



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

FILED

Dec 22, 2023, 9:51 am
OFFICE OF FAIR HEARINGS

[REDACTED]

PETITIONER,

AHCA Case No.: 23-FH2389

vs.

AGENCY FOR HEALTH CARE
ADMINISTRATION,

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned Hearing Officer convened a telephonic Fair Hearing on the instant case on November 1, 2023, at 9:30 a.m. Eastern Standard Time (“EST”).

APPEARANCES

For the Petitioner:

[REDACTED]

Petitioner’s Authorized Representative

For the Respondent:

Suzanne Chillari
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 termination of Petitioner’s behavior analysis (“ABA” or “BA”) services was correct.

PRELIMINARY STATEMENT

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

[REDACTED]), Licensed Mental Health Counselor and Lead Analyst with [REDACTED]
[REDACTED]. (“Provider”), appeared at the hearing as a witness for Petitioner.

Suzanne Chillari, Medical Health Care Program Analyst and Fair Hearing Liaison for the Agency for Health Care Administration (“Agency” or “AHCA”), appeared for the Fair Hearing as a representative for Respondent. Dr. Alissa Conway (“Dr. Conway”), Board-Certified Behavior Analyst at the Doctoral Level (“BCBA-D”) and Second Level Reviewer for eQHealth Solutions, appeared for the Fair Hearing as a witness for Respondent.

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 one hundred and thirty-six (136)-page evidence packet and a forty-nine (49)-page evidence packet. The one hundred and thirty-six (136)-page packet appears in the Office of Fair Hearings’ document management system as the file titled “[REDACTED] FH 11.01.2023.pdf”. The forty-nine (49)-page packet appears in the Office of Fair Hearings’ document management system as the file titled “Agency Evidence Legal Authorities 23-FH2389.pdf”. Absent any objections from Petitioner, the undersigned admitted the one hundred and thirty-six (136)-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 16. eQHealth is a Quality Improvement Organization contracted by the Agency to review prior authorization requests for services. See RCE 2 at 2.

2. Petitioner is [REDACTED]. See RCE 1 at 16. Petitioner is diagnosed with [REDACTED] and [REDACTED]. *Id.* at 16, 45.

3. As provided in the Provider’s Behavior Analysis Assessment (“Assessment” or “treatment plan”), dated August 24, 2023, Petitioner is engaging in the following maladaptive behaviors: [REDACTED], [REDACTED], [REDACTED], [REDACTED], and [REDACTED]. *Id.* at 49 – 50. Petitioner is learning the following replacement behaviors: [REDACTED], [REDACTED], [REDACTED], [REDACTED], [REDACTED], and [REDACTED]. *Id.* at 54 – 60.

4. As provided in the Reassessment, the data graphs for Petitioner’s maladaptive behaviors, between [REDACTED] show the following: for [REDACTED], Petitioner’s incidents have remained consistent at [REDACTED]; for [REDACTED], Petitioner’s incidents have remained consistent at [REDACTED] and for [REDACTED], Petitioner’s incidents have remained consistent at [REDACTED]. *Id.* at 52 – 53. The maladaptive behaviors of [REDACTED] and [REDACTED] are new and only have two points of data. *Id.* at 53.

5. On August 24, 2023, Petitioner requested continuation of BA services; specifically, 312 units of code 97155; 104 units of code 97156; and 2,600 units of code 97153. See RCE 1 at 22. In a Notice of Outcome (“NOO”), dated September 1, 2023, Respondent denied Petitioner’s request, terminating BA services for Petitioner. *Id.* at 22 – 26. The NOO states as follows:

Code: 97156 Family training, per 15 minutes, Lead Analyst
From: 8/29/23
Thru: 2/24/24
Total Units: Denied 104

Code: 97155 Intervention without protocol modification, per 15 minutes
From: 8/29/23
Thru: 2/24/24

Total Units: Denied 312

Code: 97153 Intervention without protocol modification, per 15 minutes, Lead Analyst, BCaBA, or RBT
From: 8/29/23
Thru: 2/24/24
Total Units: Denied 2,600

The NOO explained the basis for the termination 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. Specially, 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.

The NOO further provided:

The rationale for our decision is as follows:

PR Principal Reason – Denial:

Requested services are denied because documentation is neither showing improvement nor support for maintenance.

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 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 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 information submitted does not meet standards of care within the field of behavior analysis. This request is denied.

...

RCE 1 at 22 – 23.

6. In a Notice of Reconsideration Determination (“NRD”), dated September 20, 2023, Respondent upheld its decision. *Id.* at 34 – 37. The NRD explained the basis for the decision as follows:

PR Principal Reason – Denial

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

PR Clinical Rational – Denial: 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 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.

...

RCE 1 at 35.

7. On September 19, 2023, Petitioner requested a Fair Hearing to challenge the termination BA services. On October 10, 2023, the Office of Fair Hearings issued an Order Scheduling Fair Hearing and Prehearing Instructions, setting the hearing for November 1, 2023, at 9:30 a.m. EST.

8. Dr. Conway is a BCBA and a Second Level Reviewer for eQHealth. Dr. Conway testified as follows:

- a. eQHealth is the quality improvement organization contracted by Florida Medicaid to review requests for BA services for medical necessity. Medical necessity means that the medical or allied cares, goods, or services must meet the medical necessity criteria. Dr. Conway read the five (5) medical necessity criteria into the record.
- b. Petitioner has received BA services with this provider since [REDACTED] with this provider, over [REDACTED] years. There has been no sufficient progress and lack of modification to the treatment plan to address the lack of progress. The treatment plan does not meet condition three (3) of the medical necessity criteria: be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational. See RCE2 at 7.
- c. Dr. Conway reviewed the graphs regarding Petitioner's maladaptive behaviors.
- d. The graph for [REDACTED] and [REDACTED] [REDACTED] shows variable levels. See RCE 1 at 101. The behaviors are still occurring between [REDACTED] [REDACTED] of the time. The behaviors increased again at the end of the authorization period. The behaviors are not showing progress.
- e. The graph for [REDACTED] shows the behavior has been targeted over multiple years. See RCE 1 at 102. Petitioner's levels for this behavior spiked in [REDACTED] and continued to increase and maintain high levels. Petitioner's incidents of this behavior are around [REDACTED] at the end of the authorization period.

- f. The provider listed two new behaviors that occurred [REDACTED] – [REDACTED] and [REDACTED]. See RCE 1 at 102. They are still in baseline.
- g. When an individual is not making progress, the decision to remove replacement goals is not addressing modifications.
- h. The skill acquisition and replacement goals are the ones that should increase. Many of these skills have been worked on since [REDACTED] and Respondent expects mastery by this point.
- i. The graph for [REDACTED] and [REDACTED] shows data that overlaps and is not typically seen. See RCE 1 at 112. This authorization period begins [REDACTED] [REDACTED]. At baseline Petitioner was [REDACTED] and ended the authorization period at [REDACTED] [REDACTED].
- j. The graphs for [REDACTED], [REDACTED], [REDACTED], and [REDACTED] show level trends. See RCE 1 at 113. The goals should be increasing over time. By the end of the authorization period the Petitioner is performing at [REDACTED] [REDACTED].
- k. The graph for [REDACTED] and [REDACTED] while completing tasks show level trends with some high variability. See RCE 1 at 114. Petitioner was performing at a higher level in [REDACTED] than at the end of the authorization period.
- l. [REDACTED] is a new goal as of [REDACTED]. See RCE 1 at 114. It shows some progress in the limited time it has been targeted.

- m. The provider has not submitted significant modifications as requested. The provider decided to discontinue goals. There is no data included regarding the registered behavior technician (RBT) within the treatment plan. It is unclear with the RBT data collection is.
 - n. Overall, Respondent expected much more significant progress on basic skills, such as [REDACTED]. This is the reason for denial. The treatment plan does not meet the medically necessary criteria.
 - o. When setting goals in the field of ABA, goals should be set that a recipient can obtain. Petitioner's Lead Analyst stated Petitioner may never reach [REDACTED] goal. The typical performance is between 80% to 100%. Petitioner is nowhere near that range after multiple years of working on the goals.
 - p. Provider's treatment plan does not meet medical necessity criteria, as it indicates very minimal to no progress through multiple years of service for Petitioner. Petitioner may meet medical necessity criteria for BA services, Petitioner does not meet medical necessity criteria for services with this provider.
9. [REDACTED], Petitioner's Lead Analyst, testified as follows:
- a. Petitioner has improved over the years.
 - b. It is impossible for Petitioner to reach 100% improvement.
10. [REDACTED], Petitioner's [REDACTED], testified as follows:
- a. Petitioner really needs the services.

CONCLUSIONS OF LAW

11. 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).

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

13. 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.).

14. 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.

15. 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 40 – 42.

16. 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.

17. 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.

18. Section 2.83 of 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 23.

19. 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.
- The reviewing physician determines the recipient will not gain any additional benefit by continuing services at the current level.

RCE 2 at 34.

20. In the instant case, Respondent terminated Petitioner’s ABA services. See ¶ 5. The data did not show improvement in the maladaptive behaviors. See ¶ 4, 8. In the NOO dated September 1, 2023, Respondent explained that continuing services with the current provider were not medically necessary, specifically, that it did not meet the requirements that services must be “consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigation.” See ¶ 5. Respondent further explained that “[r]equested services are denied because documentation is neither showing improvement nor support for maintenance” and that 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.” See ¶ 5.

21. As provided by the EPSDT requirements, the recipient must meet the medical necessity criteria as outlined in Fla. Admin. Code R. 59G-1.010. See ¶ 16. As provided in section 2.83 of the Definitions Policy, a component of medical necessity is that services must be “consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational”. See ¶ 18. As shown by the record, Petitioner’s submitted treatment plan shows no improvement regarding the reduction of maladaptive behaviors and little improvement in increasing Petitioner’s replacement behaviors. See ¶ 4, 8. Dr. Conway explained that there has been no sufficient progress and lack of modification to the treatment plan to address the lack of progress. See ¶ 8. Further, Dr. Conway explained that the maladaptive behaviors show level trends throughout a majority of the authorization period, that there were significant increases in all maladaptive behaviors above baseline levels, and that the replacement goals show some minimal progress. *Id.* In all, based on Dr. Conway’s credible and convincing testimony and the lack of progress in the treatment, Respondent demonstrated that the provider’s treatment is not “consistent with generally accepted professional medical standards as determined by the Medicaid program”.

22. 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 ¶ 19. As discussed, *supra* ¶ 20, the current treatment plan is ineffective. Petitioner’s lack of improvement is well documented.


23. Upon consideration of the testimony provided, Respondent’s Composite Exhibit 1, Respondent’s Composite Exhibit 2, the EPSDT policy, and other applicable polices, the undersigned concludes that Respondent proved by a preponderance of the evidence that the

ABA services at issue do not meet medical necessity criteria. Looking at all the evidence relevant to the particular needs of Petitioner, Respondent has demonstrated that the previously authorized services, based on the treatment plans 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 22nd day of December, 2023 in Tallahassee, Leon County, Florida.


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Presley
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KAMEISHA PRESLEY, 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.

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