



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

FILED

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OFFICE OF FAIR HEARINGS

[REDACTED]

PETITIONER,

AHCA CASE NO.: 23-FH1841

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 31, 2023, at 1:00 p.m. Eastern Standard Time (“EST”).

APPEARANCES

For the Petitioner:

[REDACTED]

Petitioner’s Authorized Representative

For the Respondent:

Doris Rivera
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 Petitioner’s Applied Behavior Analysis services (“BA” or “ABA”) services was correct.

PRELIMINARY STATEMENT

All parties and witnesses appeared telephonically. Petitioner’s Authorized Representative

[REDACTED]

[REDACTED]

appeared

on behalf of Petitioner. Thelma Long (“Ms. Long”), Behavior Analyst for [REDACTED], attended as a witness for Petitioner.

Doris Rivera, Medical/Health Care Program Analyst for the Agency for Health Care Administration (“Agency” or “AHCA”), appeared on behalf of Respondent. Dr. Lissa Conway (“Dr. Conway”), BCBA at the Doctoral level and Director of Clinical Operations for eQHealth Solutions Inc. (“eQHealth”) appeared as a witness for Respondent.

Petitioner did not submit evidence for the hearing. Prior to the hearing, Respondent sent to the Office of Fair Hearings and Petitioner one hundred and forty-two (142) pages of documentary evidence, consisting of two (2) packets appearing in the Office of Fair Hearings’ document management system as file titles “[REDACTED]-FH 08.31.2023 1-100.pdf and [REDACTED] FH 08.31.2023 101-142.pdf”; and a forty-nine (49)-page evidence packet appearing in the Office of Fair Hearings’ document management system as the file title “23-FH1841 Agency BA 49 pgs.pdf”. Absent an objection from the Petitioner, the undersigned admitted the one hundred and forty-two (142)-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”).

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 is [REDACTED] old. *See* page 16 of RCE 1. Petitioner is diagnosed with [REDACTED]. *Id.* Petitioner has participated in ABA services with the [REDACTED].

current provider, [REDACTED] (“Provider”), since [REDACTED], for over twelve (12) months. *Id.* at 139.

3. As provided in the Behavior Plan Update, dated [REDACTED] (“treatment plan”), Petitioner engages in the following maladaptive behaviors: [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED] *Id.* at 46.

4. Petitioner requested continuation of ABA services for the period from May 18, 2023, through November 13, 2023. *Id.* at 22. Specifically, Petitioner requested 3,380 units of code 97153, intervention without protocol modification, per 15 minutes, Lead Analyst, BCaBA, or RBT; 156 units of code 97155, intervention with protocol modification, per 15 minutes; and 156 units of code 97156, family training, per 15 minutes, Lead Analyst. *Id.*

5. In a Notice of Outcome (“NOO”), dated May 24, 2023, Respondent denied the total units requested, including 3,380 units of code 97153; 156 units of code 97155; and 156 units of 97156, thereby terminating Petitioner’s ABA services. The NOO explained the basis for the denial as follows:

The request for services is denied in whole or in part because they are not medically necessary as defined in Rule 59G-1.010, Florida Administrative Code. Specifically, the requested services are not medically necessary under the following standard(s):

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

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

The rationale for our decision is as follows:

PR Clinical Reason – Denial:

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

PR Clinical Rationale – Denial: The provider was requested to clarify the increase of maladaptive behaviors and decrease of replacement behavior data when compared to data submitted for previous authorizations. This issue has not been addressed. The justification submitted with this treatment is insufficient given the requested units and the recipient’s maladaptive behaviors and skill deficits addressed in this treatment plan. This request for BA services is denied.

...

Pages 22 – 23 of RCE 1.

6. Petitioner requested reconsideration of the Respondent’s decision. In a Notice of Reconsideration Determination (“NRD”), dated July 29, 2023, Respondent upheld its decision. *Id.* at 33 – 36. The NRD explained the rationale for the decision as follows:

PR Recon Determination: At reconsideration all documents were carefully reviewed including prior authorization treatment plan submissions. The provider was requested to clarify the increase of maladaptive behaviors and decrease of replacement behavior data when compared to data submitted for previous authorizations. This issue has not been addressed in the reconsideration documentation submitted. The justification submitted with this treatment is insufficient given the requested units and the recipient's maladaptive behaviors and skill deficits addressed in this treatment plan. This reconsideration request has been reviewed, reconsidered and the denial is upheld.

Id. at 34.

7. On July 24, 2023, Petitioner requested a Fair Hearing to challenge the termination of ABA services. On August 16, 2023, the undersigned issued an Order Scheduling Fair Hearing and Prehearing Instructions, setting the hearing for August 31, 2023, at 1:00 p.m. EST. *Id.* at 8 - 12.

8. When reviewing the effectiveness of a treatment plan, what is looked at is whether maladaptive behaviors are being reduced and whether replacement behaviors are being

increased. See, Appendix 9.0 of the BA Policy providing Review Criteria for Behavior Analysis Services, *infra* ¶ 18.

9. Dr. Conway is a Board-Certified Behavior Analyst at the doctoral level. Dr. Conway established that eQHealth reviews behavior analysis cases to ensure that providers are giving quality care consistent with the standards enumerated in the BA Policy as well as professional medical standards of applied behavior analysis (“ABA”). eQHealth reviewed the treatment plan submitted in this case to determine whether all five (5) conditions of medical necessity are met. The current treatment plan went through a peer review process conducted by three (3) Board Certified Behavior Analysts (BCBAs), including two at the doctoral level. The reviewing BCBAs each returned the treatment plan to the Provider, requesting the Provider to clarify the increase of maladaptive behaviors and decrease of replacement behavior data when compared to data submitted for previous authorizations. The Provider revised the treatment plan, but the treatment plan was determined non-responsive and to why Petitioner’s maladaptive behaviors increased and replacement behaviors decreased from the previous authorization period to the current authorization period, therefore, the plan did not meet medical necessity criteria. RCE 1 at 22 – 23, 34.

10. Dr. Conway established that the data from the graphs measure progress in a recipient’s ABA treatment. For example, the treatment plan shows that the maladaptive behaviors of [REDACTED] [REDACTED] have decreased, as shown on the summary graphs data measured from [REDACTED] through [REDACTED]. However, Dr. Conway explained, in the previous authorization period ending the [REDACTED],

certain of these maladaptive behaviors were down significantly more than when they were measured just one (1) week later, or [REDACTED]. *Id.* at 64. For example, looking at the baseline for the behavior of [REDACTED] the occurrences were approximately thirteen (13) per week at the [REDACTED], then data shows them at [REDACTED] per week at the beginning of this current authorization; for [REDACTED] the level at end of authorization are [REDACTED] per week, but in the current authorization, they start as [REDACTED] occurrences per week; and similarly with [REDACTED], the levels are lower at the end of the last authorization than the beginning of the new authorization period. Dr. Conway further testified that this pattern continues along the skills acquisition data as well. Dr. Conway testified that the Provider was requested to clarify the sudden increase of maladaptive behaviors when compared to data shown at the end of the previous authorization, just one week earlier from the authorization period beginning on [REDACTED], since this issue has not been addressed in the reconsideration documentation submitted. Dr. Conway testified further that the data shows that Petitioner's maladaptive behaviors are extremely high for having treatment for over one (1) year. Dr. Conway concluded that the data is highly concerning, does not meet standard of care in applied behavior analysis.

11. Petitioner's authorized representative and [REDACTED], testified that the data from Petitioner's [REDACTED], authorization period shows empirical progress. [REDACTED] testified that Petitioner's maladaptive behaviors suddenly increased from the end of the previous authorization period ending [REDACTED], to the new authorization period beginning [REDACTED], because there were extenuating and external factors that existed. [REDACTED] explained that Petitioner was transferred from one [REDACTED] to

another one and changed schools at end of last authorization period, and that [REDACTED] was transferred between [REDACTED] and plans. [REDACTED] explained further that Petitioner was on [REDACTED] [REDACTED] that were changed just at the end of last period. [REDACTED] contended that significant social and educational changes for Petitioner were just around the time the certification period changed. [REDACTED] testified that [REDACTED] called Petitioner's [REDACTED], Dr. Carrasco, to find the reasons why Petitioner was behaving worse, and that Dr. Carrasco believes as [REDACTED] does that ABA services for Petitioner should continue, and not be ended because of a technicality.

CONCLUSIONS OF LAW

12. 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).

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

14. Because Respondent terminated Petitioner's 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.)

15. The 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
- 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.

16. 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

17. 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.

18. Petitioner is under age 21, and therefore EPSDT applies to [REDACTED] 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.

19. The Florida Medicaid 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.

20. The Florida Medicaid Authorization Requirements Policy (“Authorization Requirements Policy”) (June 2016), incorporated by reference in Fla. Admin. Code R. 59G-1.053, provides general requirements for providers to obtain authorization to render Florida Medicaid services.

The Authorization Requirements Policy states, in pertinent part:

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.

21. Petitioner is under the age of 21 years and diagnosed with [REDACTED] and [REDACTED] [REDACTED]. *See supra* ¶ 2. The parties agree that Petitioner currently engages in maladaptive behaviors that interfere with [REDACTED] daily functioning. *See supra* ¶ 4, 5. Respondent determined that the BA provider did not “clarify the increase of maladaptive behaviors and decrease of replacement behavior data when compared to data submitted for previous authorizations. This issue has not been addressed in the reconsideration documentation submitted.” *See supra* ¶¶ 5, 6.

22. Respondent terminated Petitioner's ABA services because the submitted documentation did not establish the medical necessity of the services. *See supra* ¶¶ 5, 6. Based on the record, Respondent determined that the documentation did not meet the following medical necessity standards: individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness under treatment, and not in excess of the patient's needs; and consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational. *See supra* ¶ 5. The medical necessity standards are expressly outlined in section 2.83 of the Definitions Policy and a critical element for behavior analysis services reassessments. *See supra* ¶ 20. The BA Policy mandates that the treatment plan must be

detailed enough to warrant the requested services and include mechanisms to monitor and evaluate its effectiveness. *See supra* ¶ 17.

23. In the instant case, Petitioner requested additional BA services for the period from May 18, 2023, through November 13, 2023. Specifically, Petitioner requested 3,380 units of code 97153; 156 units of code 97155; and 156 units of code 97156. In a NOO, dated May 24, 2023, and an NRD, dated July 25, 2023, Respondent denied all of the requested units of ABA services, *supra* ¶¶ 5, 6, determining that Petitioner’s request was not “medically necessary under the following standards: individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness under treatment, and not in excess of the patient’s needs; and consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational. *See supra* ¶¶ 5, 6.

24. As Respondent bears the burden of proof, the Respondent must show that the BA services at issue, *i.e.* the continuation of 3,380 units of code 97153, 156 units of code 97155, and 156 units of code 97156, no longer meet medical necessity criteria. Here, the record shows that Petitioner engages in the following maladaptive behaviors: [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED] *See supra* ¶ 3. However, Dr. Conway provided credible and persuasive testimony the treatment plan shows no significant improvement of maladaptive behaviors and replacement behaviors over the prior authorization period. As Dr. Conway established, based on the lack of improvement, the ABA services with this provider are not provided in a manner that is individualized and specific to Petitioner and are not designed to effectively treat Petitioner’s

symptoms of confirmed diagnosis and Petitioner would not gain any additional benefit from continuing under the treatment plan at issue. *See supra* ¶ 9.

25. Lastly, the record reflects that Petitioner’s provider believes that BA services are medically necessary. *See supra* ¶ 4. However, 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.” *See supra* ¶ 21.

26. Accordingly, Respondent has met their burden of proof to show that the requested ABA services no longer meet medically necessary criteria. Based on the all the evidence relevant to the particular needs of Petitioner, the requested additional BA services at issue are not necessary to correct or ameliorate a defect or a physical and mental illness or condition.

27. Upon consideration of the testimony provided, evidence submitted, and applicable policies, the undersigned finds that Respondent proved by a preponderance of the evidence that Respondent’s termination of the BA services at issue was correct.

IT IS HEREBY ORDERED AND ADJUDGED THAT:

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

DONE and **ORDERED** this 7th day of November 2023, in Tallahassee, Leon County, Florida.



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

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
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