



FILED

May 17, 2023, 10:55 am

OFFICE OF FAIR HEARINGS

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

████████████████████,

PETITIONER,

AHCA Case No.: 23-FH0258

vs.

**AGENCY FOR HEALTH CARE
ADMINISTRATION,**

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic Fair Hearing on the instant case on March 22, 2023, at 9:00 a.m. Eastern Standard Time (“EST”).

APPEARANCES

For the Petitioner:

████████████████████

Petitioner’s Authorized Representative

For the Respondent:

Lee Ann Williams
Medical/Health Care Program Analyst
Agency for Health Care Administration

STATEMENT OF ISSUE

The issue is whether Respondent proved by a preponderance of the evidence that Respondent’s decision to reduce Petitioner’s Applied Behavior Analysis (“BA” or “ABA”) services was correct.¹

PRELIMINARY STATEMENT

¹ The hearing on the present case proceeded with all parties agreeing that the issue was whether the Petitioner proved by a preponderance of the evidence that Respondent’s decision to deny Petitioner’s request for BA services was incorrect. Upon further review of the case, the undersigned hearing officer revised the statement of issue.

All parties and witnesses appeared telephonically. Petitioner's Authorized Representative and [REDACTED] [REDACTED] ("[REDACTED]"), appeared on behalf of Petitioner. Language interpreter George, with identification number 31578792, provided his services at the hearing interpreting testimony of the witnesses from English to Spanish, and Spanish to English.

Chrissie Simmons, Medical/Health Care Program Analyst for the Agency for Health Care Administration ("Agency" or "AHCA"), appeared on behalf of Respondent. Dr. Joseph Darling ("Dr. Darling"), BCBA at the Doctoral level and second level reviewer for eQHealth Solutions Inc. ("eQHealth") appeared as a witness for Respondent.

Prior to the hearing, Respondent sent to the Office of Fair Hearings and Petitioner a one hundred and ninety (106)-page evidence packet and a forty-nine (49)-page evidence packet. The one hundred and ninety (106)-page evidence packet appears in the Office of Fair Hearings' document management system as the file title "[REDACTED] FH 03.22.2023.pdf". The forty-nine (49)-page evidence packet appears in the Office of Fair Hearings' document management system as the file title "23-FH0258 AHCA Evidence 49.pdf". Absent an objection from the Petitioner, the undersigned admitted the one hundred and ninety (106)-page evidence packet into evidence as Respondent's Composite Exhibit 1 ("RCE 1") and the forty-nine (49)-page evidence packet into evidence as Respondent's Composite Exhibit 2 ("RCE 2").

The Petitioner did not send documentary evidence to the Office of Fair Hearings prior to the hearing, but at the hearing, [REDACTED] testified that [REDACTED] had evidence to introduce regarding Petitioner's diagnoses. The record was held open to allow the Petitioner to introduce additional evidence. Petitioner introduced a fourteen (14)-page evidence packet, appearing in the Office of Fair Hearings' document management system as the file title "23-FH0258 Evidence.pdf". The

Respondent stipulated to the admission of the evidence at the hearing on March 22, 2023, reserving the right to respond to it before the hearing concluded. The undersigned admitted the fourteen (14)-page evidence packet into evidence as Petitioner’s Composite Exhibit 1 (“PCE 1”).

In response to the admission of PCE 1, Respondent submitted a one (1)-page letter. The letter appears in the Office of Fair Hearings’ document management system as file title “Letter to [REDACTED]. [Medicaid ID].pdf”. Respondent’s letter is hereby admitted as Respondent’s Exhibit 3 (“RE 3”). The Respondent reviewed PCE 1, and responded in a letter dated March 22, 2023, that “this additional Evidence does not address the additional ABA interventions/therapy that would change the testimony provided this morning.” See Letter to AHCA [REDACTED].pdf, in document management system.

FINDINGS OF FACT

1. Petitioner receives Medicaid services on a fee-for-service basis from the Agency. eQHealth is a Quality Improvement Organization contracted by the Agency to review prior authorization requests for services. See page 2 of RCE 2.

2. Petitioner was [REDACTED] [REDACTED]-years old at the date of the Fair Hearing. See page 16 of RCE 1. Petitioner is diagnosed with [REDACTED]
[REDACTED]. See pages 8 – 9 of PCE 1.

3. As provided in the Medicaid Treatment Plan for ABA Services (“treatment plan”), Petitioner engages in the following maladaptive behaviors: [REDACTED]
[REDACTED]
[REDACTED]. See page 50 of RCE 1.

4. On January 17, 2023, Petitioner requested a reassessment for the continuation in ABA services at the previous level; specifically, for 3,120 units of code 97153; 312 units of code 97155; and 104 units of code 97156. *Id.* at 23.

5. On February 1, 2023, Respondent approved 2,496 units of code 97153, 312 units of code 97155 and 78 units of code 97156. Respondent explained the basis of the reduction as follows:

The reason for the denial is that the services are not medically necessary as defined in Rule 59G-1.010, Florida Administrative Code. Specifically, the services must be:

Individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness under treatment, and not in excess of the patient's needs.

The rationale for our decision is as follows:

PR Principal Reason - Denial:

Submitted information does not support the medical necessity for requested frequency and/or duration.

PR Clinical Rationale - Denial: According to Behavior Analysis Services Coverage Policy requests for services must be based on the medical necessity of the recipient's maladaptive behaviors. The recipient is engaging in problem behaviors that threaten access to typical environments and negatively affects activities of daily living. However, the intensity of the recipient's maladaptive behaviors does not justify the intensity of services requested. The provider is using a tiered service delivery model and has not made a compelling justification for services at the intensity requested. The requested hours of BA services are in excess of medical necessity.

Id. at 24.

6. Subsequently, a modified treatment plan was submitted by the provider and reviewed by a second and third peer reviewer at the doctoral level. After a complete review of the all the records, the reviewer upheld the reduction of 624 units of code 97153 BA services (or six (6) hours of the thirty (30) requested hours), and reversed and approved the remainder of BA

services to continue at the previous level. In the Notice of Reconsideration Determination, dated February 8, 2023, Respondent again explained, as follows:

The reason for the denial is that the services are not medically necessary as defined in Rule 59G-1.010, Florida Administrative Code. Specifically, the services must be:

Individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness under treatment, and not in excess of the patient's needs.

....

PR Recon Determination: At reconsideration, all documents were carefully reviewed. The provider submitted new documentation that supports the medical necessity of this request. According to The Behavior Analysis Services Coverage Policy, (page 6, 9.0.c-d) the recipient of ABA therapy services must engage in maladaptive behavior that interferes with the recipient's daily functioning. Although the recipient is engaging in topographies of maladaptive behaviors, the frequency and intensity of the maladaptive do not support the request for services. The current request is in excess of medically necessary BA services, but BA services are approved at a lower level than requested.

Id. at 36.

7. On February 7, 2023, Petitioner requested a Fair Hearing to challenge the denial of additional ABA services. On March 7, 2023, the undersigned issued an Order Scheduling Fair Hearing and Prehearing Instructions, setting the hearing for March 22, 2023, at 9:00 a.m. EST.

8. Dr. Darling is a Board Certified Behavior Analyst at the doctoral level. Dr. Darling testified that the treatment plan did not show whether the continued BA services at the previous level for the Petitioner was medically necessary because the plan was not individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness under treatment, and was in excess of the patient's needs. Dr. Darling contends that Petitioner needs ABA services, but not at the intensity and duration at the previous level.

9. Dr. Darling explained that a review of the graphs in the treatment plan is the most effective and accepted way to determine Petitioner's progress throughout therapy, noting that Petitioner has been receiving treatment from the provider since [REDACTED]. The most recently submitted treatment plan included graphs with baseline data of Petitioner's maladaptive behaviors starting from [REDACTED]. *Id.* at 52. Petitioner has been in therapy for nearly [REDACTED] [REDACTED] but [REDACTED] progress in decreasing maladaptive behaviors and increasing skills acquisitions or replacement behaviors, is very slow moving under the current the treatment plan. Citing to the plan's graph on [REDACTED], Dr. Darling testified that there has been no significant decrease in occurrences over a year. *Id.* at 53. Petitioner had [REDACTED] occurrences [REDACTED] [REDACTED] times per week in [REDACTED] and occurrences [REDACTED] [REDACTED] times per week in [REDACTED]. *Id.* Similarly, the plan's graph on [REDACTED] show occurrences [REDACTED] [REDACTED] times per week in [REDACTED] and occurrences of over [REDACTED] [REDACTED] times per week in [REDACTED]. *Id.* The same analysis for the other maladaptive behaviors of [REDACTED] [REDACTED], applies to the graphs included in the treatment plan. *Id.* at 55 - 62. Dr. Darling contends that there should be changes in the procedures of the plan to help effect the reduction of Petitioner's maladaptive behaviors.

10. In the replacement programs for skill acquisitions, Dr. Darling referred to the treatment plan graph with data on [REDACTED]. Dr. Darling contends that this is a very good starting point for increasing replacement behavior/skills acquisitions. In this case, the graph revealed that prior to treatment, in [REDACTED], Petitioner was able to do the skill of cooperation [REDACTED] percent [REDACTED] of the time, but by [REDACTED], [REDACTED] skill slowly increased to [REDACTED] percent

([REDACTED]) *Id.* at 68. Dr. Darling explained that in the most effective ABA plans, the learner typically is taught this skill in one day. Another graph on [REDACTED], shows that Petitioner accomplished this skill [REDACTED] percent ([REDACTED] of the time prior to treatment in [REDACTED] [REDACTED], and by [REDACTED], [REDACTED] accomplished the skill [REDACTED] percent ([REDACTED] of the time.

Id. at 69. Again, Dr. Darling contends that this is a skill that should be mastered in one day. Therefore, it appears that this plan moves very slowly, and it is not designed to make the child successfully move on to other skills. This makes the treatment a maintenance plan, designed to maintain. Dr. Darling testified that Petitioner still needs ABA services, but at a reduced rate for this slow-moving treatment plan, that the reduced hours from thirty (30) to twenty-four (24) for code 97153, should successfully implement the plan over the next six (6) months.

11. Dr. Darling's verified that his testimony was not changed by Petitioner's additional evidence of Petitioner's associated diagnoses because it does not address the additional ABA interventions/therapy. *See* RE 3, in document management system; *see also* PCE 1.

12. Petitioner's [REDACTED] [REDACTED], appeared at the hearing. [REDACTED] testified that Petitioner had been improving [REDACTED] skills in place of maladaptive behaviors, and that the current treatment plan of ABA services would help [REDACTED] to continue to improve. [REDACTED] testified that [REDACTED] daughter, Petitioner, has [REDACTED] that cause [REDACTED] to back track in [REDACTED] therapy progress, that [REDACTED] has to begin all over after [REDACTED]. [REDACTED] further testified that Petitioner is diagnosed with [REDACTED].

See PCE 1. [REDACTED] contends that Petitioner is making improvements with the treatment plan in place.

CONCLUSIONS OF LAW

13. 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 AHCA under section 409.285(2)(a).

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

15. Because Respondent reduced ABA services, Fla. Admin. Code R. 59G-1.100(17)(g) assigns the burden of proof to the 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.)

16. The BA Policy, incorporated by reference in Fla. Admin. Code. R. 59G-4.125, governs BA services available under Florida Medicaid. The BA Policy provides as follows:

1.0 Introduction

Behavior analysis (BA) services are highly structured interventions, strategies, and approaches provided to decrease maladaptive behaviors and increase or reinforce appropriate behaviors.

...

1.4.5 Medically Necessary/Medical Necessity

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

...

4.0 Coverage Information

4.1 General Criteria

Florida Medicaid covers services that meet all of the following:

- Are determined medically necessary
- Do not duplicate another
- Meet the criteria as specified in this policy

4.2 Specific Criteria

Florida Medicaid covers the following BA services in accordance with the applicable Florida Medicaid fee schedule(s), or as specified in this policy:

4.2.1 Behavior Assessment

One per fiscal year, per recipient, when completed within 30 days of the start of the assessment.

4.2.2 Behavior Analysis

Up to 40 hours per week, per recipient, consisting of services identified on the recipient's behavior plan in order to reduce maladaptive behaviors and to restore the recipient to his or her best functional level. Services include:

- Implementing behavior analysis interventions, and monitoring and assessing the recipient's progress towards goals in the behavior plan
- Behavior analysis interventions, for example, discrete trial teaching, task analysis training, differential reinforcement, non-contingent reinforcement, conducting task analyses of complex responses, and teaching using chaining, prompting, fading, shaping, response cost, and extinction
- Training the recipient's family, caregiver(s), and other involved persons on the implementation of the behavior plan and intervention strategies (the recipient must be present when clinically appropriate)

4.3 Early and Periodic Screening, Diagnosis, and Treatment

As required by federal law, Florida Medicaid provides services to be eligible recipients under the age of 21 years, if such services are medically necessary to correct or ameliorate a defect, a condition, or a physical or mental illness. Included are diagnostic services, treatment, equipment, supplies, and other measures described in sectioned 1905(a) of the Social Security Act, codified in Title 42 of the United States Code 1396d(a). As such, services for recipients under the age of 21 year exceeding the coverage described within this policy or the associated fee schedule may be approved, if medically necessary. For more information, please refer to Florida Medicaid's General Policies on authorization requirements.

17. Appendix 9.0 of the BA Policy provides Review Criteria for Behavior Analysis Services.

These Review Criteria state as follows:

Review Criteria for Behavior Analysis Services

Behavior analysis (BA) services are considered as either the treatment of choice or as an adjunct treatment modality for a variety of conditions and disorders where maladaptive behaviors are part of the recipient's clinical presentation, including behavioral manifestations of diagnoses such as Autism Spectrum Disorder and other behavioral health conditions.

Critical Elements Necessary for ANY Type of Behavior Analysis Service:

The following critical elements **MUST** be satisfied to qualify for BA services:

- a. Eligibility – The recipient must meet all criteria for BA services as outlined in the Behavior Analysis Services Coverage Policy, Rule 59G-4.125, F.A.C.
- b. Medical necessity – The recipient must meet medical necessity criteria as outlined in Rule 59G-1.010, F.A.C.
- c. The recipient currently engages in maladaptive behaviors

- d. These maladaptive behaviors interfere with the recipient's daily functioning

1. Criteria for Initial Behavior Analysis Assessment - BOTH of the following MUST be satisfied:

- a. **ALL** critical elements are met
- b. Provider submits a valid written physician's order as stipulated in the Behavior Analysis Services Coverage Policy, Rule 59G-4.125, F.A.C.

2. Criteria for Behavior Analysis Services and Reassessments – ALL of the following MUST be satisfied:

- a. **ALL** critical elements are met
- b. An assessment or, if applicable, a reassessment, authored by a lead analyst, is provided. An assessment of the maladaptive behavior(s) is a necessary element of the process of identifying the frequency and magnitude of the behaviors as well as the variables associated with the occurrence of the maladaptive behavior(s). This helps in defining what are the functional consequences of the problem behavior(s) so that an adequate behavior plan can be implemented. This (re)assessment **MUST** include, at a minimum, **ALL** of the following:

- i. A clear operational description of the maladaptive behavior(s)
...

- c. A behavior plan authored or updated by a lead analyst. The behavior plan is the cornerstone of the delivery of behavior analysis services and it is based on the information obtained in the assessment. It proposes specific interventions to reduce or eliminate the maladaptive behavior. These interventions take into consideration the variables, both present before the behavior, as well as after the behavior, that influence the occurrence of the maladaptive behavior(s). This plan also includes replacement appropriate behaviors for the recipient to engage in instead of the maladaptive behaviors in order to obtain the same function. The plan must be detailed enough to warrant the requested services and include mechanisms to monitor its effectiveness. This **MUST** include, at a minimum, **ALL** of the following:

- i. Observable and measurable descriptions of the maladaptive behavior(s)
- ii. Identified function of the maladaptive behavior(s) behavior as a result of the assessment or reassessment conducted
- iii. Goals and strategies for changing the maladaptive behavior(s)
- iv. Written detailed description of when, where, and how often these goals will be addressed and proposed strategies will be implemented
- v. System for monitoring and evaluating the effectiveness of the plan

- vi. Safety and crisis plan, if applicable
- vii. Summary and recommendations
- viii. Discharge criteria
- ix. Transition plan (if applicable)

NOTE: Although the assessment and behavior plan were addressed separately in section 2, both of them can be submitted as a single document.

3. Criteria for Continuation of Treatment at the Present Level and/or Using Current Methods: Providers must ensure that ALL of the following criteria are met to request continuation of treatment at the present level or using the current methods. **If criteria for 3a is met, but criteria for 3b and/or 3c are not met, then a reduction of the treatment level and/or change of treatment methods may be warranted.**

- a. ALL criteria listed in 2a, 2b, and 2c regarding critical elements, assessment or reassessment, and behavior plan, are met.
- b. The data provided must show evidence that the frequency of the maladaptive behavior(s) has decreased since the last review and, if not, that there is a modification of the behavior plan.
- c. The level of functional impairment justifies continuation of BA services. The reviewer utilizes the information provided below as a guide as it relates to the level of functional impairment as expressed through the following behaviors:
 - i. Safety – aggression, self-injury, property destruction, elopement
 - ii. Communication – problems with expressive/receptive language, poor understanding or use of non-verbal communications, stereotyped, repetitive language
 - iii. Self-stimulating, abnormal, inflexible, or intense preoccupations
 - iv. Self-care – difficulty recognizing risks or danger, grooming, eating, or toileting
 - v. Other – behaviors not identified above

18. States must provide Early and Periodic Screening, Diagnostic, and Treatment (“EPSDT”) services to Medicaid-eligible children under age 21 when requested under the Medicaid state plan. *See* 42 U.S.C. § 1396a(a)(43); 42 U.S.C. § 1396d(a)(4). According to 42 U.S.C. § 1396d(r)(5), EPSDT services mean, in relevant part, the following items and services:

Such other necessary health care, diagnostic services, treatment, and other measures described in subsection (a) of this section to correct or ameliorate defects and physical and mental illness and conditions discovered by the screen services, whether or not such services are covered under the state plan.

19. Petitioner is under age 21, and therefore EPSDT applies to ■■■ request for services. However, a state may place medical necessity limitations on EPSDT services. See 42 C.F.R. §§ 440.230(a), (b), (d). Fla. Stat. § 409.905(2) limits EPSDT services with a medical necessity standard:

The [Agency] shall pay for early and periodic screening and diagnosis of a recipient under age 21 to ascertain physical and mental problems and conditions and all services determined by the agency to be medically necessary for the treatment, correction, or amelioration of these problems and conditions, including personal care, private duty nursing, durable medical equipment, physical therapy, occupational therapy, speech therapy, respiratory therapy, and immunizations.

20. The 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.

21. The Florida Medicaid Authorization Requirements Policy (“Authorization Policy”), incorporated by reference in Fla. Admin. Code R. 59G-1.053, provides as follows:

3.2.1 Continued Authorization Requests

The QIO shall not deny or reduce the amount, frequency, or duration of a service that is already being provided, unless:

- The reduction is to correct for factual error or omissions in prior certifications.
- There is a documented improvement in the recipient's medical condition.
- There is a documented change in the recipient's circumstances.
- The reviewing physician determines the recipient will not gain any additional benefit by continuing services at the current level.

22. As provided by the EPSDT requirements, the recipient must meet the medical necessity criteria as outlined in Fla. Admin. Code R. 59G-1.010. As provided in section 2.83 of the Definitions Policy, a component of medical necessity is that services must be "consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational."

23. In the instant case, Respondent reduced Petitioner's ABA services under the current treatment plan. See supra ¶ 6. In the Notice of Reconsideration Determination, dated January 20, 2023, Respondent explained that continuing services at the prior level was not medically necessary, specifically, that it did not meet the requirement that services must be "individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness under treatment, and not in excess of the patient's needs." *Id.* Respondent further explained "the recipient of ABA therapy services must engage in maladaptive behavior that interferes with the recipient's daily functioning. Although the recipient is engaging in topographies of maladaptive behaviors, the frequency and intensity of the maladaptive do not support the request for services. The current request is in excess of medically necessary BA services, but BA services are approved at a lower level than requested." *Id.* At the Fair Hearing Dr. Darling provided credible evidence that the treatment plan is moving slower than expected. See ¶ 9. For example, the skills "[REDACTED]"

and “ [REDACTED] ” are typically mastered in a day, whereas in this case Petitioner has not mastered those skills. See ¶ 10. Additionally, there have been no significant decreases in Petitioner’s maladaptive behaviors. See ¶ 9. In all, Respondent demonstrated that Petitioner’s services at the prior level were “in excess” of the Petitioner’s needs.

24. As QIO for the Agency, eQHealth is authorized to reduce the amount, frequency and duration of ABA services that are already being provided unless “[t]here is a documented improvement in the recipient’s medical condition,” or “[t]he reviewing physician determines the recipient will not gain any additional benefit by continuing services at the current level.” See supra ¶ 21. Here, based on the lack of progress, it was shown that there was no documented improvement in Petitioner’s medical condition, and, consequently, the Respondent’s physicians who reviewed Petitioner’s current treatment plan determined the Petitioner would not receive additional benefit by continuing services at the current level. See supra ¶ 5, 6, 8, 9, 10.

25. Upon consideration of the testimony provided, evidence submitted, and applicable polices, relevant to the particular needs of Petitioner, Respondent has demonstrated that the continuation applied behavioral analysis services at the current level are not individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness under treatment, and that they are in excess of the patient’s needs. Therefore, the ABA services being provided to Petitioner at the current level are not medically necessary for the treatment, correction, or amelioration of Petitioner’s physical and mental problems and conditions. Accordingly, Respondent has proved by a preponderance of the evidence that Respondent’s reduction of ABA services was correct.

IT IS HEREBY ORDERED AND ADJUDGED THAT:

Respondent's denial of Petitioner's behavioral analysis services is **AFFIRMED**. Petitioner's appeal based on Respondent's denial of services is **DENIED**.

DONE and ORDERED this 17th day of May, 2023, in Tallahassee, Leon County, Florida.



Debbie K. Winicki
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DEBBIE K. WINICKI, Hearing Officer
Agency for Health Care Administration
Office of Fair Hearings
2727 Mahan Drive, Mail Stop # 11
Tallahassee, FL 32308-5407

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:



AHCA Medicaid Hearing Unit
MedicaidHearingUnit@ahca.myflorida.com