



**FILED**

Aug 18, 2023, 10:23 am

OFFICE OF FAIR HEARINGS

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

████████████████████,

**PETITIONER,**

**AHCA Case No.: 23-FH1024**

**vs.**

**AGENCY FOR HEALTH CARE  
ADMINISTRATION,**

**RESPONDENT.**

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**FINAL ORDER**

Pursuant to notice, the undersigned convened a telephonic Fair Hearing on the instant case on June 26, 2023, at 1:00 p.m. Eastern Standard Time (“EST”).

**APPEARANCES**

For the Petitioner:

████████████████████  
Counsel for Petitioner

For the Respondent:

Bradley Butler, Esq.  
Counsel for Respondent

**STATEMENT OF ISSUE**

The first issue is whether Respondent proved by a preponderance of the evidence that Respondent’s decision to reduce Petitioner’s Behavior Analysis (“BA” or “ABA”) services was correct.

The second issue is whether Petitioner proved by a preponderance of the evidence that Respondent’s denial of Petitioner’s request for an increase in ABA services was incorrect.

**PRELIMINARY STATEMENT**

All parties and witnesses appeared telephonically. Petitioner's Counsel, [REDACTED], [REDACTED], appeared on behalf of Petitioner. The following attended as witnesses for Petitioner: [REDACTED], Petitioner's [REDACTED] Kelsey Brown, Board Certified Behavior Analyst ("BCBA") for Petitioner; Lorraine Zevallos, BCBA for Petitioner; and Laura Garcia, BCBA for Petitioner.

Bradley Butler, Esq., Counsel for the Agency for Health Care Administration ("Agency" or "AHCA"), appeared on behalf of Respondent. The following attended as witnesses for Respondent: Dr. David Bicard ("Dr. Bicard"), BCBA at the doctoral level and Director for Clinical Operations for eQHealth Solutions Inc. ("eQHealth"); and Doris Rivera, Medical/Health Care Program Analyst for AHCA.

Prior to the hearing, Petitioner sent to the Office of Fair Hearings and Respondent a 371-page evidence packet. The evidence packet appears in the Office of Fair Hearings' document management system as the file titles: "23-FH1024 Evidence Part 1of 2.pdf"; "23-FH1024 Evidence Part 2a of 2.pdf"; "23-FH1024 Post Hearing Evidence.pdf"; and "23-FH1024 Post Hearing Evidence (2).pdf". Absent an objection from the Respondent, the undersigned admitted the 371-page evidence packet into evidence as Petitioner's Composite Exhibit 1 ("PCE 1"). Petitioner submitted a six (6) page packet. The six (6) page packet appears in the Office of Fair Hearings' document management system as file title "23-FH1024 Post Hearing Evidence (3).pdf". Absent an objection from the Respondent, the undersigned admitted the six (6) page document as Petitioner's Exhibit 2 ("PE 2").

Prior to the hearing, Respondent sent to the Office of Fair Hearings and Petitioner a 466-page evidence packet. The 466-page packet appears in the Office of Fair Hearings' document management system as the file titles "[REDACTED] FH 1-174.pdf", "[REDACTED] FH 175 - 339.pdf",



[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 or injury under treatment, and not in excess of the patient's needs.

The NOO further provided:

PR Clinical Rationale – Denial: The supporting documentation does not meet generally accepted practices within the field of applied behavior analysis and standards set forth in the Florida Behavior Analysis Services Coverage Policy (Pages 6-7). The plan includes restraint and holds as an active consequence (not crisis) strategy (pg 61). According to the Florida Behavior Analysis Service Coverage Policy (5.2, page 3), restraint procedures are not covered services and cannot be approved if included in the plan as a strategy for managing behavior.

...

Pages 24 – 25 of RCE 1.

4. Petitioner requested reconsideration of the Respondent's decision. In a NRD dated May 4, 2023, Respondent upheld its decision. *Id.* at 35 – 37. The NRD explained the basis for the decision as follows:

PR Recon Determination: At reconsideration all documents were carefully reviewed. This request for 2:1 service is denied. The provider must have detailed protocols for each provider rendering services. There must be a detailed schedule of services that shows a BCBA will be on site during the implementation of the 2:1 protocols. There must be a statement of how the environment will be customized to meet the needs of the patient. Services cannot be approved solely to render crisis care in the event of high intensity maladaptive behavior. This request does not meet medical necessity criteria. According to the Florida Medicaid State Plan (Appendix 9.3.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. 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 the provider will address human error. The recommendations are insufficient to support continued care. This reconsideration request has been reviewed, reconsidered and the denial is upheld.

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Page 36 of RCE 1.

5. The responsibilities of the second provider in 2:1 therapy were described as follows:

**Responsibilities During Routines and Outside of a Tantrum or Crisis**

...

**Second Provider:**

- Follows the lead of the first provider
- Places naturally occurring demands
- Responsible for environmental manipulations as antecedent manipulations for [Petitioner's] safety
  - Moving chairs out of the way and turning them to avoid [REDACTED]
  - Tilting the tables down to avoid [REDACTED]
  - Closing and locking doors if possible
  - Blocking potential high risk [REDACTED] opportunities with body positioning in any room or environment
  - Removing dangerous objects when entering a room
- Gathering materials needed for specific tasks or for [REDACTED] items to provider immediate reinforcement for appropriate requests
- Collects and graphs data

...

**Second Provider Clinical Responsibilities:**

- The first provider is the lead and the point person for placing contrived demands to limit multiple individuals placing demands at one time. However, the second provider is continuously taking data on [Petitioner's] behaviors and responses during the procedures. Procedural fidelity is ongoing as the second provider is assessing the procedure implementation of the first provider and communicating with [REDACTED] team via [REDACTED] team's chat to collaborate with all BCBA's and RBT's on [Petitioner's] current schedule.
- If a naturally occurring demand arises, such as transitions, bringing an item to an individual, or moving [REDACTED] body position to due to activities within the room, the second provider naturally places demands and contingencies in those moments.
- [Petitioner's] [REDACTED] is at a severe level and occurs without a clear antecedent at times. As mentioned above in the antecedent strategies, the

second provider will immediately implement priming and reminders using clear and concise language for [Petitioner] to understand and make alternative choices through the use a [REDACTED]. If [Petitioner] chooses to [REDACTED] in the absence of a dangerous behavior, regardless of [REDACTED], the first provider transitions with [Petitioner] to [REDACTED] alternative choice and the second provider removes the triggering object or activity without placing a [REDACTED] to reinforce the [REDACTED].

...

Pages 1 – 3 of PE 2.

6. On May 3, 2023, Petitioner requested a Fair Hearing to challenge the termination of ABA services. On June 2, 2023, the undersigned issued an Order Scheduling Fair Hearing and Prehearing Instructions, setting the hearing for June 26, 2023, at 1:00 p.m. EST.

7. Prior to the hearing, Respondent issued a new NRD that approved the following services: 832 units of code 97155; 104 units of code 97156; and 4,160 units of code 97153. See page 2 of RE 2.

8. Dr. Bicard is a BCBA at the doctoral level. Dr. Bicard testified to the following:

- a. In this case, the services were initially denied due to a lack of progress. This denial was in place until the beginning of the Fair Hearing process. The provider submitted updated documents, some of the hours were reinstated and additional hours were added – specifically 1,040 units of code 97153.
- b. Petitioner is approved for approximately 40 hours of direct therapy, 8 hours of case management, and 1 hour of parent training. Thus, Petitioner has 2:1 services for approximately 20% of [REDACTED] therapy.
- c. To demonstrate progress in reducing maladaptive behaviors, the graphs should go in a downward direction.

- d. Petitioner's maladaptive behaviors are graphed with separate entries for Provider 1 and Provider 2. It is unclear from the presentation of the graphs, whether this graphing represents the difference when one (1) provider or two (2) providers are present; or whether this represents two (2) separate individuals graphing the same behaviors. If the former is the case, then many of Petitioner's maladaptive behaviors are not changed at all by the presence of a second provider. For example, [REDACTED]
- e. The graph for [REDACTED] show highly variable data, and appear to increase in both frequency and intensity. See page 77 of RCE 1. There is a set of graphs for a second provider, that is of similar appearance to the first set of graphs – it is unclear whether this is for a second therapist alone or when there are two therapists present. *Id.* at 78. Thus, it appears that having a second therapist present may not have an effect.
- f. The code 0373T is for 2:1 services and is typically intended for children in in-patient settings. There are four (4) main criteria for approval for this code:
- i. Must be administered by a physician (or other qualified provider) who is on site;
  - ii. With the assistance of two (2) or more technicians;
  - iii. For a patient who exhibits destructive behavior;
  - iv. Completed in an environment customized for the patient's behavior.
- g. The list of responsibilities of the Second Provider and Second Provider Clinical Responsibility, see ¶ 5, do not require specific training in ABA, thus it does not

meet the criteria of 0373T. In all, the responsibilities of the second technician do not meet medical necessity and can be implemented by a person with less training for less cost, and does not meet the criteria in the service code.

- h. As 832 units of code 97155 were approved, Petitioner will actually have 3:1 services for approximately 20% of █ therapy – which is far outside the standards of care in the field.
- i. Dr. Bicard did not review the prior request for ABA services.

9. █ is Petitioner's █ testified to the following:

- a. █ Petitioner. Petitioner has been in █ since █. Petitioner was in █.
- b. Petitioner has never received ABA services 2:1 until █ was with █ current provider.
- c. █ is concerned that Petitioner may require █ if the 2:1 services are not continued.

10. Ms. Brown is Petitioner's ABA. Ms. Brown testified to the following:

- a. Ms. Brown has an undergraduate degree in Special Education and a master's degree in ABA, with a specialty in █ Ms. Brown has been a certified BCBA since 2014.
- b. Ms. Brown is one of the co-owners of █
- c. For graphs that show one (1) and two (2) provider occur when there two (2) providers collecting data simultaneously, which is why those graphs are so similar. As such, the graphs do not show the difference between behaviors when

Petitioner has only one (1) provider present versus when two (2) providers are present.

- d. Ms. Brown believes that Petitioner’s diagnosis of [REDACTED] affects the amount of time it takes for Petitioner to benefit from therapy. Ms. Brown believes that the [REDACTED] Petitioner has experienced in [REDACTED] along with the diagnosis of [REDACTED] has impacted the intensity of Petitioner’s behaviors.
- e. Ms. Brown explained that Petitioner needs repetition. Petitioner will persevere on the [REDACTED] [REDACTED] in [REDACTED] past.
- f. Ms. Brown believes that it is medically necessary for Petitioner because when [REDACTED] occur and those [REDACTED] occur, it is essential to intervene. It is important to deescalate before [REDACTED] behaviors escalate. Ms. Brown believes that a second individual would need to have specialized trained – at a minimum be a Registered Behavior Technician (“RBT”). This will ensure that the procedures are being run with fidelity.
- g. Ms. Brown explained that the environment has been tailored to Petitioner, specifically that [REDACTED], [REDACTED], and [REDACTED] as Petitioner [REDACTED] and had [REDACTED]. The play area has [REDACTED].
- h. The amount of time between Petitioner’s precursors and [REDACTED] maladaptive behaviors occurring has increased. Because of this, two (2) providers are able to deescalate Petitioner’s behavior.

- i. Ms. Brown believes that the procedures cannot be fully implemented without two (2) people, which puts a single provider and others at risk. The relative intensity and severity of maladaptive behaviors may be impacted by having only one (1) provider. The reinforcement is able to be provided quicker for appropriate behaviors when two (2) providers are present.
- j. Ms. Brown's goal is to ultimately fade the 2:1 services, but she does not believe that Petitioner is ready for that transition.

### **CONCLUSIONS OF LAW**

11. 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).

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

13. Because Respondent terminated a previously approved service, Fla. Admin. Code R. 59G-1.100(17)(g) assigns the burden of proof to the Respondent, regarding to the termination of 3,120 units of code 0373T. 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.)

14. Because Petitioner is requesting an increase in previously approved service, Fla. Admin. Code R. 59G-1.100(17)(g) assigns the burden of proof to the Petitioner, regarding the request for an additional 1,040 units of code 0373T. The standard of proof in an administrative hearing is a

preponderance of the evidence. The preponderance of the evidence standard requires proof by “the greater weight of the evidence” (Black’s Law Dictionary at 1201, 7th Ed.)

15. The Florida Medicaid Behavior Analysis Services Coverage Policy (October 2017) (“BA Policy”), incorporated by reference in Fla. Admin. Code. R. 59G-4.125, governs BA services available under Florida Medicaid. The BA Policy provides as follows:

**1.0 Introduction**

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

...

**1.4.5 Medically Necessary/Medical Necessity**

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

...

**4.0 Coverage Information**

**4.1 General Criteria**

Florida Medicaid covers services that meet all of the following:

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

**4.2 Specific Criteria**

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

**4.2.1 Behavior Assessment**

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

**4.2.2 Behavior Analysis**

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

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

...

#### **4.3 Early and Periodic Screening, Diagnosis, and Treatment**

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

...

Pages 1 – 3 of BA Policy.

16. Appendix 9.0 of the BA Policy provides Review Criteria for Behavior Analysis Services.

These Review Criteria state as follows:

#### **Review Criteria for Behavior Analysis Services**

Behavior analysis (BA) services are considered as either the treatment of choice or as an adjunct treatment modality for a variety of conditions and disorders where maladaptive behaviors are part of the recipient's clinical presentation, including behavioral manifestations of diagnoses such as Autism Spectrum Disorder and other behavioral health conditions.

#### **Critical Elements Necessary for ANY Type of Behavior Analysis Service:**

The following critical elements **MUST** be satisfied to qualify for BA services:

- a. Eligibility – The recipient must meet all criteria for BA services as outlined in the Behavior Analysis Services Coverage Policy, Rule 59G-4.125, F.A.C.
- b. Medical necessity – The recipient must meet medical necessity criteria as outlined in Rule 59G-1.010, F.A.C.
- c. The recipient currently engages in maladaptive behaviors
- d. These maladaptive behaviors interfere with the recipient's daily functioning

**1. Criteria for Initial Behavior Analysis Assessment - BOTH** of the following **MUST** be satisfied:

- a. **ALL** critical elements are met
- b. Provide submits a valid written physician's order as stipulated in the Behavior Analysis Services Coverage Policy, Rule 59G-4.125, F.A.C.

**2. Criteria for Behavior Analysis Services and Reassessments – ALL** of the following **MUST** be satisfied:

- a. **ALL** critical elements are met
- b. An assessment or, if applicable, a reassessment, authored by a lead analyst, is provided. An assessment of the maladaptive behavior(s) is a necessary element of the process of identifying the frequency and magnitude of the behaviors as well as the variables associated with the occurrence of the maladaptive behavior(s). This helps in defining what are the functional consequences of the problem behavior(s) so that an adequate behavior plan can be implemented. This (re)assessment **MUST** include, at a minimum, **ALL** of the following:
  - i. A clear operational description of the maladaptive behavior(s)
  - ...
- c. A behavior plan authored or updated by a lead analyst. The behavior plan is the cornerstone of the delivery of behavior analysis services and it is based on the information obtained in the assessment. It proposes specific interventions to reduce or eliminate the maladaptive behavior. These interventions take into consideration the variables, both present before the behavior, as well as after the behavior, that influence the occurrence of the maladaptive behavior(s). This plan also includes replacement appropriate behaviors for the recipient to engage in instead of the maladaptive behaviors in order to obtain the same function. The plan must be detailed enough to warrant the requested services and include mechanisms to monitor its effectiveness. This **MUST** include, at a minimum, **ALL** of the following:
  - i. Observable and measurable descriptions of the maladaptive behavior(s)
  - ii. Identified function of the maladaptive behavior(s) behavior as a result of the assessment or reassessment conducted
  - iii. Goals and strategies for changing the maladaptive behavior(s)
  - iv. Written detailed description of when, where, and how often these goals will be addressed and proposed strategies will be implemented
  - v. System for monitoring and evaluating the effectiveness of the plan
  - vi. Safety and crisis plan, if applicable
  - vii. Summary and recommendations
  - viii. Discharge criteria
  - ix. Transition plan (if applicable)

NOTE: Although the assessment and behavior plan were addressed separately in section 2, both of them can be submitted as a single document.

**3. Criteria for Continuation of Treatment at the Present Level and/or Using**

**Current Methods:** Providers must ensure that ALL of the following criteria are met to request continuation of treatments at the present level or using the current methods. If criteria for 3a is met, but criteria for 3b and/or 3c are not met, then a reduction of the treatment level and/or change of treatment methods may be warranted.

- a. ALL criteria listed in 2a, 2b, and 2c regarding critical elements, assessment or reassessment, and behavior plan, are met.
- b. The data provided must show evidence that the frequency of the maladaptive behavior(s) has decreased since the last review and, if not, that there is a modification of the behavior plan.
- c. The level of functional impairment justifies continuation of BA services. The reviewer utilizes the information provided below as a guide as it relates to the level of functional impairment as expressed through the following behaviors:
  - i. Safety – aggression, self-injury, property destruction, elopement
  - ii. Communication – problems with expressive/receptive language, poor understanding or use of non-verbal communications, stereotyped, repetitive language
  - iii. Self-stimulating, abnormal, inflexible, or intense preoccupations
  - iv. Self-care – difficulty recognizing risks or danger, grooming, eating, or toileting
  - v. Other – behaviors not identified above

...

Pages 6 – 8 of BA Policy.

17. States must provide Early and Periodic Screening, Diagnostic, and Treatment (“EPSDT”) services to Medicaid-eligible children under age 21 when requested under the Medicaid state plan. See 42 U.S.C. § 1396a(a)(43); 42 U.S.C. § 1396d(a)(4). According to 42 U.S.C. § 1396d(r)(5),

EPSDT services mean, in relevant part, the following items and services:

Such other necessary health care, diagnostic services, treatment, and other measures described in subsection (a) of this section to correct or ameliorate defects and physical and mental illness and conditions discovered by the screen services, whether or not such services are covered under the state plan.

18. Petitioner is under age 21, and therefore EPSDT applies to the request for services.

However, a state may place medical necessity limitations on EPSDT services. See 42 C.F.R. §§

440.230(a), (b), (d). Fla. Stat. § 409.905(2) limits EPSDT services with a medical necessity standard:

The [Agency] shall pay for early and periodic screening and diagnosis of a recipient under age 21 to ascertain physical and mental problems and conditions and all services determined by the agency to be medically necessary for the treatment, correction, or amelioration of these problems and conditions, including personal care, private duty nursing, durable medical equipment, physical therapy, occupational therapy, speech therapy, respiratory therapy, and immunizations.

19. 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.

20. 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.

...

Page 3 of Authorization Policy.

21. In the instant case, Petitioner requested continuation of ABA services, along with an increase of 1,040 units of codes 97153 and 0373T. See ¶ 3. Respondent initially terminated the entirety of Petitioner's ABA services, but subsequently reinstated the majority of them, as well as approving the addition of 1,040 units of code 97153. See ¶ 7. At issue is both the termination of 3,120 units and the denial of an additional 1,040 units of code 0373T.

22. 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 "[c]onsistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational" and "[i]ndividualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs." These two components were identified as not being met in the NOO. See ¶ 3.

23. At the Fair Hearing, Dr. Bicard explained the criteria there are four (4) criteria that reviewers use to determine the necessity of 2:1 ABA services. See ¶ 8(f). Here, the record shows that Petitioner has largely satisfied this criteria, in that Petitioner's services are administered by a qualified provider; Petitioner's exhibits destructive behavior; and that Petitioner's treatment is administered in a customized environment, see ¶ 10(g). Dr. Bicard further opined that the

services being administered did not necessitate a trained ABA professional, however, Ms. Brown provided credible testimony that a second individual would have to be an RBT at a minimum. See ¶ 10(f). Moreover, Ms. Brown provided credible testimony, that, based on the unique needs of the Petitioner, a second provider is medically necessary for Petitioner. See ¶ 10(d). For example, the diagnosis of [REDACTED] and Petitioner's [REDACTED] poses challenges that may not be found in other patients. As such, Respondent did not demonstrate that 2:1 therapy is in excess of Petitioner's needs nor that it was not "consistent with generally accepted professional medical standards."

24. Lastly, as Petitioner bears the burden of proof regarding the request for additional services, Petitioner must show that the request for an additional 1,040 units was medically necessary. At the Fair Hearing, Ms. Brown provided credible testimony that the services cannot be fully implemented without (2) people and that the intensity and severity of maladaptive behaviors may be impacted by having only one (1) provider. See ¶ 10(i). Moreover, Respondent approved the addition of 1,040 units of code 97153, based on the reasoning *supra* ¶ 23, it follows that an additional provider would be necessary to provide therapy concurrently.

25. Upon consideration of the testimony provided, evidence submitted, and applicable polices, the undersigned concludes that Respondent did not prove by a preponderance of the evidence that the reduction of ABA services was necessary. Looking at all the evidence relevant to the particular needs of Petitioner, Respondent has not demonstrated that the previously authorized services, are not necessary to correct or ameliorate a defect or a physical and mental illness or condition. Accordingly, Respondent did not prove by a preponderance of the evidence that Respondent's reduction of ABA services was correct. Furthermore, Petitioner demonstrated


by a preponderance of the evidence that the additional units of service were necessary for Petitioner.

**IT IS HEREBY ORDERED AND ADJUDGED THAT:**

Respondent's termination of 3,120 units of code 0373T is **REVERSED**. Petitioner's appeal based on Respondent's termination is **GRANTED**.

Respondent's denial of 1,040 units of code 0373T is **REVERSED**. Petitioner's appeal based on Respondent's denial is **GRANTED**.

**DONE and ORDERED** this 18<sup>th</sup> day of August, 2023, in Tallahassee, Leon County, Florida.

 Joseph Mabry  
23-FH1024  
2023.08.18 07:49:54 -04'00'

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**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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