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

FILED
Nov 13, 2023, 11:43 am
OFFICE OF FAIR HEARINGS

[redacted],

PETITIONER, **AHCA Case No.: 23-FH2001**

vs.

AGENCY FOR HEALTH CARE ADMINISTRATION,

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, a hearing officer convened a telephonic Fair Hearing on the instant case on October 10, 2023, at 9:02 a.m. Eastern Standard Time ("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 Petitioner proved by a preponderance of the evidence that Respondent's decision to deny Petitioner's behavior analysis ("ABA" or "BA") services was incorrect.

PRELIMINARY STATEMENT

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

Smiljana Clark ("Ms. Clark") is a Board-Certified Behavior Analyst ("BCBA") and appeared at the Fair Hearing as a witness for Petitioner.

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

Prior to the Fair Hearing, Petitioner sent to the Office of Fair Hearings and Respondent a thirteen (13)-page evidence packet and a sixty-six (66)-page evidence packet. The thirteen (13)-page packet appears in the Office of Fair Hearings' document management system as the file titled "23-FH2001 Supporting Documents.pdf". The sixty-six (66)-page packet appears in the Office of Fair Hearings' document management system as the file titled "23-FH2001 Faxed Evidence.pdf." Absent any objections from Respondent, the undersigned admitted the thirteen (13)-page evidence packet as Petitioner's Composite Exhibit 1 ("PCE 1") and the sixty-six (66)-page evidence packet as Petitioner's Composite Exhibit 2 ("PCE 2").

Prior to the Fair Hearing, Respondent sent to the Office of Fair Hearings and Petitioner a seventy (70)-page evidence packet and a forty-nine (49)-page evidence packet. The seventy (70)-page packet appears in the Office of Fair Hearings' document management system as the file titled "[redacted] FH 10.10.2023.pdf". The forty-nine (49)-page packet appears in the Office of Fair Hearings' document management system as the file titled "23-FH2001 BA AHCA Evidence pkt.pdf". The undersigned admitted the seventy (70)-page evidence packet as Respondent's

Composite Exhibit 1 ("RCE 1") and the forty-nine (49)-page evidence packet as Respondent's Composite Exhibit 2 ("RCE 2").

FINDINGS OF FACT

1. Petitioner receives Medicaid services on a fee-for-service basis through the Agency. *See* RCE 1 at 16. eQHealth is a Quality Improvement Organization contracted by the Agency to review prior authorization requests for services. *See* RCE 2 at 2.

2. As of the date of the hearing, Petitioner is [redacted]. *See* RCE 1 at 16. Petitioner is diagnosed with [redacted], [redacted] ([redacted]), [redacted], [redacted], [redacted], [redacted], and [redacted]. *Id*. at 35.

3. As provided in the [redacted] ABA Assessment and Treatment Plan Progress Report ("Treatment Plan"), dated June 10, 2023, Petitioner is engaging in the following maladaptive behaviors: [redacted] ([redacted]; [redacted]), [redacted], [redacted], [redacted] ([redacted]), [redacted]; [redacted], [redacted], [redacted], [redacted], and [redacted]. *Id.* at 36, 46 – 47. Petitioner is learning the following replacement behaviors: [redacted], [redacted], [redacted]: [redacted], [redacted], [redacted], [redacted], [redacted], [redacted] tasks, [redacted], [redacted], [redacted], [redacted], [redacted], [redacted], us[redacted], [redacted], [redacted]", and [redacted]. *Id.* at 48 – 65.

4. As testified to by Dr. Conway, for the period of July 3, 2023, through December 28, 2023, Petitioner was approved to receive the following ABA services: 1,560 units of code 9715; 208 units of 97155, and 52 units of 97156.

5. On July 3, 2023, Petitioner requested a modification of BA services; specifically, 208 units of code 97155 and 1,820 units of code 97153. *See* RCE 1 at 23. In a Notice of Outcome ("NOO"), dated July 13, 2023, Respondent denied Petitioner's request. *Id.* at 23 – 26. The NOO states as follows:

> Code: 97153 Intervention without protocol modification, per 15 minutes, Lead Analyst, BCaBA, or RBT
> From: 7/3/23
> Thru: 12/28/23
> Total Units: Denied 1,820
>
> Code: 97155 Intervention without protocol modification, per 15 minutes
> From: 7/3/23
> Thru: 12/28/23
> Total Units: Denied 208

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.

> PR Clinical Rationale – Denial: According to the Behavior Analysis Services Coverage Policy, all requested services must be based on maladaptive behavior emitted by the recipient. Services cannot be approved on a speculative basis and services cannot be approved based on the convenience of the provider, the availability of the recipient, or the recipient's caretaker. The information submitted by the provider [does] not support this request for modification of services. The request for modification of treatment units is denied.

. . .
RCE 1 at 22 – 23.

6. On August 15, 2023, Petitioner requested a Fair Hearing to challenge the termination of PPEC services. On September 8, 2023, the undersigned issued an Order Scheduling Fair Hearing by Telephone and Prehearing Instructions, setting the hearing for October 10, 2023, at 9:00 a.m. EST.

7. Ms. Clark, a BCBA with Petitioner's provider, testified as follows:

a. Ms. Clark has worked with Petitioner for over [redacted].

b. Petitioner has [redacted]

c. Petitioner has had several changes in [redacted] These changes have been barriers to treatment. There is an RBT scheduled to join Petitioner's case, but she is not scheduled to start yet. The last day Petitioner had a RBT was [redacted]. Petitioner's services are currently paused while waiting for an RBT to start, but Ms. Clark has provided some therapy for Petitioner.

d. Data shows Petitioner has an increase in behavior.

e. Over the last two (2) authorization periods, Petitioner's hours have been lowered. Ms. Clark believes this is because of Petitioner's age.

f. There is an upwards trend in [redacted], [redacted] behavior, [redacted], and [redacted]. *See* pages 27 – 33 of PCE 2.

g. [redacted] also has [redacted].

h. Petitioner submitted a letter of support from Petitioner's doctor regarding medical necessity.

i. Ms. Clark read from a letter she wrote on [redacted]. The letter refers to Petitioner's [redacted]. *See* PCE 1 at 11. The duration of Petitioner's [redacted] is approximately [redacted].

j. Ms. Clark explained that some behaviors, such as [redacted], appear to occur at low levels, but that is because Petitioner does not always have the opportunity to engage in those behaviors.

8. [redacted], Petitioner's [redacted], testified to the following:

a. Petitioner's medication was decreased due to some of the side effects.

9. Dr. Conway is a BCBA and a Second Level Reviewer for eQHealth. Dr. Conway testified to the following:

a. eQHealth is the quality improvement organization contracted by Florida Medicaid to review requests for BA services for medical necessity. Medical necessity means that the medical or allied cares, goods, or services must meet the medical necessity criteria. Dr. Conway read the five (5) medical necessity criteria into the record. *See* RCE 2 at 7.

b. Petitioner has received BA services with this provider since [redacted]. The modification to add additional services for code 97153 and code 97155 was

denied. The code 97153 modification request was to add an additional eighteen (18) hours per week of services. The code 97155 modification request was to add an additional two (2) hours per week of services.

c. The provider did not submit a medically necessary reason or updated protocols that require more hours to implement.

d. The request does not meet conditions two (2) and five (5) of the medical necessity criteria: 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; and be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider. *See* RCE 2 at 7.

e. Dr. Conway reviewed the treatment plan and the graphs regarding problem behaviors.

f. The graph for [redacted] shows [redacted] levels across multiple weeks. *See* RCE 1 at 38. This behavior is not occurring.

g. The graph for [redacted] shows very low levels, with the highest level occurring at [redacted] per session during the last several weeks. *See* RCE 1 at 39.

h. The graph for [redacted] shows a downward trend with the highest level per session at [redacted] total task refusals. at *See* RCE 1 at 40. Again, these are low levels compared to previous sessions.

i. The graph for [redacted] shows the maximum number of [redacted] of [redacted] over the last several sessions. *See* RCE 1 at 42. Overall, there was an increase in the last several months but a max of [redacted].

j. To meet the standard of care in the field of behavior analysis, graphs are needed that are not anecdotal or indirect reports. Respondent needs the data clearly represented so they can see if there is an increase in duration, what interventions are being put in place, if the interventions are working, etc.

k. The graph for [redacted] shows some spikes in the middle of the graph, but decreases in the last several months, with the highest level being [redacted]. *See* RCE 1 at 43. There are multiple sessions with [redacted] instances of [redacted].

l. The graph for [redacted] shows [redacted] instances. *See* RCE 1 at 44.

m. The graph for [redacted] shows most days at [redacted] instances, with the most recent dates showing [redacted] instances. *See* RCE 1 at 45.

n. The graph for [redacted] shows a decreasing trend. *See* RCE 1 at 46. The behavior shows low levels overall.

o. The graph for [redacted] shows very low levels, about [redacted] per session over the last several weeks. *See* RCE 1 at 47.

p. The graphs for [redacted] indicate mastery of several goals. *See* RCE 1 at 48 – 65. The skill of [redacted] is showing variable progress. *See* RCE 1 at 51.

q. There are no additional goals or protocols that lead to the increase based on medical necessity.

r. Overall, the modification request to add an additional eighteen (18) hours per week of services and an additional two (2) hours per week of code 97155 services was in excess of medical necessity.

s. Moreover, there is not an RBT to administer the additional hours.

CONCLUSIONS OF LAW

10. The Agency's Office of Fair Hearings has jurisdiction over the subject matter of this proceeding and the parties pursuant to second 409.285(2), Florida Statutes (2019). This order is the final administrative decision of AHCA under section 409.285(2)(a).

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

12. Because Petitioner requested a new service, Fla. Admin. Code R. 59G-1.100(17)(b) 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.).

13. 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 – 41.

14. 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 than 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 <u>evidence that the frequency of the maladaptive behavior(s) has decreased</u> since the last review and, if not, that there is a <u>modification of the behavior plan.</u>
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.

15. 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.

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

17. 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 18.

18. 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 33.

19. In the instant case, Respondent denied Petitioner's request for additional ABA services. *See* ¶ 5. In the NOO dated July 13, 2023, Respondent explained that additional ABA services with the current provider were not medically necessary, specifically, that the request was not "consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigation." *See* ¶ 5. Respondent further

explained that the "submitted information does not support the medical necessity for requested frequency and/or duration" and "[s]ervices cannot be approved on a speculative basis and services cannot be approved based on the convenience of the provider, the availability of the recipient, or the recipient's caretaker." *See* ¶ 5.

20. As Petitioner bears the burden of proof, Petitioner must show that it is medically necessary for Petitioner to receive the requested service. As explained in Appendix 9.0 of the BA Policy, BA services may be discharged if the data provided information shows the recipient has made no progress toward any goals in the last twelve (12) consecutive months. *See* ¶ 14. Here, Dr. Conway provided credible testimony that Petitioner has received BA services with this provider since [redacted] and that the provider did not submit a medically necessary reason or updated protocols that require more hours to implement the treatment plan. *See* ¶ 9. Although Petitioner's BCBA, Ms. Clark, testified that Petitioner is having increased behaviors, both Ms. Clark and Petitioner's [redacted], [redacted], testified that Petitioner's increased behaviors may be attributed to a decrease in medication. *See* ¶ 7, 8. Further, the record shows that Petitioner's maladaptive behaviors overall remained consistent. See ¶ 4. Again, Dr. Conway provided credible and persuasive testimony that the information provided by the provider does not meet the standard of care in the field of behavior analysis. *See* ¶ 9.

21. Lastly, although the record reflects that Petitioner's provider has recommended that services continue, 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* ¶ 17.

22. Upon consideration of the testimony provided, Petitioner's Composite Exhibit 1, Petitioner's Composite Exhibit 2, Respondent's Composite Exhibit 1, Respondent's Composite Exhibit 2, the EPSDT policy, and all other applicable polices, the undersigned concludes that Petitioner has not demonstrated that the modification of services is necessary to correct or ameliorate a defect or a physical and mental illness or condition. Accordingly, Petitioner did not show that Respondent's denial of behavioral analysis 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 of BA services is **DENIED**.

DONE AND ORDERED this 13th day of November, 2023 in Tallahassee, Leon County, Florida.

_____

JOSEPH MABRY, 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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