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

FILED
Feb 14, 2024, 12:04 pm
OFFICE OF FAIR HEARINGS

[redacted],

PETITIONER, **AHCA Case No.: 23-FH2960**

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 January 24, 2024, at 9:00 a.m. EST.

APPEARANCES

For the Petitioner: [redacted]
Petitioner's Authorized Representative

For the Respondent: Sandra Durden
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 behavior analysis ("BA") services was correct.

PRELIMINARY STATEMENT

All parties and witnesses appeared telephonically. Petitioner's Authorized Representative [redacted], ("[redacted]"), appeared on behalf of the Petitioner.

Sandra Durden, Medical Health Care Program Analyst for the Agency for Health Care Administration ("Agency" or "AHCA"), appeared on behalf of Respondent. Dr. Joseph Darling ("Dr. Darling"), BCBA at the Doctoral Level ("BCBA-D") and a 2nd level reviewer for eQHealth Solutions, Inc. ("eQHealth"), attended as a witness for Respondent.

Petitioner did not introduce any exhibits at the Fair Hearing.

Prior to the hearing, Respondent sent to the Office of Fair Hearings and Petitioner a four hundred and eighteen (418)-page evidence packet. The packet appears in the Office of Fair Hearings' case management system as "[redacted] FH 01.24.2024 1-75.pdf", "[redacted] FH 01.24.2024 76-109.pdf", "[redacted] FH 01.24.2024 110-143.pdf", "[redacted] FH 01.24.2024 144-179.pdf", "[redacted] FH 01.24.2024 180-213.pdf", "[redacted] FH 01.24.2024 214-247.pdf", "[redacted] FH 01.24.2024 248-290.pdf", "[redacted] FH 01.24.2024 291-340.pdf", "[redacted] FH 01.24.2024 341-374.pdf", "[redacted] FH 01.24.2024 375-408.pdf" and "[redacted] FH 01.24.2024 409-418.pdf." Absent an objection from the Petitioner, the undersigned admitted the evidence packet into evidence as Respondent's Composite Exhibit 1.

Prior to the hearing, Respondent sent to the Office of Fair Hearings and Petitioner a forty-nine (49)-page evidence packet. The packet appears in the Office of Fair Hearings' case management system as "23-FH2960 AHCA EVIDENCE PKT.pdf." Absent an objection from the Petitioner, the undersigned admitted the evidence packet into evidence as Respondent's Composite Exhibit 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* Respondent's Composite Exhibit 2 at page 2.

2. Petitioner is [redacted]. *See* Respondent's Composite Exhibit 1 at page 16. The Petitioner has been diagnosed with [redacted] The Petitioner has exhibited maladaptive behaviors including: [redacted] were recently added with the current authorization period. *Id.* at 60.

3. Petitioner requested the continuation of the following BA services: 2,600 units of code 97153, 104 units of code 97156, 208 units of code 97155 HN, 104 units of code 97155 and 104 units of code 97156 HNfor the certification period of September 26, 2023, through March 23, 2024. *Id*. at 20-21.

4. On September 26, 2023, Respondent requested Petitioner's provider to submit an updated Behavior Plan and to address several of the behavior definitions. The provider did respond to the request on September 27, 2023.

5. The provider submitted additional documents and data graphs that are not consistent with data that are typically reported in behavior analytic treatment. Many of the graphs for maladaptive behavior and skill acquisition show the same general pattern, level and trend in data. The Respondent again requested that the provider review definitions that did not conform to the Florida Behavior Analysis Coverage Policy. Provider's behavioral definitions should have clear,

complete, objective and free of unobservable intentional states. The behaviors should have clear boundaries, definite on-sets and off-sets, should not overlap with other target behaviors and not be a listing of behaviors that the recipient does not engage in.

6. On October 12, 2023, Respondent issued a Notice of Outcome ("NOO"), terminating Petitioner's BA services. *Id.* at 24-26. The NOO explained the basis for the termination as follows:

> [T]he 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 NOO further provided:

> Requested services are denied because documentation is neither showing improvement nor support for maintenance.
>
> PR Clinical Rationale – Denial: All goals must include those to address recipient behaviors/skill deficits that significantly interfere with normal functioning by threatening access to typical environments and negatively affecting activities of daily living. There are caregiver goals listed that do not meet medical necessity criteria (ie. Pg 85 data collection, [redacted]). Additionally, According to The Florida Medicaid State Plan (page 8, 6.2.3), the data provided must show evidence that the frequency of the maladaptive behavior(s) has decreased since the last review and, if not, that there is a modification of the behavior plan. The recommendations for procedural modifications include: additions/changes to treatment plan to impact behaviors targeted for reduction. Procedural modifications should include one or more of the following: antecedent manipulation modifications, modifications of prompting procedures used in acquisition, modifications in consequence-based strategies—ones that either reduce maladaptive behavior or reinforce replacement behavior (e.g., manipulation of reinforcement schedules, switch to a different decelerative procedure), or if lack of progress was due to therapist error (e.g., poor data collection or poor training on intervention methods), how 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 or the proposed changes have little chance at improving behavior. The

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

Id. at 24-25.

7. Petitioner requested reconsideration of the Respondent's decision. On November 22, 2023, Respondent issued a Notice of Reconsideration Determination ("NRD") upholding its decision. *Id.* at 36-37. The NRD states, in pertinent part as follows:

> Specifically the services must be:
>
> 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.
> . . .
> At reconsideration all documents were carefully reviewed. According to the Florida Medicaid State Plan (page 8, 6.2.3), 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 or reinforcement schedules, switch to a different decelerative procedure), or if lack of progress was due to therapist error (e.g., poor data collection or poor training on intervention methods), how the provider will address human error. The 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 or the proposed changes have little chance at improving behavior. The information submitted does not meet standards of care within the field of behavior analysis. The denial is upheld.

Id. at 37.

8. Dr. Darling 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. Dr. Darling asserted that Petitioner's services were terminated because the treatment plan is not consistent with symptoms under treatment and was in excess of the patient's needs; not consistent with generally accepted professional medical standards as determined by the Medicaid program, and not reflective of the level of service that can be safely furnished for which there is no equally effective less costly treatment available.

9. Dr. Darling testified that both the first and second level reviewers from eQHealth requested that the provider submit additional corrective definitions contained in the treatment plan. Further, the Treatment Plan did not show evidence that the frequency of Petitioner's maladaptive behaviors has decreased and the plan contained caregiver goals that are outside of the ABA services. The second level reviewer denied the treatment plan and the request for services. The provider submitted a third revision for consideration during the reconsideration determination period. The third reviewer found that there was little chance improving the recipient's behavior under the submitted plan and again denied the requested services. Therefore, according to the review, the Treatment Plan does not meet standards of care in ABA and is not effective.

10. Dr. Darling also established that in this particular case, the recipient is diagnosed with [redacted]. Dr. Darling acknowledged that there are valuable ABA treatments for this recipient with this diagnosis, however, there are also other therapy options that could be effective in improving the recipient's behaviors. To clarify that point even more, Dr. Darling referred to RCE 1 at page 54, which is part of the local schools IEP (individual education plan) for this recipient. The IEP established that this recipient would be taking general education courses

leading to a standard diploma. Dr. Darling brings this point out to established that while some ABA services are needed, this recipient performs well in the school environment and by using other available services can master needed skills and behaviors.

11. Referring to the data graphs in Petitioner's third submitted Treatment Plan, Dr. Darling established that Petitioner's maladaptive behaviors have not improved and the provider has not implemented any interventions to address the lack of progress. Dr. Darling reviewed the data graph for [redacted]. RCE 1 at page 191. Dr. Darling noted that there had been no improvement in the maladaptive behavior and further, no intervention or modification was indicated on the graph. *Id.* The graph shows that the maladaptive behavior increased from [redacted] times a week. *Id.* With no improvement in the behavior, a modification of the treatment plan must be made. This is an example of ineffective treatment. The data graph for [redacted] shows the same type of result. *Id.* at 193. The graph shows no improvement of the maladaptive behavior and no modifications or interventions to change the trajectory of the behavior. *Id.* At the beginning of the treatment period there are [redacted] per week and 6 months later they have increased to [redacted] per week. Once again, ineffective treatment. Dr. Darling testified that each of the graphs submitted with the treatment plan have the same results. The graph for [redacted], [redacted], [redacted], [redacted], [redacted], and [redacted], all show increasing trends during the last six months of treatment. *Id.* at 195, 197, 199, 200, 202, and 204. Based on the documentation provided, Dr. Darling opined that the Treatment Plan did not support the medical necessity of the requested services because the documentation does not show a reduction in the maladaptive behavior or modifications to reduce the maladaptive behavior or reinforce replacement behavior.

12. Dr. Darling also reviewed the skill acquisition and replacement behavior aspects of the treatment plan. In considering the skill/replacement graphs, they should reflect an increase over time. The first graph for review is [redacted]. This graph shows that this skill is occurring [redacted] of the time, however there is a drop off during the last five data points without any explanation. *Id.* at 223. However, Dr. Darling testified that with this individuals' abilities as shown in the IEP, this skill training is very basic and the individual was performing at a [redacted], it is time to move on beyond this skill activity. The next skills training graph is [redacted]. *Id.* at 224. The situation is similar to the last graph reviewed. The skill is occurring [redacted] of the time, this is a basic social skill, and this individual is ready to move on to additional skills training. The next skills training graph is for [redacted]. *Id.* at 226. This skill occurs between [redacted] of the time. This graph is the same as the previous graphs and this individual is no longer learning new skills. The remaining graphs include [redacted], *Id.* at 228, [redacted], *Id.* at 229, and [redacted], *Id.* at 231, all showing a high percentage of compliance. All of the reviewers of this Treatment Plan agreed that it was time for this individual to move on to new and additional skills and continuing with the current treatment plan will not allow this individual to gain any additional benefits. Thus, it is Dr. Darlings opinion that this Treatment Plan is ineffective. Dr. Darling also stated that he felt that this individual could continue to benefit from ABA as well as other available types of therapy.

13. [redacted], the recipient's [redacted], did testify. [redacted] testified that [redacted] has been dealing with [redacted] circumstances since [redacted] was [redacted]. [redacted] has seen [redacted] behaviors and medications go up and down and is concerned that [redacted] does not recognize

[redacted]. [redacted] feels that it is very unfair to take away all of [redacted] hours while [redacted] still needs services. [redacted] also stated that [redacted] does participate in other types of therapy as well.

14. Dr. Darling provided a rebuttal statement confirming [redacted] opinion that the provider's Treatment Plan as written was ineffective in providing any benefit to [redacted]'s [redacted]. However, a well written, well thought out plan would provide benefits for this individual. While Dr. Darling agreed that the Recipient needed ABA services, the current Treatment Plan fails to meet the conditions to be medically necessary. Specifically, Dr. Darling found that the Treatment Plan was not 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; further, that the Treatment Plan was not consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational, and the Treatment Plan was not 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.

CONCLUSIONS OF LAW

15. 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).

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

17. Because Respondent terminated a previously approved service, Fla. Admin. Code R. 59-1.100(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.).

18. 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).

19. 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.

20. A state may place medical necessity limitations on EPSDT services. *See* 42 C.F.R. §§ 440.230(a), (b), (d).

21. Section 409.905(2), Florida Statutes, 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.

22. 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.

Respondent's Composite Exhibit 2 at page 23

23. The 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.
. . .
4.0 Coverage Information
4.1 General Criteria
Florida Medicaid covers services that meet all of the following:
- Are determined medically necessary
- Do no duplicate another
- Meet the criteria as specified in this policy

Respondent's Composite Exhibit 2 at page 40, 42.

24. 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

. . .

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 than an adequate behavior plan can be implemented. This (re)assessment **MUST** include, at a minimum, **ALL** of the following:
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 Self-stimulating, abnormal, inflexible, or intense preoccupations Self-care - difficulty recognizing risks or danger, grooming, eating, or toileting
    iii. Other- behaviors not identified above

. . .

5. Criteria for Discharge from Behavior Analysis Services - ONE or **MORE** of the following **MUST**

be satisfied:

a. The critical elements are **no longer met.**
b. The data provided shows that the frequency and severity of maladaptive behavior(s) has declined to the point that they no longer pose a barrier to the child's ability to function in his/her environment.
c. The data provided shows the recipient has made no progress toward any goals in the last 12 consecutive months.
d. The level of functional impairment as expressed through behaviors no longer justifies continued BA services.
e. Parent/guardian withdraws consent for treatment.

Respondent's Composite Exhibit 2 at pages 45-47.

25. 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.

Respondent's Composite Exhibit 2 at pages 32-34.

26. In this case, Respondent terminated Petitioner's BA services. The NOO and NRD explained that Petitioner's request for continuation of services did not meet medical necessity as the treatment plan was not "[c]onsistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational" and not "individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness under treatment, and not in excess of the patient's needs." *See* supra ¶ 6-8.

27. As provided in the BA policy (Appendix 9.0, section (a)), and the EPSDT requirements, the recipient must meet the medical necessity criteria as outlined in Fla. Admin. Code R. 59G-1.010. A component of medical necessity is that services must be "consistent with generally accepted professional medical standards." As outlined above, Dr. Darling provided credible and persuasive testimony identifying several instances where the revised Treatment Plan did not follow generally accepted standards of BA. For example, the Treatment Plan does not show evidence that the frequency of Petitioner's maladaptive behaviors has decreased and does not show that there was a modification or intervention to address Petitioner's lack of progress. *See* supra ¶ 11. The data graphs for maladaptive behaviors show that no reduction occurred for [redacted], [redacted], [redacted], [redacted], [redacted], [redacted], [redacted], and [redacted]. *See* supra ¶ 11. Thus, Respondent demonstrated that, based on the information in the record, the requested BA services are not "consistent with generally accepted professional medical standards." Because the services are not consistent with generally accepted professional medical standards, the critical element of medical necessity is not met. *See* supra ¶ 14.

28. In this case, Petitioner's provider recommended the continuation of BA services. 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 ¶ 22.

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

30. Upon consideration of the testimony provided, Respondent's Composite Exhibit 1, Respondent's Composite Exhibit 2, and the applicable law and policies, the undersigned finds that Respondent proved by a preponderance of the evidence that Respondent's termination of BA services was correct.

DECISION

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 14th day of February 2024, in Tallahassee, Leon County, Florida.

George L. Winslow, Jr. 23-FH2960 2024.02.14 07:30:25 -05'00'

GEORGE WINSLOW, 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]

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