



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

FILED

Mar 19, 2024, 10:52 am

OFFICE OF FAIR HEARINGS
AHCA Case No.: 23-FH2702

[REDACTED]

PETITIONER,

vs.

AGENCY FOR HEALTH CARE
ADMINISTRATION,

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned Hearing Officer convened telephonic Fair Hearings in the instant case on December 5, 2023, at 1:03 p.m. Eastern Standard Time (“EST”), on January 25, 2024, at 9:45 a.m. EST, and on March 4, 2024, at 1:00 p.m.

APPEARANCES

For the Petitioner:

[REDACTED]

Petitioner’s Authorized Representative

For the Respondent:

Marielisa Amador
Medical Health Care Program Analyst
Agency for Health Care Administration

STATEMENT OF ISSUE

The issue is whether Petitioner proved by a preponderance of the evidence that Respondent’s decision to deny Petitioner’s request for behavior analysis (“BA” or “ABA”) services was incorrect.

PRELIMINARY STATEMENT

All parties and witnesses appeared telephonically. Petitioner’s Authorized Representative and [REDACTED], [REDACTED] (“[REDACTED]”), appeared on behalf of Petitioner at the December 5, 2023, hearing and the March 4, 2024, hearing. [REDACTED] (“[REDACTED]”), Board Certified Behavior Analyst (“BCBA”), and [REDACTED], BCBA and Owner [REDACTED] [REDACTED] (“the provider”), appeared at the hearing as witnesses for Petitioner.

Marielisa Amador, Medical Health Care Program Analyst for the Agency for the Agency for Health Care Administration (“Agency” or “AHCA”), appeared on behalf of Respondent at all three hearings. Dr. Joseph Darling (“Dr. Darling”), Board-Certified Behavior Analyst at the Doctoral Level (“BCBA-D”) and Second Level Reviewer for eQHealth Solutions Inc. (“eQHealth”), appeared as a witness for Respondent.

Prior to the Fair Hearing, Petitioner sent to the Office of Fair Hearings and Respondent a forty-eight (48)-page evidence packet. The forty-eight (48)-page packet appears in the Office of Fair Hearings’ document management system as the file titled “23-FH2702 Received Mail Evidence.pdf.” Absent any objections from Respondent, the undersigned admitted the forty-eight (48)-page evidence packet as Petitioner’s Composite Exhibit 1 (“PCE 1”).

Prior to the Fair Hearing, Respondent sent to the Office of Fair Hearings and Petitioner a one hundred and seventy-seven (177)-page evidence packet and a forty-nine (49)-page evidence packet. The one hundred and seventy-seven (177)-page packet appears in the Office of Fair Hearings’ document management system as the files titled “[REDACTED] FH 12.05.2023 1-102.pdf,” “[REDACTED] FH 12.05.2023 103-172.pdf,” and “[REDACTED] FH 12.05.2023 173-177.pdf.” The forty-nine (49)-page packet appears in the Office of Fair Hearings’ document management system as the file titled “23-FH2702 AHCA Evidence (Pages 1-49 of 49).pdf.” Absent any objections from

Petitioner, the undersigned admitted the one hundred and seventy-seven (177)-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 16. 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]. See RCE 1 at page 16. Petitioner is diagnosed with [REDACTED] [REDACTED] [REDACTED]. *Id.* at 16, 53.

3. As provided in the ABA Assessment and Treatment Plan (“Assessment”, “treatment plan” or “behavior plan”) dated May 26, 2023, as reported by the provider, Petitioner is engaging in the following maladaptive behaviors: [REDACTED], [REDACTED], [REDACTED], [REDACTED], [REDACTED], [REDACTED], [REDACTED], [REDACTED], and [REDACTED]. *Id.* at 154. The data graphs for Petitioner’s maladaptive behaviors in the Assessment show the following during the last authorization period: for [REDACTED], Petitioner’s incidents increased from approximately [REDACTED] [REDACTED]; for [REDACTED], Petitioner’s incidents remained consistent at 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], incidents decreased from approximately [REDACTED] [REDACTED] for [REDACTED], incidents remained consistent at [REDACTED] for [REDACTED],

Petitioner's incidents decreased from approximately [REDACTED] for [REDACTED]
[REDACTED], Petitioner's incidents decreased from approximately [REDACTED] for
[REDACTED], Petitioner's incidents decreased from approximately [REDACTED]; for
[REDACTED], Petitioner's incidents decreased from approximately [REDACTED] and for
[REDACTED], Petitioner's incidents decreased from [REDACTED]
[REDACTED] *Id.* at 155 – 160.

4. On June 1, 2023, Petitioner requested BA services; specifically, 3,536 units of code 97153; 104 units of code 97154; 416 units of code 97155; 24 units of code 97156; and 104 units of code 97158, for the authorization period of June 5, 2023, through December 1, 2023. See RCE 1 at 25. In a Notice of Outcome – Partial Denial (“NOO”), dated July 25, 2023, Respondent approved 2,288 units of code 97153; 104 units of code 97154; 416 units of code 97155; 24 units of code 97156; and 24 units of code 97158. *Id.* at 25 – 29. Respondent denied 1,248 units of code 97153 and 80 units of code 97158. *Id.* at 25. The NOO states 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):

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

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.

PR Clinical Rationale –Denial: According to Behavior Analysis Services Coverage Policy requests for services must be based on the medical necessity of the recipient's maladaptive behaviors and skill deficits. The recipient is engaging in problem behaviors that threaten access to typical environments and negatively

affects activities of daily living. However, the frequency, intensity, or severity of the recipient's maladaptive behaviors does not justify the requested units of services. The requested units of BA services are in excess of medical necessity.

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RCE 1 at 26.

5. Petitioner requested reconsideration of the Respondent's decision. In a Notice of Reconsideration Determination ("NRD"), dated July 25, 2023, Respondent upheld its decision. *Id.*

at 37 – 41. The NRD explained the basis for the decision as follows:

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

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.

PR Recon Determination: At reconsideration, all documents were carefully reviewed. The provider submitted new documentation that supports the medical necessity of this request. According to The Behavior Analysis Services Coverage Policy, (page 6. 9.0.c-d) the recipient of ABA therapy services must engage in maladaptive behavior that interferes with the recipient's daily functioning. Although the recipient is engaging in topographies of maladaptive behaviors, the frequency and intensity of the maladaptive do not support the request for services. The current request is in excess of medically necessary BA services, but BA services are approved at a lower level than requested.

...

RCE 1 at 38.

6. On October 23, 2023, Petitioner requested a Fair Hearing to challenge the partial denial of BA services. On November 9, 2023, the undersigned issued an Order Scheduling Fair Hearing and Prehearing Instructions, setting the hearing for December 5, 2023, at 1:00 p.m. EST. During the December 5, 2023, hearing, Petitioner's Authorized Representative requested for the Fair Hearing to be continued. Absent an objection to the request to continue, the Office of Fair Hearings issued an Order Granting Continuance on December 8, 2023, and a Second Order Scheduling Fair Hearing and Prehearing Instructions, dated December 18, 2023, setting the

hearing for January 25, 2024, at 9:30 a.m. EST. The Office of Fair Hearings issued an Order to Show Cause based upon Petitioner's failure to appear at the scheduled Fair Hearing on January 25, 2024. On February 2, 2024, the Office of Fair Hearings received Petitioner's Authorized Representative's response to the Order to Show Cause. On February 12, 2024, the Office of Fair Hearings issued a Second Order Scheduling Fair Hearing and Prehearing Instructions, setting the hearing for March 4, 2024, at 1:00 p.m. EST.

7. [REDACTED], Petitioner's [REDACTED] and Authorized Representative, testified to the following:

- a. [REDACTED] has seen great progress in Petitioner's behavior.
- b. Skill acquisition goals could not be worked on due to significant problem behaviors.

8. [REDACTED], a BCBA with Petitioner's provider, testified to the following:

- a. Petitioner has made substantial progress.

9. Ms. Knoll, a BCBA with and owner of Petitioner's provider, testified to the following:

- a. Petitioner's medical referral from a medical doctor stated that Petitioner has a severe diagnosis of [REDACTED].

10. Petitioner provided a letter from [REDACTED], dated July 21, 2022, which stated in pertinent part:

It is deemed medically necessary for this pt. to receive behavioral analysis services (ABA). Consultation with a Certified Analyst. (EMBER therapy)

11. Dr. Darling, a BCBA-D and a Second Level Reviewer for eQHealth, testified to the following:

- a. eQHealth has been hired by ACHA to provide assurance of quality services to Medicaid recipients. Respondent follows the five (5) medically necessary criteria that medical or allied care, goods, or services furnished or ordered must meet. Dr. Darling read the five (5) medical necessity criteria into the record. See RCE 2 at 7. Based on the treatment plan submitted by the provider, criterion two was not met, specifically that the request in the treatment plan was in excess of Petitioner's needs based on the described treatment, and criterion three, specially that with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational.
- b. Petitioner's treatment plan was reviewed by three (3) behavior analysts and Respondent partially approved Petitioner's requested BA service hours. The severity of the behaviors or the skill deficits that lead to the therapy showed there was a need for BA services for Petitioner. The issue is how the maladaptive behaviors are being addressed in the treatment plan.
- c. Based on the submitted information, respondent approved twenty-five (25) hours per week of intensive one-on-one therapy and one (1) hour of group therapy. Petitioner is currently receiving (20) hours per week of intensive one-on-one therapy.
- d. Petitioner's treatment plan is missing specifics on how to implement each of the procedures to address the maladaptive behaviors. It is unclear what the replacement behaviors are.

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 Petitioner is requesting a new service, Fla. Admin. Code R. 59G-1.100(17)(g) assigns the burden of proof to the Petitioner. 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 Florida Medicaid Behavior Analysis Services Coverage Policy (October 2017) ("BA Policy"), incorporated by reference in Fla. Admin. Code. R. 59G-4.125, governs BA services available under Florida Medicaid. The BA Policy provides as follows:

1.0 Introduction

Behavior analysis (BA) services are highly structured interventions, strategies, and approaches provided to decrease maladaptive behaviors and increase or reinforce appropriate behaviors.

...

1.4.5 Medically Necessary/Medical Necessity

As defined in Rule 59G-1.010, F.A.C.

...

4.0 Coverage Information

4.1 General Criteria

Florida Medicaid covers services that meet all of the following:

- Are determined medically necessary
- Do not duplicate another service
- Meet the criteria as specified in this policy

4.2 Specific Criteria

Florida Medicaid covers the following BA services in accordance with the applicable Florida Medicaid fee schedule(s), or as specified in this policy:

4.2.1 Behavior Assessment

One per fiscal year, per recipient, when completed within 30 days of the start of the assessment.

4.2.2 Behavior Analysis

Up to 40 hours per week, per recipient, consisting of services identified on the recipient's behavior plan in order to reduce maladaptive behaviors and to restore the recipient to his or her best functional level. Services include:

- Implementing behavior analysis interventions, and monitoring and assessing the recipient's progress towards goals in the behavior plan
- Behavior analysis interventions, for example, discrete trial teaching, task analysis training, differential reinforcement, non-contingent reinforcement, conducting task analyses of complex responses, and teaching using chaining, prompting, fading, shaping, response cost, and extinction
- Training the recipient's family, caregiver(s), and other involved persons on the implementation of the behavior plan and intervention strategies (the recipient must be present when clinically appropriate)

...

4.3 Early and Periodic Screening, Diagnosis, and Treatment

As required by federal law, Florida Medicaid provides services to eligible recipients under the age of 21 years, if such services are medically necessary to correct or ameliorate a defect, a condition, or a physical or mental illness. Included are diagnostic services, treatment, equipment, supplies, and other measures described in sectioned 1905(a) of the Social Security Act, codified in Title 42 of the United States Code 1396d(a). As such, services for recipients under the age of 21 years exceeding the coverage described within this policy or the associated fee schedule may be approved, if medically necessary. For more information, please refer to Florida Medicaid's General Policies on authorization requirements.

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RCE 2 at 40 – 42.

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. 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

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RCE 2 at 45 – 47.

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.

RCE 2 at 4 – 5.

18. 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.

19. 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.

20. In the instant case, Petitioner requested the following ABA services: 3,536 units of code 97153; 104 units of code 97154; 416 units of code 97155; 24 units of code 97156; and 104 units of code 97158. See ¶ 4. In the NOO, dated July 25, 2023, Respondent explained that the request for services did not meet the following medical necessity criteria: “[i]ndividualized, specific, and consistent with symptoms or confirmed diagnosis of the illness under treatment, and not in excess of the patient's needs.” See ¶ 4. Respondent further explained that the “submitted information does not support the medical necessity for requested frequency and/or duration” and that “the frequency, intensity, or severity of [Petitioner’s] maladaptive behaviors does not justify the requested units of services.” See ¶ 4.

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 ¶ 18. As provided in section 2.83 of the Definitions Policy, a component of medical necessity is that services must be “[i]ndividualized, specific, and consistent with symptoms or confirmed diagnosis of the illness under treatment, and not in excess of the patient's needs.” See ¶ 19. This component was identified as not being met in the NOO and NRD. See ¶ 4 – 5. As shown by the record, Petitioner’s maladaptive behaviors have decreased. See ¶ 3, 7 – 8. The record does not identify any skill acquisition goals.

In fact, [REDACTED] testified that skill acquisition goals could not be worked on due to significant problem behaviors. See ¶ 7. Further, Dr. Darling testified that Petitioner's treatment plan is missing specifics on how to implement each of the procedures to address the maladaptive behaviors and that it is unclear what the replacement behaviors are. See ¶ 11. Petitioner has failed to identify where the currently approved hours of service are lacking. As such, Petitioner did not demonstrate that the denied service hours are "not in excess of the patient's needs."

22. Lastly, although the record reflects that Petitioner's provider recommended the BA services, the recommendation does not make the service a covered service. Section 2.83 of the Definitions Policy mandates that "[t]he 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 ¶ 19. Coupled with the graphs demonstrating an overall downward trend of maladaptive behaviors, Petitioner has failed to demonstrate that additional behavioral analysis services are medically necessary.

23. Upon consideration of the testimony provided, Petitioner's Composite Exhibit 1, Respondent's Composite Exhibit 1, Respondent's Composite Exhibit 2, and the applicable laws and policies, the undersigned concludes that Petitioner did not prove by a preponderance of the evidence that the denied units of BA services are medically necessary. Looking at all the evidence relevant to the particular needs of Petitioner, Petitioner has not demonstrated that the additional services based on this treatment plan, are necessary to correct or ameliorate a defect or a physical and mental illness or condition. Accordingly, Petitioner did not prove by a preponderance of the evidence that Respondent's partial denial of additional BA services was incorrect.

IT IS HEREBY ORDERED AND ADJUDGED THAT:

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

DONE and **ORDERED** this 19th day of March, 2024, in Tallahassee, Leon County, Florida.



Kameisha 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.

Copies Furnished To:



AHCA Medicaid Hearing Unit
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