

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



FILED

Sep 15, 2023, 11:18 am

OFFICE OF FAIR HEARINGS

[REDACTED]

PETITIONER,

AHCA Case No.: 23-FH1343

vs.

AGENCY FOR HEALTH CARE
ADMINISTRATION,

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic Fair Hearing on the instant case on August 2, 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 terminate Behavior Analysis services was correct.

PRELIMINARY STATEMENT

All parties and witnesses appeared telephonically. Petitioner's Authorized Representative and [REDACTED], [REDACTED] (" [REDACTED] "), appeared on behalf of Petitioner. [REDACTED]

Petitioner's [REDACTED], appeared as a witness for Petitioner. George Menendez, Clinical Director of [REDACTED], appeared as an observer for Petitioner.

Lee Ann Williams, Medical Health Care Program Analyst for the Agency for Health Care Administration ("Agency" or "AHCA"), appeared on behalf of Respondent. Dr. David Bicard ("Dr. Bicard"), BCBA at the doctoral level and Director of Clinical Operations at eQHealth Solutions Inc. ("eQHealth") appeared as a witness for Respondent.

Prior to the hearing, Petitioner sent to the Office of Fair Hearings an eighty-two (82)-page evidence packet. The evidence packet appears in the Office of Fair Hearings' document management system as "23-FH1343 Emailed Correspondence(2).pdf." Absent an objection from the Respondent, the undersigned admitted the evidence packet into evidence as Petitioner's Composite Exhibit 1.

Prior to hearing, Respondent sent to the Office of Fair Hearings and Petitioner a three hundred and forty-six (346)-page evidence packet. The evidence packet appears in the Office of Fair Hearings' document management system as "[REDACTED] FH 08.02.2023 1-135.pdf," "[REDACTED] FH 08.02.2023 136-298.pdf," and "[REDACTED] FH 08.02.2023 299-346.pdf." Absent an objection from the 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 forty-nine (49)-page evidence packet appears in the Office of Fair Hearings document management system as the file title "23-FH1343 AHCA evidence packet 49 pages.pdf." Absent an objection from the 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. 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.

2. Petitioner is [REDACTED]. See Respondent’s Composite Exhibit 1 at page 16. Petitioner is diagnosed with [REDACTED]. *Id.*

3. As provided in the [REDACTED] Intervention Plan: Update (“treatment plan”), Petitioner is engaging in the following maladaptive behaviors: [REDACTED], [REDACTED], [REDACTED], [REDACTED], [REDACTED], [REDACTED], [REDACTED], [REDACTED]. *Id.* at 182.

4. Petitioner requested the continuation of BA services. In a Notice of Outcome (“NOO”), dated May 26, 2023, Respondent terminated Petitioner’s BA services. *Id.* at 24 – 25. The NOO explained the basis for the determination as follows:

[T]he 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.

The NOO further provided:

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

PR Clinical Rationale – Denial: According to the Florida Medicaid State Plan (Appendix 9.3.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. The recommendations for procedural modifications should include one or more of the following: antecedent manipulation modifications, modifications of prompting procedures used in

acquisition, modifications in consequence-based strategies – ones that either reduce maladaptive behavior or reinforce replacement behavior (e.g., manipulation of reinforcement schedules, switch to a difference decelerative procedure), or if lack or progress was due to therapist error (e.g., poor data collection or poor training on intervention methods), how you will address human error. The provider has not adequately address the lack of significant clinical progress during the last observation period and did not amend the treatment plan in relation to he lack of progress.

Id.

5. Petitioner requested reconsideration of the Respondent’s decision. In a Notice of Reconsideration Determination (“NRD”), dated June 5, 2023, Respondent upheld its decision. *Id.* at 36-37. The NRD explained the basis for the decision as follows:

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

- Consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational.
- Individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness under treatment, and not in excess of the patient’s needs.
- Not duplicative of services being rendered by another party.

PR Recon Determination: The provider was requested to revise the treatment plan to conform to the Florida Behavior Analysis Services Coverage Policy. According to Florida Behavior Analysis Service Coverage policy, all services must be designed to ameliorate the symptoms of a confirmed diagnosis and cannot be academic, vocational, or duplicative services. The provider has listed treatment goals that are not covered by the Behavior Analysis Services Coverage Policy (listening to a story). Additionally, the recipient has been in service with this provider since [REDACTED] without progress. At reconsideration all documents were carefully reviewed. According to the Florid Medicaid state Plan (Appendix 9.3.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. The recommendations for procedural modifications include: additions/changes to treatment plan to impact behaviors targeted for reduction. Procedural modifications should include one or more of the following: antecedent manipulation modifications, modifications of prompting procedures used in acquisition, modifications in consequence-based strategies – one that either reduce maladaptive behavior or reinforce replacement behavior (e.g.,

manipulation of reinforcement schedules, switch to a different decelerative procedure), or if lack of progress was due to therapist error (e.g., poor data collection or poor training on intervention methods), how the provider will address human error. The recommendations are insufficient to support continued care. This reconsideration request has been reviewed, reconsidered and the denial is upheld.

Id.

6. On June 2, 2023, Petitioner requested a Fair Hearing to challenge the termination of additional BA services. On July 6, 2023, the undersigned issued an Order Scheduling Fair Hearing and Prehearing Instructions, setting the hearing for August 2, 2023, at 9:00 a.m. EST.

7. [REDACTED] testified that BA therapy has helped Petitioner and that progress has been made.

8. Mr. Menendez testified to his role as clinical director. He testified that the provider removed non-covered services from the treatment plan. He indicated that Petitioner has made progress, and he recommended that a new lead analyst should be assigned to Petitioner's case and that data collection methods be reviewed. He agreed that modifications need to be made to the treatment plan but asserted that services should not be terminated.

9. Dr. Bocard testified to the following:

- a. Petitioner has received more than thirty (30) hours per week of BA services with the current provider since [REDACTED].
- b. If there is a lack of progress without modifications to the treatment plan to address the lack of progress, then the treatment plan does not meet standards of care in the field of BA.
- c. At first level review at eQHealth, the treatment plan was pended to give the provider the opportunity to improve the treatment plan. The provider removed

some non-covered services from the treatment plan but did not suggest any modifications to treatment to address Petitioner's lack of progress of maladaptive behaviors.

- d. At reconsideration, the case was reviewed by a different BCBA at the doctoral level at eQHealth who upheld the denial. Dr. Bicard reviewed all documentation and agrees with the determinations of the previous eQHealth reviewers.
- e. Referring to the BA Policy Criteria 3, 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 to address the lack of progress. See Respondent's Composite Exhibit 2 at page 46. In this case, the data graphs maladaptive behaviors have a lot of variability, maladaptive behaviors have not improved in over a year of service with no modifications to address the lack of progress, and some of the graphs for maladaptive behaviors show that behaviors have gotten worse during treatment. See Respondent's Composite Exhibit 1 at pages 281 – 288. When data are variable, it means that the provider does not have a good indication of what is controlling the maladaptive behavior and has not captured that in treatment. Further, when a recipient does not respond to treatment (improve), it is the responsibility of the provider to develop interventions to address the lack of progress and that was not done in this treatment plan.
- f. With regard to skill acquisition, the treatment plan data show that there has been no progress on skill acquisition since [REDACTED]. The data are below 50% and

that is considered chance level. When data are below 50% or chance level, that means that the BA provider has not identified the relevant environmental events surrounding and supporting the maladaptive behavior. See Respondent's Composite Exhibit 1 at pages 303 – 324. In this case, there are readily available and relatively easy interventions that could have been implemented to address the lack of progress.

- g. Referring to BA Policy Criteria 5, Petitioner meets the criteria for discharge because the treatment plan shows no progress towards identified goals in the past twelve (12) months. Dr. Bicard considered EPSDT and the BA Policy, and determined that Petitioner would not benefit from continuing treatment under an ineffective treatment plan.

CONCLUSIONS OF LAW

10. 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).

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

12. Because Respondent terminated a previously approved service, Fla. Admin. Code R. 59G-1.100(17)(g) assigns the burden of proof to Respondent. The standard of proof in an administrative hearing is a preponderance of the evidence. The preponderance of the evidence standard requires proof by "the greater weight of the evidence" (Black's Law Dictionary at 1201, 7th Ed.)

13. The Florida Medicaid Behavior Analysis Services Coverage Policy (October 2017) (“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 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:

4.2.1 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 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 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.

...

Pages 1 – 3 of BA Policy.

14. 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. Provide 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 treatments 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

...

5. Criteria for Discharge from Behavior Analysis Services - ONE or MORE of the following MUST be satisfied:

- a. The critical elements are **no longer met**.
- b. The data provided shows that the frequency and severity of maladaptive behavior(s) has declined to the point that they no longer pose a barrier to the child’s ability to function in his/her environment.
- c. The data provided shows the recipient has made no progress toward any goals in the last 12 consecutive months.
- d. The level of functional impairment as expressed through behaviors no longer justifies continued BA services.
- e. Parent/guardian withdraws consent for treatment.

Pages 6 – 8 of BA Policy.

15. 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.

16. Petitioner is under age 21, and therefore EPSDT applies to the request for services. However, a state may place medical necessity limitations on EPSDT services. See 42 C.F.R. §§ 440.230(a), (b), (d). Section 409.905(2), Florida Statutes, 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.

17. The Florida Medicaid Definitions Policy (“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.

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

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 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.

Page 3 of Authorization Policy.

19. In the instant case, Respondent terminated Petitioner’s BA services. *See supra* ¶ 4, 5. In the NOO Respondent explained that the services at issue do not meet medical necessity criteria. Specifically, the submitted information did not support the medical necessity for the requested frequency and/or duration. *See supra* ¶ 4, 5.

20. As provided by the BA Policy and EPSDT requirements, the BA services at issue must meet the medical necessity criteria outlined in Fla. Admin. Code R. 59G-1.010. *See supra* ¶ 14. Section 2.83 of the Definitions Policy states that all five components of medical necessity must be met.

Two components of medical necessity are that services must be “[i]ndividualized, specific, and consistent with symptoms or confirmed diagnosis of the illness under treatment, and not in excess of the patient’s needs” and “[c]onsistent with generally accepted professional medical standards as determined by the Medicaid program.” See supra ¶ 17. The behavior plan is the cornerstone of the delivery of behavior analysis services, and it is based on the information obtained in the assessment. See supra ¶ 14. The Authorization Requirements Policy states that eQHealth may deny service if it cannot substantiate medical necessity based upon the information submitted. See supra ¶ 18. Further, the BA Policy states that services may be terminated when “the critical elements are no longer met” or the “data provided shows the recipient has made no progress toward any goals in the last 12 consecutive months.” See supra ¶ 14.

21. In this case, Dr. Bicard provided credible and persuasive testimony that the requested services are not consistent with generally accepted professional medical standards. For example, the data graphs for maladaptive behaviors show a lot of variability, maladaptive behaviors (such as [REDACTED]) have not improved in over a year of service with no modifications to address the lack of progress, and some of the graphs for maladaptive behaviors (such as [REDACTED], [REDACTED], and [REDACTED]) show that behaviors have gotten worse over the course treatment. See supra ¶ 9. As Dr. Bicard established, when data are variable, it means that the provider does not have a good indication of what is controlling the maladaptive behavior and has not captured that in treatment. See supra ¶ 9. Further, when a recipient does not respond to treatment, it is the responsibility of the provider to develop interventions to address the lack of progress and that was not done in this treatment plan. See supra ¶ 9. The undersigned concludes that the data

provided does not show evidence that the frequency of the maladaptive behavior(s) has decreased since the last review and that there was a modification of the behavior plan to address the lack of progress.


22. With regard to skill acquisition, Dr. Bicard provided credible and persuasive testimony that the treatment plan data show no progress on skill acquisition since [REDACTED] (over one year). See supra ¶ 9. The data graphs are below 50% or chance level. When data are below 50% or chance level, that means that the BA provider has not identified the relevant environmental events surrounding and supporting the maladaptive behavior. See supra ¶ 9. In this case, Dr. Bicard established that there are readily available and relatively easy interventions that could have been implemented to address the lack of progress but no modifications were made to the treatment plan. Therefore, the treatment plan is not consistent with generally accepted professional medical standards as determined by the Medicaid program.

23. Upon consideration of the testimony provided, evidence submitted, and applicable polices, Respondent proved by a preponderance of the evidence that the BA services at issue no longer meet medical necessity criteria. Looking at all the evidence relevant to the particular needs of Petitioner, Respondent has demonstrated that the BA services, based on the treatment plan at issue in this case, are not necessary to correct or ameliorate a defect or a physical and mental illness or condition. Accordingly, Respondent proved by a preponderance of the evidence that Respondent's termination of BA services was correct.

IT IS HEREBY ORDERED AND ADJUDGED THAT:

Respondent's termination of BA services is **AFFIRMED**. Petitioner's appeal based on Respondent's termination is **DENIED**.

DONE and **ORDERED** this 15th day of September 2023, in Tallahassee, Leon County,
Florida.

Laura Gallagher
23-FH1343
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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:



AHCA Medicaid Hearing Unit
MedicaidHearingUnit@ahca.myflorida.com