

Doris Rivera, Medical Health Care Program Analyst for the Agency and Fair Hearing Liaison for Health Care Administration (“Agency” or “AHCA”), appeared for the Fair Hearing as a representative for Respondent. Dr. David Bicard (“Dr. Bicard”), Board-Certified Behavior Analyst (“BCBA”) at the doctoral level and Director of Clinical Operations for eQHealth Solutions Inc. (“eQHealth”), appeared as a witness for Respondent.

Jorge, translator number 223611, appeared at the hearing to provide Spanish translation services.

Petitioner did not introduce any exhibits at the Fair Hearing.

Prior to the Fair Hearing, Respondent sent to the Office of Fair Hearings and Petitioner a two hundred and seventy-eight (278)-page evidence packet and a forty-nine (49)-page evidence packet. The two hundred and seventy-eight (278)-page packet appears in the Office of Fair Hearings’ document management system as the file titled “██████████ FH 08.21.23 1 - 166.pdf” and “██████████ FH 08.21.23 167 - 278.pdf”. The forty-nine (49)-page packet appears in the Office of Fair Hearings’ document management system as the file titled “23-FH1589 Agency Evidence BA 49 pgs.pdf”. Absent any objections from Petitioner, the undersigned admitted the two hundred and seventy-eight (278)-page evidence packet as Respondent’s Composite Exhibit 1 (“RCE 1”) and the forty-nine (49)-page evidence packet as Respondent’s Composite Exhibit 2 (“RCE 2”).

FINDINGS OF FACT

1. Petitioner receives Medicaid services on a fee-for-service basis through the Agency. See RCE 1 at page 21. eQHealth is a Quality Improvement Organization contracted by the Agency to review prior authorization requests for services. See RCE 2 at page 2.

2. Petitioner is [REDACTED] ([REDACTED] [REDACTED]) old. See RCE 1 at page 21. Petitioner is diagnosed with [REDACTED]. *Id.*

3. As provided in the Behavior Analysis Service Plan (“treatment plan” or “behavior plan”), Petitioner is engaging in the following maladaptive behaviors: [REDACTED]

[REDACTED]
[REDACTED]. *Id.*

at 55.

4. As provided in the Individual Implementation Plan, for the period from [REDACTED] through [REDACTED], Petitioner has made the following progress in reducing [REDACTED] maladaptive behaviors: for [REDACTED] Petitioner’s incidents increased from approximately [REDACTED] to approximately [REDACTED] for [REDACTED], Petitioner’s incidents increased from approximately [REDACTED] to approximately [REDACTED] for [REDACTED], Petitioner’s incidents increased from approximately [REDACTED] to approximately [REDACTED] for [REDACTED] Petitioner’s incidents increased from approximately [REDACTED] to approximately [REDACTED] for [REDACTED] Petitioner’s incidents increased from approximately [REDACTED] to approximately [REDACTED] for [REDACTED], Petitioner’s incidents decreased from approximately [REDACTED] to approximately [REDACTED] for [REDACTED] Petitioner’s incidents decreased from approximately [REDACTED] to approximately [REDACTED] for [REDACTED] Petitioner’s incidents remained consistent at approximately [REDACTED] and for [REDACTED], Petitioner’s incidents remained consistent at approximately [REDACTED]. *Id.* at 90 – 99.

5. On April 26, 2023, Petitioner requested continuation of BA services; specifically, 2,080 units of code 97153; 208 units of code 97155; and 208 units of code 97156. *Id.* at 28. In a Notice

of Outcome (“NOO”), dated May 12, 2023, Respondent terminated Petitioner’s BA services. *Id.*

at 28 - 32. The NOO explained the basis for the termination 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:

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 carefully reviewed. Several maladaptive behaviors are indicating increasing trends such as [REDACTED]. According to the Florida Medicaid State Plan (Appendix 9.3.b), the date provided must show evidence that the frequency of 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 – ones 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 you will address human error. The provider has not addressed the lack of progress during the last observation period and did not amend the treatment plan in relation to the lack of progress. The provider was requested to submit additional information on treatment modifications to determine the medical necessity of this request and the provider has either failed to submit this information or the information submitted does not meet standards of care within the field of behavior analysis or the information submitted is insufficient to address the lack of progress indicated. This request for BA services is denied.

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6. Petitioner requested reconsideration of the Respondent’s decision. In a Notice of Reconsideration Determination (“NRD”), dated May 31, 2023, Respondent upheld its decision.

Id. 40 – 43. The NRD explained the basis for the decision as follows:

PR Recon Determination: At reconsideration all documents were carefully reviewed. 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 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—ones 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. The reconsideration request has been reviewed, reconsidered and the denial is upheld.

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7. On May 30, 2023, Petitioner requested a Fair Hearing to challenge the termination of BA services. On July 28, 2023, the Office of Fair Hearings issued an Order Scheduling Fair Hearing and Prehearing Instructions, setting the hearing for August 21, 2023, at 9:00 a.m. EST.

8. Dr. Bicard is a BCBA at the doctoral level. Dr. Bicard testified to the following:

a. Dr. Bicard cited the definition of medical necessity criteria for the state of Florida, in that for any type of request for behavior analysis services for Medicaid, services must meet all five (5) of the following conditions:

1. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;

2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and

3. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;

4. 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; and

5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.

* * *

(c) 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.

RCE 2 at page 7.

- b. Petitioner has received BA services from the provider, [REDACTED], since at least [REDACTED] Respondent only has data from [REDACTED] because that is when eQHealth took over the contract for Florida Medicaid.
- c. A provider must provide BA services that are within generally accepted professional standards of care. When a child does not respond to treatment very well, then the provider must develop different methods and ways of doing things to get the behavior to respond to treatment. This provider has not done that. The provider was asked to identify different types of treatments for Petitioner's maladaptive behaviors. The provider did not do that. Instead, the provider collected baseline data on new behaviors, which is not the same as looking at the maladaptive behaviors Petitioner is engaging in. The provider submitted no new information. The provider has not addressed the lack of progress for Petitioner.

- d. The graph for [REDACTED] ([REDACTED]) shows data collected since [REDACTED] [REDACTED]. See RCE 1 at 241. The information shows that for the last year Petitioner has not made improvements on this behavior over the course of the treatment that has been provided. There are no interventions in this treatment plan other than the note of “no medication”.
- e. The graph for [REDACTED] goes back to [REDACTED]. See RCE 1 at 242. There is a lack of real data; it appears this is monthly data. Dr. Bicard hopes that the provider is collecting data more than once a month. There should be intervention information and there is no intervention, the behavior has not improved. The data is not going in a downward direction. The data shows the behavior is not getting worse and is not getting better. This is an indication that the treatment with this provider has received maximum benefit and there is no real hope that the behavior will change unless the provider makes specific changes. The provider has not made specific changes.
- f. The graph for [REDACTED] goes back to [REDACTED]. See RCE 1 at 243. The behavior has gotten worse in the last year with this provider. There is no intervention. It is not clear what this provider is doing to try and help the Petitioner.
- g. The graph for [REDACTED] shows a slight increase in the frequency of this behavior during the last year of treatment. See RCE 1 at 243.
- h. The graph for [REDACTED] goes all the way back to [REDACTED]. See RCE 1 at 244. There is no change in the data from [REDACTED]. This shows that Petitioner is not

responding to the treatment identified by the provider, and the provider has not identified any real interventions to try and change this behavior.

- i. The graph for [REDACTED] goes all the way back to [REDACTED] See RCE 1 at 245. There is no change in behavior in the last year; it is at the same level. There is no intervention.
- j. The graph for [REDACTED] goes back to [REDACTED] See RCE 1 at 246. For the last six (6) months there is no improvement of behavior.
- k. Another topography of [REDACTED] shows no improvement of behavior. See RCE 1 at 247.
- l. The graph for [REDACTED] shows no improvement as provided by the provider since [REDACTED] See RCE 1 at 249.
- m. The replacement programs show that Petitioner is not able to engagement in independent behavior. See RCE 1 at 249. All of the goals the provider have identified are with modeling prompts. A modeling prompt is when the provider or therapist demonstrates how to do something and Petitioner does it after that. In the field of BA, especially for children like Petitioner, instructions are begun with prompts. Those prompts have to be quickly faded out, meaning Petitioner has to learn to engage in the behavior and the prompts are systematically removed. The goal is for independent responding. None of the goals identified by the provider are for independent responding, except for [REDACTED] [REDACTED], which is a low duration. This is an unacceptable level of progress for

Petitioner, especially since [REDACTED] has participated with this provider since at least [REDACTED].

- n. Overall, there is a lack of progress related to maladaptive behaviors and a lack of progress related to Petitioner's replacement behaviors or skill acquisition goals (things the provider is trying to teach Petitioner). This is not within standards of care within the field of behavior analysis and does not meet specification of the BA policy.
- o. The Criteria for Continuation of Treatment states the data provided must show evidence that the frequency of the maladaptive behaviors has decreased since the last review and, if not, that there is a modification of the behavior plan. *See RCE 2 at 46.* Clearly, the frequency of maladaptive behaviors for Petitioner has not improved and there are not any modifications to the behavior plan identified by the provider. This does not meet the specification in the behavior analysis coverage policy.
- p. The Criteria for Discharge from Behavior Analysis Services allows BA services to be discharged if the data provided shows the recipient has made no progress toward any goals in the last twelve (12) consecutive months. *See RCE 2 at 47.* The information submitted by the provider with the best available data and treatment that the provider has identified does not show Petitioner has become more independent in [REDACTED] activities of daily living and functioning, and the maladaptive behaviors appear to be mostly stable. This is why services were denied.

- q. The provider was given several opportunities to make changes to the treatment plan, and those changes were never made by the provider.
 - r. Dr. Bicard stated that Petitioner is entitled to effective services and that the treatment this provider has identified is substandard.
9. [REDACTED] is Petitioner's [REDACTED] [REDACTED] testified to the following:
- a. [REDACTED] suspended Petitioner's medication in [REDACTED] because Petitioner was [REDACTED]. Petitioner did not have medication to help [REDACTED] calm down and focus for the first six (6) months of [REDACTED].
 - b. [REDACTED] believes Petitioner has improved a lot and [REDACTED] is thankful with the provider and therapist.

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)(b) 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.).

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 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
- 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 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.

RCE 2 at 40, 42.

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

RCE 2 at 45 – 46.

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.

RCE 2 at 4 – 5.

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). 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.

RCE 2 at 13.

17. 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.

RCE 2 at 7, 23.

18. The Florida Medicaid Authorization Requirements Policy (“Authorization Requirements 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 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.

Respondent demonstrated that BA services through this provider are not consistent with generally accepted professional medical standards.

21. As QIO for the Agency, eQHealth is authorized to terminate services when “the reviewing physician determines the recipient will not gain any additional benefit by continuing services at the current level.” See ¶ 17. As discussed, *supra* ¶ 19, Petitioner has not made progress with this provider and this provider has failed to adequately demonstrate a decrease in maladaptive behaviors or a modification of the behavior plan. Accordingly, the record shows that Petitioner will not benefit from continuing services with this provider.

22. Upon consideration of the testimony provided, evidence submitted, and applicable polices, the undersigned concludes that Respondent proved by a preponderance of the evidence that the termination of ABA services was necessary. Looking at all the evidence relevant to the particular needs of Petitioner, Respondent has demonstrated that the previously authorized 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 ABA services was correct.

IT IS HEREBY ORDERED AND ADJUDGED THAT:

Respondent’s termination of ABA services is **AFFIRMED**. Petitioner’s appeal based on Respondent’s termination is **DENIED**.

DONE AND ORDERED this 28th day of August, 2023 in Tallahassee, Leon County, Florida.



Kameisha Presley

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KAMEISHA PRESLEY, Hearing Officer
Agency for Health Care Administration
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NOTICE OF A RIGHT TO JUDICIAL REVIEW

A PARTY WHO IS ADVERSELY AFFECTED BY THIS FINAL ORDER IS ENTITLED TO JUDICIAL REVIEW, WHICH SHALL BE INSTITUTED BY FILING THE ORIGINAL NOTICE OF APPEAL WITH THE AGENCY CLERK OF AHCA, AND A COPY, ALONG WITH THE FILING FEE PRESCRIBED BY LAW, WITH THE DISTRICT COURT OF APPEAL IN THE APPELLATE DISTRICT WHERE THE AGENCY MAINTAINS ITS HEADQUARTERS OR WHERE A PARTY RESIDES. REVIEW PROCEEDINGS SHALL BE CONDUCTED IN ACCORDANCE WITH THE FLORIDA APPELLATE RULES. THE NOTICE OF APPEAL MUST BE FILED WITHIN 30 DAYS OF THE RENDITION OF THE ORDER TO BE REVIEWED.

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