



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

FILED

Jun 30, 2023, 3:21 pm
OFFICE OF FAIR HEARINGS

[REDACTED],

PETITIONER,

AHCA Case No.: 23-FH0503

vs.

AGENCY FOR HEALTH CARE
ADMINISTRATION,

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic Medicaid Fair Hearing in the instant case on May 25, 2023, at 9:00 a.m., Eastern Standard Time (“EST”).

APPEARANCES

For the Petitioner:

[REDACTED]

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 Behavior Analysis services for the certification period of [REDACTED], through [REDACTED], was correct.

PRELIMINARY STATEMENT

All parties and witnesses appeared telephonically. [REDACTED] (“[REDACTED]”), a Board Certified behavior Analyst (“BCBA”) at [REDACTED] and Petitioner’s Authorized Representative, appeared as Petitioner’s representative and testified on Petitioner’s behalf. [REDACTED] (“[REDACTED]”), Petitioner’s [REDACTED] and Lorene Stogner (“Ms. Stogner”), support coordinator, appeared as a witness for Petitioner. Petitioner also testified at the Fair Hearing.

Lee Ann Williams, Medical Health Care Program Analyst for the Agency for Health Care Administration (“Agency” or “AHCA”), appeared as a representative on behalf of Respondent. Dr. Alissa Conway (“Dr. Conway”), Board Certified Behavior Analyst at the doctoral level (“BCBA-D”) at eQHealth Solutions, Inc. – Florida Division (“eQHealth”), appeared as a witness for Respondent.

Petitioner did not introduce any exhibits at the Fair Hearing. Prior to the hearing, Respondent sent to the Office of Fair Hearings and Petitioner a one hundred and ten (110)-page evidence packet. The evidence packet appears in the Office of Fair Hearings’ case management system as “[REDACTED] FH 05.25.2023.pdf.” Absent an objection from Petitioner, the undersigned admitted the evidence packet into evidence as Respondent’s Composite Exhibit 1.

Prior to the hearing, Respondent sent to the Office of Fair Hearings and Petitioner a forty-nine (49)-page evidence packet. The evidence packet appears in the Office of Fair Hearings’ case management system as “23-FH0503 AHCA Evidence packet 49 pages.pdf.” Absent an objection from Petitioner, the undersigned admitted the evidence packet into evidence as Respondent’s Composite Exhibit 2.

FINDINGS OF FACT

1. Petitioner receives Medicaid services on a fee-for-service basis from the Agency. See respondent's Composite Exhibit 1 at page 16. eQHealth is a Quality Improvement Organization contracted by the Agency to review prior authorization requests for services. See Respondent's Composite Exhibit 2 at page 2. The Agency, through contractual agreement, authorized eQHealth to make Medical Necessity determinations for services requiring prior authorizations, including BA services. *Id.*

2. Petitioner is an [REDACTED] ([REDACTED]-[REDACTED]-old diagnosed with [REDACTED]. See Respondent's Composite Exhibit 1 at page 16. According to the Behavior Plan submitted to eQHealth on March 6, 2023 ("Treatment Plan"), Petitioner engages in the following maladaptive behaviors: [REDACTED]

[REDACTED]

Id. at 100-101.

3. Petitioner's provider, [REDACTED], submitted a request to eQHealth for the continuation of behavior analysis services during the certification period of [REDACTED], through [REDACTED]. *Id.* at 19-20. Specifically, the provider requested the continuation of 312 units of code 97155, 312 units of code 97155HN, 104 units of code 97156, 104 units of code 971156HN, and 1,040 units of code 97153. *Id.*

4. On February 13, 2023, eQHealth sent Petitioner a Notice of Outcome ("NOO") initially terminating Petitioner's behavior analysis services. *Id.* at 23 - 24. The NOO explained as follow, in pertinent part:

The requested services are not medically necessary under the following standard(s):

Consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational.

PR Principal Reason – Denial:

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

PR Clinical Rationale – Denial:

All records were reviewed during the Pend process. Provider, submitted a revised Treatment Plan, however; ACT therapy techniques (page 7) are not an empirically supported procedure within the conceptual system of behavior analysis for treating the functions of maladaptive behavior of children with [REDACTED]. According to Behavior Analysis Services Coverage Policy (page-6-7), treatment that does not meet generally accepted standards of care within the field of applied behavior analysis are not covered under the behavior analysis services coverage policy.

Id. at 24.

5. Petitioner requested reconsideration and, on March 11, 2023, eQHealth sent Petitioner a Notice of Reconsideration Determination (“NRD”) modifying the decision. *Id.* at 35-37. The NRD authorized the requested 104 units of code 97156, 104 units of code 971156 HN, and 1,040 units of code 97153. *Id.* at 36. However, the NRD only authorized 104 units of code 97155 (312 were requested) and 104 units of 97155 HN (312 units were requested). The NRD explained as follows:

Specifically, the services must be:

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

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

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 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.

Id.

6. On March 10, 2023, Petitioner requested a Fair Hearing on behalf of Petitioner based on the reduction of BA services. The Fair Hearing was set for May 25, 2023, and all parties were duly notified.

7. As Dr. Conway testified that the services were reduced because the requested level of services were in excess of Petitioner's needs. However, Dr. Conway's testimony also confirmed that intensity, complexity, and safety are all factors that would be considered in determining whether Petitioner has an increased need for supervision services.

8. [REDACTED], [REDACTED], and Ms. Stogner provided credible and persuasive testimony regarding the elevated intensity and prolonged duration of Petitioner's maladaptive behaviors. They asserted that the 2 additional hours per week of BA services at issue are medically necessary for parent training and for supervision, de-escalation, and diffusion due to the intensity of Petitioner's behaviors, which have involved [REDACTED] and [REDACTED]. [REDACTED] testified that, due to the intensity and duration of the maladaptive behaviors, [REDACTED] is frequently making modifications "in the moment" as Petitioner's BCBA and needs to continue to do so.

CONCLUSIONS OF LAW

8. 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) of the Florida Statutes (2019). This order is the final administrative decision of AHCA under section 409.285(2)(a).

9. This hearing was held as a *de novo* proceeding pursuant to Florida Administrative Code (“Fla. Admin. Code R.”) 59G-1.100(17)(b), which states “[e]ach fair hearing shall be a *de novo*, evidentiary proceeding, and shall be conducted in a manner that meets the requirements of this rule.”

10. 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.

11. In the instant case, the Respondent reduced a previously approved service. As such, 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.).

12. The Florida Medicaid policy that applies to the requested services is the BA Policy. The Agency’s BA Policy has been incorporated, by reference, into Florida Administrative Code Rule 59G-4.125. 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.

1.1 Florida Medicaid Policies

This policy is intended for use by providers that render BA services to eligible Florida Medicaid recipients. It must be used in conjunction with Florida Medicaid's General Policies (as defined in section 1.3) and any applicable service-specific and claim reimbursement policies with which providers must comply.

Note: All Florida Medicaid policies are promulgated in Rule Division 59G, Florida Administrative Code (F.A.C.). Coverage policies are available on the Agency's Web site at <http://ahca.myflorida.com/Medicaid/review/index.shtml>.

...

2.2 Who Can Receive

Florida Medicaid recipients under the age of 21 years requiring medically necessary BA services. 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 covers services that meet all of the following:

- Are determined medically necessary
- Do not duplicate another service
- 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:

...

4.2.2 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 possible 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; and
- 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)

4.2.3 Behavior Reassessment

Up to three per fiscal year, per recipient

BA Policy at pages 1-3.

13. The BA Policy states the following additional review criteria for BA Services:

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 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)
 - ii. Baseline and/or updated treatment data (if reassessment)
 - iii. Progress toward identified goals (if a reassessment)
 - iv. Identification of the events, times, and situations that appear to be associated to the occurrence of the maladaptive behavior(s)
 - v. Identification of the functional consequences of the maladaptive behavior(s)
 - vi. Development of hypotheses and summary statements that describe the maladaptive behavior(s) and its(their) functions
 - vii. Summary and recommendations

- 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 Goals and strategies for changing the maladaptive behavior(s)
 - iii. Written detailed description of when, where, and how often these goals will be addressed and proposed strategies will be implemented System for monitoring and evaluating the effectiveness of the plan Safety and crisis plan, if applicable Summary and recommendations Discharge criteria 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 Self-stimulating, abnormal, inflexible, or intense preoccupations
- iii. Self-care – difficulty recognizing risks or danger, grooming, eating, or toileting
- iv. Other – behaviors not identified above

...

4. Criteria to Assess the Intensity of Behavior Analysis Services: Providers may request up to 40 hours of BA services per week, per recipient, based upon the following:

As a rule, higher number of maladaptive behaviors, higher severity and frequency of behaviors, as well as the multiplicity of settings where the behaviors occur, would usually justify a higher number of services hours. The greater the number of goals targeted to reduce maladaptive behaviors, the more the likelihood that a higher number of services hours could also be warranted.

Providers **MUST** ensure that proper justification for the requested hours of services is adequately documented in the behavior plan. Based on the information provided in the assessment, behavior plan, and any other supporting documentation, 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

BA Policy, Appendix 9.0, at pages 6-8.

14. The BA Coverage Policy states the following with respect to authorization requirements of BA services:

7.0 Authorization

7.1 General Criteria

The authorization information described below is applicable to the fee-for-service delivery system. For more information on general authorization requirements, please refer to Florida Medicaid's General Policies on authorization requirements.

7.2 Specific Criteria

Providers must obtain authorization from the quality improvement organization (QIO) prior to the initiation of BA services and at least every 180 days thereafter.

Providers may request authorization more frequently upon a change in the recipient's condition requiring an increase or decrease in services.

The QIO uses the review criteria specified in section 9.0 for the first level review. For more information on how the QIO uses the criteria in the review process, please refer to Florida Medicaid's General Policies on authorization requirements.

BA Policy at page 4.

15. The Authorization Policy, incorporated by reference in Fla. Admin. Code RR. 59G-1.053, provides general requirements for providers to obtain authorization to render Florida Medicaid services. It states the following:

1.2 Definitions

The following definitions are applicable to this policy. For additional definitions that are applicable to all sections of Rule Division 59G, F.A.C., please refer to the Florida Medicaid definitions policy.

...

1.3.1 Authorization

The process of obtaining approval for reimbursement of a service based on medical necessity.

...

1.3.6 Provider

The term used to describe any entity, facility, person, or group that has been approved for enrollment or registered with Florida Medicaid.

1.3.7 Quality Improvement Organization

Entity designated to perform utilization review, quality assurance, and quality improvement activities for Florida Medicaid-covered services rendered by fee-for-service providers (also known as the QIO).

...

2.0 Authorization Requirements

...

2.3 Who Can Request Authorization

Authorization requests must be submitted by the provider who plans to render the service unless otherwise specified in the service-specific coverage policy.

...

2.4.2 Requests for Additional Information

The QIO may request additional information, as necessary, to determine medical necessity.

...

3.0 Determination Process

3.1 Review Criteria

The QIO may use a national standardized set of criteria, or other set of criteria, approved by AHCA, as a guide for authorizations performed at the first review level. If services cannot be approved at the first level review, the QIO's physician peer reviewer will determine medical necessity using his or her clinical judgment, acceptable standards of care, state and federal laws, and AHCA's medical necessity definition.

3.2 Review Process

The QIO will review each authorization request and will approve, deny, or request additional information. The QIO may deny a portion of the requested units of service if it cannot substantiate medical necessity based upon the information submitted.

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 errors 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.

Florida Medicaid Authorization Requirements Policy at pages 1-3.

16. The BA Policy provides the following with respect to Florida Medicaid recipients under the age of 21 years, requesting coverage for behavior analysis services:

4.3 Early and Periodic Screening, Diagnosis, and Treatment

As required by federal law, Florida Medicaid provides services to 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 section 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 years 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.

BA Policy at page 3.

17. Given that Petitioner is currently under twenty-one (21) years old, the BA Coverage Policy permits coverage for the BA services at issue. However, the Early and Periodic Screening, Diagnosis, and Treatment (“EPSDT”) requirements of the BA Policy limit this coverage to those instances that are medically necessary. See 42 U.S.C. §§ 1396d(r)(1)-(5). Section 409.905, Florida Statutes, states the following with respect to EPSDT requirements:

(2) EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT SERVICES.

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.

18. Once a service has been identified as requested under EPSDT, the Florida Medicaid program determines the amount or necessity for that service based on the State of Florida’s published definition of medical necessity. The Definitions Policy, which is incorporated by reference in Fla. Admin. Code R. 59G-1.010, defines “medically necessary” or “medical necessity” as follows:

2.83 Medically Necessary or Medical Necessity

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

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

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

19. In the instant case, Respondent reduced Petitioner's BA services because the treatment plan did not show the necessity for continuation of services at the previous level. The NOO and Dr. Conway explained that Petitioner's request for continuation of services did not meet medical necessity as the request 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." See supra ¶ 5, 7.

20. The BA Policy states that the level of functional impairment is a consideration in the determining whether to continue services at the current level. See supra ¶ 13. Safety ([REDACTED]) is a factor in determining the level of functional impairment. See supra ¶ 13. Generally speaking, the higher the severity and frequency of behaviors, as well as the multiplicity of settings where the behaviors occur, would usually justify a higher number of services hours. See supra ¶ 13. Services can be reduced when, among other things, the reviewing physician determines the recipient will not gain any additional benefit by continuing services at the current level. See supra ¶ 15.

21. In this case the undersigned finds the testimony of [REDACTED], [REDACTED], and Ms. Stogner to be credible and persuasive regarding the intensity and duration of Petitioner's maladaptive behaviors. See supra ¶ 8. Dr. Conway's testimony confirmed that intensity, complexity, and safety are all factors that should be considered in determining whether Petitioner has an increased need for supervision. See supra ¶ 7. In this case, it was not shown by a preponderance of the evidence that the recipient will not gain any additional benefit by

continuing services at the current level as required by the Authorizations Policy due to safety considerations.

22. Therefore, upon consideration of the testimony provided, evidence submitted, and applicable policies, the undersigned finds that Respondent did not prove by a preponderance of the evidence that Respondent's reduction of BA technician services for the certification period of [REDACTED], through [REDACTED], was correct.

DECISION

Respondent's reduction in Petitioner's behavior analysis technician services is **REVERSED**.

Petitioner's request for relief is hereby **GRANTED**.

DONE and **ORDERED** this 30th day of June, 2023, in Tallahassee, Leon County, Florida.

Laura Gallagher

23-FH0503



2023.06.30 15:18:31

-04'00'


LAURA GALLAGHER, 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:

[REDACTED]



AHCA Medicaid Hearing Unit
MedicaidHearingUnit@ahca.myflorida.com