766.316 were met. With respect to the notice issue, as the proponents of the proposition that appropriate notice was given or that notice was not required, the burden on this issue of notice is upon Intervenor. *Tabb v. Fla. Birth-Related Neurological Injury Comp. Ass'n.*, 880 So. 2d 1253, 1257 (Fla. 1st DCA 2004).

85. Section 766.316, entitled "Notice to obstetrical patients of participation in the plan," provides as follows:

> Each hospital with a participating physician on its staff and each participating physician, other than residents, assistant residents, and interns deemed to be participating physicians under s. 766.314(4)(c), under the Florida Birth-Related Neurological Injury Compensation Plan shall provide notice to the obstetrical patients as to the limited no-fault alternative for birth-related neurological injuries. Such notice shall be provided on forms furnished by the association and shall include a clear and concise explanation of a patient's rights and limitations under the plan. The hospital or the participating physician may elect to have the patient sign a form acknowledging receipt of the notice form. Signature of the patient acknowledging receipt of the notice form raises a rebuttable presumption that the notice requirements of this section have been met. Notice need not be given to a patient when the patient has an emergency medical condition as defined in s. 395.002(8)(b) or when notice is not practicable.

86. As set forth in the Findings of Fact, it is concluded that Petitioners were provided with a copy of the NICA brochure on September 8, 2016, 20 days prior to delivery. In *Galen of Florida, Inc. v. Braniff*, 696 So. 2d 308 (Fla. 1997), the court addressed the issue of when notice must be given, pursuant to section 766.316. The court held that "as a condition precedent to invoking [the Plan] as a patient's exclusive remedy, health care providers must, when practicable, give their obstetrical patients notice of the participation in the plan a reasonable time prior to delivery." *Galen*, 696 So. 2d at 309. The undersigned concludes that Petitioner was timely provided a copy of the NICA brochure. The undersigned further concludes that, on September 8, 2016, Intervenors provided timely notice to Petitioners of their participation in the Plan. Accordingly, it is concluded that Intervenor satisfied the notice requirements of section 766.316.

## CONCLUSION

Based on the foregoing Findings of Fact and Conclusions of Law, it is ORDERED that:

1. Ian did not sustain a "birth-related neurological injury," as defined in section 766.302(2) and, therefore Petitioners' claims is not compensable under the Plan.

2. Obstetrical services were delivered by a participating physician, Dr. DeNardis, in the course of labor, delivery, or resuscitation in the immediate post-delivery period in a hospital.

3. Intervenor satisfied the notice requirements of section 766.316.

DONE AND ORDERED this 24th day of November, 2020, in Tallahassee, Leon County, Florida.

TODD P. RESAVAGE
Administrative Law Judge
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Filed with the Clerk of the
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## NOTICE OF RIGHT TO JUDICIAL REVIEW

A party who is adversely affected by this Final Order is entitled to judicial review pursuant to section 120.68, Florida Statutes. Review proceedings are governed by the Florida Rules of Appellate Procedure. Such proceedings are commenced by filing the original notice of administrative appeal with the agency clerk of the Division of Administrative Hearings within 30 days of rendition of the order to be reviewed, and a copy of the notice, accompanied by any filing fees prescribed by law, with the clerk of the district court of appeal in the appellate district where the agency maintains its headquarters or where a party resides or as otherwise provided by law.