



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

FILED

Jan 22, 2024, 9:30 am

OFFICE OF FAIR HEARINGS

AHCA Case No.: 23-FH2599

[REDACTED],

PETITIONER,

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 28, 2023, at 9:37 a.m. Eastern Standard Time (“EST”).

APPEARANCES

For the Petitioner:

[REDACTED]

Petitioner’s Authorized Representative

For the Respondent:

Diana Hearod
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, appeared at the Fair Hearing on behalf of Petitioner.

Diana Hearod, 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 representative for Respondent. Dr. Joseph Darling (“Dr. Darling”), 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.

Andrea, translator number 379449, provided Spanish translation services during the Fair Hearing.

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-seven (137)-page evidence packet and a forty-nine (49)-page evidence packet. The one hundred and thirty-seven (137)-page packet appears in the Office of Fair Hearings’ document management system as files titled “[REDACTED] FH 11.28.2023 1 - 123.pdf” and “[REDACTED] FH 11.28.2023 124 - 137.pdf”. The forty-nine (49)-page packet appears in the Office of Fair Hearings’ document management system as the file titled “23-FH2599_BA_AHCA Evidence PKT_49 PGS_[Petitioner’s Name].pdf”. Absent any objections from Petitioner, the undersigned admitted the one hundred and thirty-seven (137)-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 21. 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 21. Petitioner is diagnosed with [REDACTED]. *Id.* at 21, 52.

3. As provided in the [REDACTED] Behavior Analysis Assessment (“Assessment”), dated July 30, 2023, Petitioner is engaging in the following maladaptive behaviors: [REDACTED], [REDACTED], [REDACTED], [REDACTED], [REDACTED], [REDACTED], [REDACTED] and [REDACTED]. *Id.* at 52. Petitioner is learning the following replacement behaviors: [REDACTED]; [REDACTED]; [REDACTED]; [REDACTED]; [REDACTED]; [REDACTED]. *Id.* at 69 – 73.

4. According to the data graphs for maladaptive behaviors in the Assessment, Petitioner has made the following progress in reducing [REDACTED] maladaptive behaviors, between March 2023 and July 2023: for [REDACTED], Petitioner’s incidents decreased from approximately [REDACTED] [REDACTED]; for [REDACTED], Petitioner’s incidents decreased from approximately [REDACTED] [REDACTED]; for [REDACTED], Petitioner’s incidents decreased from approximately [REDACTED] [REDACTED]; for [REDACTED], Petitioner’s incidents decreased from approximately [REDACTED] [REDACTED]; for [REDACTED], Petitioner’s incidents decreased from approximately [REDACTED] [REDACTED]; for [REDACTED], Petitioner’s incidents decreased from approximately [REDACTED] [REDACTED]; for [REDACTED], Petitioner’s incidents decreased from approximately [REDACTED] [REDACTED]; for [REDACTED], Petitioner’s incidents decreased from approximately [REDACTED] [REDACTED]; and for [REDACTED], Petitioner’s incidents remain decreased from approximately [REDACTED]. *Id.* at 65 – 69.

From: 8/28/23
Thru: 2/21/24
Total Units: Denied 312

Code: 97153 Intervention without protocol modification, per 15 minutes, Lead Analyst, BCaBA, or RBT
From: 8/28/23
Thru: 2/21/24
Total Units: Denied 3,120

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:

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

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

PR Clinical Rationale – Denial: Provider, there are behaviors listed for decrease and goals for increase that do not meet medical necessity criteria (). All goals must significantly interfere with normal functioning by threatening access to typical environments and negatively affecting activities of daily living.

Provider, the graphs included do not meet the standard of care in the field of behavior analysis. The y-axes on multiple maladaptive and replacement graphs do not have appropriate scales. The y-axis should begin at 0 for all graphs and for percentage graphs should end at 100%. Additionally, the recipient has been in services for over a year and the goals show minimal progress. 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 29 – 30.

7. In a Notice of Reconsideration Determination (“NRD”), dated October 12, 2023, Respondent upheld its decision. *Id.* at 41 – 44. 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 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.

...

RCE 1 at 40.

8. On October 10, 2023, Petitioner requested a Fair Hearing to challenge the termination BA services. On November 2, 2023, the Office of Fair Hearings issued an Order Scheduling Fair Hearing and Prehearing Instructions, setting the hearing for November 28, 2023, at 9:30 a.m. EST.

9. Dr. Darling is a BCBA-D and a Second Level Reviewer for eQHealth. Dr. Darling's testimony established the following:

- a. eQHealth is the quality improvement organization contracted by Florida Medicaid to provide assurance of quality services for Medicaid recipients. Respondent follows the five (5) medically necessary criteria that medical or allied cares, goods, or services must meet. Dr. Darling read the five (5) medical necessity criteria into the record. *See* RCE 2 at 7. The submitted treatment plan does not show progress, which means the third criteria is not being met. Respondent determined that adequate progress was not being made.
- b. Respondent terminated Petitioner's BA services because there was no progress being made after [REDACTED] of thirty (30) hours per week of intensive ABA therapy and because there were no changes to the treatment plan to address the lack of progress. The graphs provided by the provider did not meet the standards of care in the field of ABA therapy. Most of the x-axes on the graphs did not have appropriate scales. The x axis should begin at zero (0) for all graphs, and should end at 100% for all percentage graphs. The way the graphs are presented in the treatment plan hides the lack of progress Petitioner has made in the past year.

- c. Respondent determined that the therapist overseeing the treatment plan did not make any changes based on the slow progress made across all targeted behaviors in the treatment plan.
- d. The graph for [REDACTED] shows that after a year of intensive therapy, the frequency of [REDACTED] is down to about twenty-one (21) times per week. See RCE 1 at 107. This shows a very slow reduction of this behavior. The graph hides the lack of progress because the graph starts with a [REDACTED]. The graph for [REDACTED] begins at [REDACTED]. See RCE 1 at 108. A proper graph would show a high rate of [REDACTED] and a very slow decrease. The graph for [REDACTED] also shows a slow decrease of the behavior. See RCE 1 at 108. These graphs are constructed in a way to hide the lack of progress. The progress that has been made is insignificant. There is no indication that there were any changes in the procedures for any of the maladaptive behaviors to help them decrease at a faster rate. If this rate continues, it will be years before these behaviors are extinguished. The graph for [REDACTED] should go up to 100% but it only goes up to [REDACTED]. See RCE 1 at 116. The graph is hiding [REDACTED] of lack of progress.
- e. None of the graphs for skill acquisition goals go above [REDACTED] much after a year of thirty (30) hours per week of intensive therapy. The progress has been extremely slow.
- f. Respondent determined that Petitioner needs effective BA services to improve [REDACTED] life and that Petitioner has not been getting effective BA services for the past year.

10. [REDACTED], Petitioner's [REDACTED], testified as follows:

- a. Petitioner has made progress.
- b. [REDACTED] does not understand the treatment plan.

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 45 – 46.

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 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.

...

RCE at 13.

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 ¶ 6. The data did not show significant improvement in the maladaptive behaviors. See ¶ 4, 9. In the NOO dated August 22, 2023, Respondent explained that continuing services with the current provider were not medically necessary, specifically, that the services 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 ¶ 6. Respondent further explained that the “submitted information does not support the medical necessity for requested frequency and/or duration” and that “[t]he 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 ¶ 6.

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 ¶ 17. 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 in the Assessment shows little improvement regarding the reduction of maladaptive behaviors and little improvement in increasing Petitioner’s replacement behaviors. See ¶ 4 – 5, 9. Dr. Darling testified that there was no progress being made after [REDACTED] of thirty (30) hours per week of intensive ABA therapy and because there were no changes to the treatment plan to address the lack of progress. See ¶ 9. Further, Dr. Darling testified that the data graphs submitted in the Assessment were presented hides the lack of progress Petitioner has made in the past year, that the graphs are constructed in a way to hide the lack of progress, and that the therapist overseeing the treatment plan did not make any changes based on the slow progress made across all targeted behaviors in the treatment plan. See ¶ 9. Although Petitioner needs ABA therapy, the data graphs in the Assessment demonstrate that Petitioner is not getting the effective therapy he should be getting. See ¶ 9. In all, based on Dr. Darling’s

credible and convincing testimony and the lack of progress in the Assessment, 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 – 21, the current treatment plan is ineffective. Here, 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 all other applicable policies, 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 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 January, 2024 in Tallahassee, Leon County, Florida.


Kameisha Presley
23-FH2599
2024.01.22
09:02:20 -05'00'

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.

COPIES FURNISHED TO:

[REDACTED]
[REDACTED]

**AHCA Medicaid Hearing Unit
MedicaidHearingUnit@ahca.myflorida.com**