



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

FILED

Nov 09, 2023, 2:15 pm

OFFICE OF FAIR HEARINGS

AHCA Case No.: 23-FH1927

[REDACTED]

PETITIONER,

vs.

AGENCY FOR HEALTH CARE
ADMINISTRATION,

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic Fair Hearing on the instant case on September 28, 2023, at 1:02 p.m. Eastern Standard Time (“EST”).

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 Respondent proved by a preponderance of the evidence that Respondent’s decision to terminate Petitioner’s Behavior Analysis (“BA” or “ABA”) services was correct.

PRELIMINARY STATEMENT

All parties and witnesses appeared telephonically. Petitioner’s Authorized Representative and [REDACTED], [REDACTED] (“[REDACTED]”), appeared on behalf of Petitioner. Yenny Driggs (“Ms. Driggs”), with [REDACTED], attended as a witness for Petitioner.

Marielisa Amador (“Ms. Amador”), Medical/Health Care Program Analyst for the Agency for Health Care Administration (“Agency” or “AHCA”), appeared on behalf of Respondent. Dr. David Bicard (“Dr. Bicard”), Board Certified Behavior Analyst and Director of Clinical Operations for eQHealth Solutions Inc. (“eQHealth”), appeared as a witness for Respondent.

Petitioner did not introduce any exhibits at the hearing. Prior to the hearing, Respondent sent to the Office of Fair Hearings and Petitioner a one-hundred and ninety-four (194)-page evidence packet and a forty-nine (49)-page evidence packet. The one-hundred and ninety-four (194)-page evidence packet appears in the Office of Fair Hearings’ Document Management System as the file titles “[REDACTED] FH 09.28.2023 1 - 162.pdf” and “[REDACTED] FH 09.28.2023 163 – 194.pdf”. The forty-nine (49)-page evidence packet appears in the Office of Fair Hearings’ document management system as the file title “23-FH1927 AHCA Evidence (Pages 1-49 of 49).pdf”. Absent an objection from the Petitioner, the undersigned admitted the one-hundred and ninety-four (194)-page evidence packet into evidence as Respondent’s Composite Exhibit 1 (“RCE 1”) and the forty-nine (49)-page evidence packet into evidence as Respondent’s Composite Exhibit 2 (“RCE 2”).

FINDINGS OF FACT

1. Petitioner receives Medicaid services on a fee-for-service basis from the Agency. eQHealth is a Quality Improvement Organization contracted by the Agency to review prior authorization requests for services. See page 2 of RCE 2.

2. Petitioner is [REDACTED]. See page 16 of RCE 1. Petitioner is diagnosed with [REDACTED]. *Id.*

3. Petitioner requested continuation of BA services; specifically, 3,120 units of code 97153; 416 units of code 97155; and 208 units of code 97156. *Id.* at 23. In a Notice of Outcome (“NOO”), dated July 11, 2023, Respondent terminated Petitioner’s ABA services. The NOO explained the basis for the termination as follows:

[T]he 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.

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

The NOO further provided:

PR Clinical Rationale – Denial: According to (the Florida Behavior Analysis Services Coverage Policy, page 6, 9.2.i), the behavioral definitions must be 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 definitions, and not be a listing of behaviors that the recipient does not engaging in. The behavior definitions for [REDACTED] in this treatment plan do not conform to generally accepted standards of care within the field of applied behavior analysis. Further, 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 affects activities of daily living. The goals for [REDACTED] does not meet medical necessity. The provider was requested to review and amend the definitions and the provider did not satisfy the request. This request is denied.

...

Pages 23 – 24 of RCE 1.

4. Petitioner requested reconsideration of the Respondent's decision. In a Notice of Reconsideration Determination ("NRD"), dated August 9, 2023, Respondent upheld its decision.

Id. at 35. The NRD explained the basis for the decision as follows:

PR Recon Determination: At reconsideration all documents were carefully reviewed. According to (the Florida Behavior Analysis Services Coverage Policy, page 6, 9.2.i), the behavioral definitions must be 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 definitions, and not be a listing of behaviors that the recipient does not engaging in. The behavior definitions for [REDACTED] in this treatment plan do not conform to generally accepted standards of care within the field of applied behavior analysis. Further, 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 affects activities of daily living. The goals for [REDACTED] does not meet medical necessity. The provider was requested to review and amend the definitions and the provider did not satisfy the request. Additionally, the provider has not submitted graphs of data for the last authorization period. This denial is upheld.

...

Pages 35 – 36 of RCE 1.

5. On August 8, 2023, Petitioner requested a Fair Hearing to challenge the termination of ABA services. *Id.* at 8. On September 1, 2023, the undersigned issued an Order Scheduling Fair Hearing by Telephone and Prehearing Instructions, setting the hearing for September 28, 2023, at 1:00 p.m. EST. *Id.*

6. Dr. Bicard is a Board-Certified Behavior Analyst and Director of Clinical Operations for eQHealth. Dr. Bicard testified to the following at the Fair Hearing:

- a. In this case, the second level reviewer of the treatment plan asserted that there were behaviors listed that do not meet medical necessity criteria. The reviewer sent a request to the provider for more information. The provider did not change

the treatment plan, resulting in a denial of service. At reconsideration, no new treatment plan was submitted. The provider was given the opportunity to amend the treatment plan but did not do so.

- b. In the treatment plan, there are some behavioral definitions that do not meet medical necessity criteria and do not comply with specifications in the Behavior Analysis Services Coverage Policy. Dr. Bicard stated that the behavioral definitions in the plan are poorly written, contain intentional states, and exhibit overlapping descriptions. The definitions for [REDACTED], [REDACTED], and [REDACTED] in the treatment plan exhibit overlap. See page 126 of RCE 1. Dr. Bicard stated it is important for the behavior analyst to precisely define and measure each maladaptive behavior. If there is overlap, the resulting data may not be clear and complete, and the data are relied upon to make determinations regarding treatment.
- c. Dr. Bicard stated that [REDACTED] is not a behavior, but rather a skill deficit, and should instead be a skill acquisition goal. *Id.* at 127. Dr. Bicard stated the absence of a behavior cannot be defined as a maladaptive behavior. The definition of [REDACTED] in the treatment plan overlaps with the definitions for [REDACTED] and [REDACTED]. *Id.* Dr. Bicard stated that [REDACTED] is not a behavior, but rather a skill deficit. *Id.* at 128. Dr. Bicard also stated that refusal is an intentional state. Dr. Bicard stated the field of behavior analysis does not utilize intentional states to define behavior.

and "[REDACTED]". *Id.* at 173-175. Dr. Bicard stated that these are the same goals written in different ways.

g. The treatment plan is deficient in most of the criteria for behavior analysis services and reassessments in the Behavior Analysis Services Coverage Policy. *See* pages 45 and 46 of RCE 2.

h. Petitioner's case is a transfer case from a prior agency. Dr. Bicard stated [REDACTED] assumption was that the provider, [REDACTED], wrote this treatment plan. Dr. Bicard stated that it was a mistake for the new provider to follow the assessment from the previous provider, as well as that the provider [REDACTED] should not have submitted a treatment plan that they did not write.

7. [REDACTED] is the [REDACTED] of Petitioner. [REDACTED] testified to the following at the Fair Hearing:

a. [REDACTED] stated, while questioning Dr. Bicard, that [REDACTED] understanding was that the poorly written treatment plan [REDACTED] was referencing was written by Petitioner's previous provider, not the current provider. [REDACTED] stated [REDACTED] understanding was that the new provider followed the assessment from the previous provider, and only established a new baseline.

b. [REDACTED] stated that Petitioner needs the behavior services. Petitioner exhibits [REDACTED], [REDACTED], [REDACTED], [REDACTED], and does not [REDACTED]. [REDACTED] stated that Petitioner gets [REDACTED].

- c. [REDACTED] stated that Petitioner has told [REDACTED] that [REDACTED] needs help with [REDACTED] behaviors. [REDACTED] stated that Petitioner struggles with academics and behavior issues at school. [REDACTED] stated Petitioner [REDACTED] [REDACTED] with family members.

8. Ms. Driggs is employed with [REDACTED]. Ms. Driggs testified to the following at the Fair Hearing:

- a. Petitioner was transferred to [REDACTED] on [REDACTED]. Ms. Driggs stated she has no graphs or references regarding what happened with the previous provider. Ms. Driggs stated she received the reassessment, which was approved six (6)-months ago. Ms. Driggs stated that the analyst who wrote the treatment plan no longer works with [REDACTED]. This analyst used the behaviors and skills from the previous provider and established a new baseline.
- b. Ms. Driggs stated that [REDACTED] can assign a new behavior analyst to this case and make several modifications to the treatment plan, but the provider first needs approval.

CONCLUSIONS OF LAW

9. 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).

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

11. Because Respondent terminated a previously approved service, Fla. Admin. Code R. 59G-1.100(17)(g) assigns the burden of proof to the Respondent. The standard of proof in an administrative hearing is a preponderance of the evidence. The preponderance of the evidence standard requires proof by “the greater weight of the evidence” (Black’s Law Dictionary at 1201, 7th Ed.)

12. 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.

13. 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

14. 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.

15. Petitioner is under age 21, and therefore EPSDT applies to 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.

16. 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.

17. The Florida Medicaid Authorization Requirements Policy (“Authorization 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 error 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.

18. In the instant case, Respondent terminated Petitioner's ABA services. See ¶ 3. In the NOO dated July 11, 2023, Respondent explained that continuing services at the prior level was 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 investigational", as well as "individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness under treatment, and not in excess of the patient's needs." *Id.* Respondent further explained that "there are behaviors listed for decrease and goals for increase that do not meet medical necessity criteria." *Id.* Furthermore, Respondent explained that "the provider was requested to review and amend the definitions and the provider did not satisfy the request." *Id.*

19. As provided by the EPSDT requirements, the recipient must meet the medical necessity criteria as outlined in Fla. Admin. Code R. 59G-1.010. As provided in section 2.83 of the Definitions Policy, two components of medical necessity are that services must be "consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational", as well as "individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness under treatment, and not in excess of the patient's needs." As shown by the record, there are many insufficiencies within the current treatment plan. Dr. Bicard identified several components which do not meet medical necessity and do not comply with the Behavior Analysis Services Coverage Policy. See ¶ 6. Dr. Bicard

testified that the behavioral definitions in the treatment plan are poorly written, with there being significant overlap among behavioral definitions. *Id.* The treatment plan also misidentified certain skill deficits as maladaptive behaviors, while some behavioral descriptions included intentional states not utilized in the field of behavior analysis. *Id.* Dr. Bicard also stated that the treatment plan did not meet the medical necessity criterion that services be individualized to Petitioner, as the plan contained a general listing of procedures. *Id.* There are also treatments in the behavior plan that do not exist within the field of behavior analysis. *Id.* Dr. Bicard further testified that some replacement behaviors do not meet medical necessity and exhibit overlap in behavioral descriptions. *Id.* All caregiver goals either do not meet medical necessity or exhibit significant overlap. *Id.* Dr. Bicard testified that the treatment plan is deficient in most of the criteria for behavior analysis services and reassessments in the Behavior Analysis Services Coverage Policy. *Id.* Dr. Bicard further stated the provider [REDACTED] should not have submitted a treatment plan that they did not write. *Id.* While Ms. Driggs testified that the author of the treatment plan is no longer employed by the agency, [REDACTED] appears to be the agency responsible for submitting treatment plan at issue. *See* ¶ 8. Ms. Driggs testified that the author of the plan used the behaviors and skills from the previous provider. *Id.* Nonetheless, the current provider was asked to amend the treatment plan, but did not do so, nor did the provider submit a new treatment plan at reconsideration. *See* ¶¶ 3, 4, 6. As Dr. Bicard's testimony elucidated the many deficiencies of the treatment plan, the record shows that Petitioner will not gain any additional benefit by continuing services at the current level.

20. 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 ¶ 17. As discussed, *supra* ¶ 19, and according to an expert in the field of behavior analysis, the treatment plan in this case does not meet medical necessity criteria, nor does it satisfy specifications in the Behavior Analysis Services Coverage Policy.

21. Upon consideration of the testimony provided, evidence submitted, and 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 plan 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 ABA services was correct.

IT IS HEREBY ORDERED AND ADJUDGED THAT:

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

DONE and **ORDERED** this 9th day of November, 2023, in Tallahassee, Leon County, Florida.

 Lynne Ringers
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LYNNE RINGERS, 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
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