

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



FILED

Jan 17, 2023, 8:57 am

OFFICE OF FAIR HEARINGS

[REDACTED]
PETITIONER,

AHCA Case No.: [REDACTED]

vs.

AGENCY FOR HEALTH CARE
ADMINISTRATION,

RESPONDENT.
_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic Fair Hearing on the instant case on November 14, 2022, at 9:30 a.m. Eastern Standard Time ("EST").

APPEARANCES

For the Petitioner:

[REDACTED]
Petitioner's Authorized Representative

For the Respondent:

Doris Rivera
Medicaid 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 denial of Petitioner's request for Behavior Analysis ("BA") services was incorrect.

PRELIMINARY STATEMENT

All parties appeared for the Fair Hearing telephonically. [REDACTED]

[REDACTED] Petitioner's Authorized Representative and friend of the family, appeared for the Fair

Hearing and provided testimony on behalf of Petitioner. [REDACTED] (“[REDACTED]”), Petitioner’s [REDACTED], provided testimony on Petitioner’s behalf.

Doris Rivera, Medical Health Care Program Analyst for the Agency for Health Care Administration (“Agency” or “AHCA”), appeared for the Fair Hearing as a representative for Respondent. Dr. David Bicard (“Dr. Bicard”), Director of Clinical Operations for eQHealth Solutions - Florida, appeared for the Fair Hearing as a witness for Respondent.

Interpreter Joseph, ID No. 31579212, with Global Interpreting Network, provided Spanish translation services for Petitioner.

Petitioner introduced a four (4) page exhibit at the Fair Hearing. The exhibit is maintained in the Office of Fair hearings’ case management system as “22-FH1605 DAR & Supporting Documents.pdf.” Without objection, this evidence packet was admitted into evidence as Petitioner’s Composite Exhibit 1.

Respondent introduced a seventy-six (76)-page evidence packet. The evidence packet appears in the Office of Fair Hearings’ case management system as “[REDACTED] FH 11.14.2022.pdf.” Without objection the evidence packet was admitted into evidence as Respondent’s Composite Exhibit 1. Respondent also introduced a forty-nine (49) page evidence packet, which appears in the Office of Fair Hearings’ case management system as “22-FH1605 AHCA evidence BA 49 pgst.pdf.” Without objection, this evidence packet was admitted into evidence as Respondent’s Composite Exhibit 2.

FINDINGS OF FACT

1. Petitioner receives Medicaid services on a fee-for-service basis through the Agency. See Respondent’s Composite Exhibit 1 at page 21.

2. eQHealth is a Quality Improvement Organization (“QIO”) contracted by the Respondent to review prior authorization requests for services. See Respondent’s Composite Exhibit 2 at page

2. Respondent, through contractual agreement, authorizes eQHealth to make medical necessity determinations for services requiring prior authorization, including BA services. *Id.*

3. As of the date of the Fair Hearing, Petitioner is a [REDACTED]. Petitioner’s pediatrician diagnosed Petitioner with [REDACTED]. See Respondent’s Composite Exhibit 1 at page 46.

4. Petitioner is independent with [REDACTED] activities of daily living (“ADLs”). *Id.* at 48. When the [REDACTED], conducted the Comprehensive Diagnostic Evaluation on [REDACTED], [REDACTED] observed Petitioner to be cooperative and able to answer the questions asked.

Id. at 48. The Content Scale and Index *T*-Score Profile (“*T*-Score Profile”) in the CDE is based on [REDACTED] rating of Petitioner’s behavior using the BASC-3 Parent rating Scales form. *Id.* at

49. The *T*-Score profile shows a *T*-score of between [REDACTED] for [REDACTED], [REDACTED], [REDACTED], [REDACTED], [REDACTED], [REDACTED], [REDACTED], [REDACTED], and [REDACTED]. The score is below [REDACTED] for [REDACTED] and [REDACTED]. The *T*-score is [REDACTED] for [REDACTED], and [REDACTED] for [REDACTED]. *Id.* at 52.

5. Petitioner’s Individualized Educational Plan (“IEP”) with the [REDACTED] Public Schools states that Petitioner is eligible for ESE under “Other Health Impaired.” *Id.* at 57. The IEP shows that Petitioner primarily experiences problems with reading. *Id.* at 60. The IEP states that Petitioner is respectful of others even when impulsive. *Id.* at 64. With regard to independent functioning, the IEP states that Petitioner has trouble [REDACTED] and [REDACTED]. *Id.* at 65. However, no significant maladaptive behaviors are identified that interfere with Petitioner’s daily functioning. *Id.*

6. On July 27, 2022, Respondent issued a Notice of Outcome (“NOO”) denying Petitioner’s request for BA services. *Id.* at 26-27. The NOO states as follows:

Code: H2019 Behavior Assessment
From: 7/20/2022
Thru: 7/31/2022
Denied

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. Specifically, 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.

...

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 Florida Behavior Analysis Services Coverage Policy (page 6, 9.0.c-d) the recipient of ABA therapy services must engage in maladaptive behaviors that interferes with the recipient’s daily functioning for which ABA therapy is medically necessary. There is no submitted evidence that the recipient is engaging in behaviors for which ABA therapy is medically necessary under Florida Medicaid Rules or the proper treatment modality given the diagnosis and presenting maladaptive behaviors.

Id. at 26.

7. On August 16, 2022, Respondent issued a Notice of Reconsideration Determination (“NRD”) upholding the denial of BA services. *Id.* at 35-36. The NRD states 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:

Consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational.

.

The rationale for our decision is as follows:

PR Recon Determination: At reconsideration all documents were carefully reviewed. According to the Florida Behavior Analysis Services Coverage Policy (page 6, 9.0.c-d) the recipient of ABA therapy services must engage in maladaptive behaviors that interferes with the recipient's daily functioning for which ABA therapy is medically necessary. There is no submitted evidence that the recipient is engaging in behaviors for which ABA therapy is medically necessary under Florida Medicaid Rules. ABA therapy is not the proper treatment for the recipient's maladaptive behaviors given the recipient's diagnosis and etiology or the problem behaviors. This reconsideration request has been reviewed, reconsidered and the denial is upheld.

Id.

8. On August 29, 2022, Petitioner requested a Fair Hearing on Respondent's decision to deny the BA services requested by Petitioner. *Id.* at 8. On September 27, 2022, the Office of Fair Hearings issued an order scheduling the Fair Hearing for November 14, 2022, at 9:30 p.m. and all parties were duly notified.

9. [REDACTED] testified that Petitioner struggles with [REDACTED] and [REDACTED]. [REDACTED] stated that Petitioner's school psychologist contacted [REDACTED] due to Petitioner's problem behaviors. [REDACTED] testified that Petitioner's [REDACTED] psychologist was calling [REDACTED] twice per week because Petitioner was [REDACTED] and [REDACTED].

10. At the Fair Hearing, Dr. Bicard explained the peer review process that Petitioner's request underwent at eQHealth. The First Level Review was conducted by a BCBA who determined that there was no evidence that the recipient is engaging in behaviors for which ABA therapy is medically necessary and that the requested service is not consistent with generally accepted professional medical standards as determined by the Medicaid program. *Id.* at 22. The Second Level review was conducted by an experienced BCBA at the doctoral level ("BCBA-D") who

reviewed the documentation, agreed with the determination, and added that ABA therapy is not the proper treatment for the diagnosis, and the etiology of the problem behaviors. *Id.* at 22. Dr. Bicard provided credible and persuasive testimony that he reviewed all documentation submitted by Petitioner and that he agrees with the previous eQHealth reviewers that the documentation does not show that Petitioner is engaging in maladaptive behaviors that interferes with [REDACTED] daily functioning.

11. Dr. Bicard testified that the IEP shows that Petitioner struggles in school with [REDACTED] and primarily with reading, but it does not identify maladaptive behaviors that interferes with Petitioner's daily functioning. Further the *T*-scores in the CDE do not show that Petitioner is having significant behavioral problems because the scores are not at two standard deviations above the median.

CONCLUSIONS OF LAW

12. Pursuant to section 409.285(2), Florida Statutes (2019), the Agency's Office of Fair Hearings has jurisdiction over the subject matter of this proceeding and the parties. This Final Order is the final administrative decision of AHCA.

13. Pursuant to Florida Administrative Code Rule ("Fla. Admin. Code R.") 59G-1.100(17)(b), this hearing was held as a *de novo* proceeding.

14. Pursuant to Fla. Admin. Code R. 59G-1.100(17)(g), the burden of proof is as follows:

The burden of proof is on the party asserting the affirmative of an issue, except as otherwise required by statute. The burden of proof is on the Agency or plan, whichever is applicable, when the issue presented is the suspension, reduction, or reduction of a previously authorized service. The burden of proof is on the recipient or enrollee, when the issue presented is the denial or a limited authorization of a service. The party with the burden of proof shall establish its position to the satisfaction of the Hearing Officer by a preponderance of the evidence.

15. Because Petitioner requested a Behavior Analysis Assessment, the burden of proof is on the Petitioner. *See* Fla. Admin. Code R. 59G-1.100(17)(g). The standard of proof in an administrative hearing is a preponderance of the evidence. *Id.* The preponderance of the evidence standard requires proof by “the greater weight of the evidence” (Black’s Law Dictionary at 1201, 7th Ed.).

16. The Behavior Analysis Services Coverage Policy (October 2017) (“BA Policy”), incorporated by reference in Fla. Admin. Code R. 59G-4.125, governs the BA services available to Medicaid recipients in the State of Florida. *See* Respondent’s Composite Exhibit 2 at pages 38 -

47. The BA Policy states as follows in pertinent part:

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.

1.1 Florida Medicaid Policies

This policy is intended for use by providers that render BA services to eligible Florida Medicaid recipients. It must be used in conjunction with Florida Medicaid’s General Policies (as defined in section 1.3) and any applicable service-specific and claim reimbursement policies with which providers must comply.

Note: All Florida Medicaid policies are promulgated in Rule Division 59G, Florida Administrative Code (F.A.C.). Coverage policies are available on the Agency Web site at <http://ahca.myflorida.com/Medicaid/review/index.shtml>.

...

1.4 Definitions

The following definitions are applicable to this policy. For additional definitions that are applicable to all sections of Rule Division 59G, F.A.C., please refer to the Florida Medicaid definitions policy.

1.4.4 Lead Analyst

Practitioner responsible for the implementation of BA services including: the completion and review of behavior assessments, reassessments, behavior plans, and behavior plan reviews.

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:

4.2.2 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 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.

...

6.0 Documentation

6.1 General Criteria

For information on general documentation requirements, please refer to Florida Medicaid's General Policies on recordkeeping and documentation.

...

6.2 Specific Criteria

Providers must maintain the following documentation in the recipient's file:

- Behavior assessment, and assessment review that must be reviewed and signed by a lead analyst;
- Behavior plan, and behavior plan review that must be reviewed and signed by a lead analyst;
- Notations when the recipient's family or caregiver is not able to participate in BA services, and instances when it was clinically inappropriate for the recipient to be present during training services; and
- Written physician's order.

...

7.0 Authorization

7.1 General Criteria

The authorization information described below is applicable to the fee-for-service delivery system. For more information on general authorization requirements, please refer to Florida Medicaid's General Policies on authorization requirements.

7.2 Specific Criteria

Providers must obtain authorization from the quality improvement organization (QIO) prior to the initiation of BA services and at least every 180 days thereafter.

Providers may request authorization more frequently upon a change in the recipient's condition requiring an increase or decrease in services.

The QIO uses the review criteria specified in section 9.0 for the first level review. For more information on how the QIO uses the criteria in the review process, please refer to Florida Medicaid's General Policies on authorization requirements.

Id.

17. The BA Policy's Appendix states the following review criteria:

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 Behavior Analysis 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 in Rule 59G-1.010, F.A.C.;
- c. The recipient currently engages in maladaptive behaviors; and
- 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 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)
 - ii. Baseline and/or updated treatment data (if reassessment)
 - iii. Progress toward identified goals (if a reassessment)
 - iv. Identification of the events, times, and situations that appear to be associated to the occurrence of the maladaptive behavior(s)
 - v. Identification of the functional consequences of the maladaptive behavior(s)
 - vi. Development of hypotheses and summary statements that describe the maladaptive behavior(s) and its(their) functions
 - vii. Summary and recommendations
- 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 [redacted] justifies continuation of BA services. The reviewer utilizes the information provided below as a guide as it relates to the level of [redacted] 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

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

- 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). 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.

19. Petitioner is under age 21, and therefore eligible for EPSDT services. However, a state may place appropriate limits on a service based on such criteria as medical necessity. *See* 42 C.F.R. §§ 440.230(a), (b), (d). 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.

20. The Florida Medicaid Definitions Policy (“Definitions Policy”) (August 2017), which is incorporated by reference in Fla. Admin. Code R. 59G-1.010, defines Medical Necessity as:

2.83 Medically Necessary or Medical Necessity

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 severe 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.

Definitions Policy at page 7.

21. 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:

1.2 Definitions

The following definitions are applicable to this policy. For additional definitions that are applicable to all sections of Rule Division 59G, F.A.C., please refer to the Florida Medicaid definitions policy.

1.3.1 Authorization

The process of obtaining approval for reimbursement of a service based on medical necessity.

1.3.6 Provider

The term used to describe any entity, facility, person, or group that has been approved for enrollment or registered with Florida Medicaid.

1.3.7 Quality Improvement Organization

Entity designated to perform utilization review, quality assurance, and quality improvement activities for Florida Medicaid-covered services rendered by fee-for-service providers (also known as the QIO).

...

2.0 Authorization Requirements

2.4.2 Requests for Additional Information

The QIO may request additional information, as necessary, to determine medical necessity.

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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 [redacted] 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.

Florida Medicaid Authorization Requirements Policy at pages 1-3.

22. Petitioner is under the age of 21 years and diagnosed with [REDACTED]. See supra ¶

3. Respondent determined that Petitioner submitted insufficient documentation to justify the requested Behavior Analysis Assessment. See supra ¶ 6-7. Based on the record, Respondent determined that the documentation did not meet the following medical necessity standard: [c]onsistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational. See supra ¶ 6-7, 10. The medical necessity criteria are expressly outlined in section 2.83 of the Definitions Policy and are a critical element for BA services. See supra ¶ 16, 17. Moreover, the Authorization Requirements Policy states that eQHealth may deny the requested service if it cannot substantiate medical necessity based upon the information submitted. See supra ¶ 21.

23. Dr. Bicard testified that the requested Behavior Analysis Assessment is not the proper treatment given the Petitioner's [REDACTED] diagnosis and the etiology of the problem behaviors, and

that the request is inconsistent with generally accepted professional medical standards as determined by the Medicaid program. *See supra* ¶ 10-11. Dr. Bicard further asserted that the documentation provided insufficient justification for the requested service. *See supra* ¶ 10.

24. Dr. Bicard provided credible and persuasive testimony concerning a number of areas in which the documentation was insufficient to justify a Behavior Analysis Assessment. For example, in the CDE, the school psychologist observed Petitioner to be cooperative and able to answer the questions asked. *See supra* ¶ 5. Further, the data graph for Petitioner's *T*-Score profile does not demonstrate significant behavioral problems affecting Petitioner's daily functioning. *See supra* ¶ 4. As Dr. Bicard testified, Petitioner's *T*-scores are not at the requisite two standard deviations above the median to qualify for BA services. *See supra* ¶ 4, 11. Petitioner's IEP states that Petitioner is respectful of others even when impulsive, primarily experiences problems with reading, and has trouble [REDACTED] and [REDACTED]. *See supra* ¶ 5, 11. Based on the foregoing, the record does not demonstrate that the Behavior Analysis Assessment at issue is consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational.

25. Accordingly, Petitioner has not shown that the requested Behavior Analysis Assessment is medically necessary. Looking at all the evidence relevant to the particular needs of Petitioner, the requested BA service is not necessary to correct or ameliorate a defect or a physical and mental illness or condition.


26. Upon consideration of Petitioner's Composite Exhibit 1, Respondent's Composite Exhibit 1, Respondent's Composite Exhibit 2, the testimony, and the applicable laws and policies, the

undersigned concludes that Petitioner did not prove by a preponderance of the evidence that the denial of a Behavior Analysis Assessment was incorrect.

DECISION

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

DONE and ORDERED this 17th day of January 2023, in Tallahassee, Leon County, Florida.

Joseph Mabry
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for LAURA GALLAGHER, Hearing Officer
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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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