

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



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OFFICE OF FAIR HEARINGS

[REDACTED]

PETITIONER,

AHCA Case No.: 23-FH1207

vs.

AGENCY FOR HEALTH CARE
ADMINISTRATION,

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned Hearing Officer convened a telephonic Fair Hearing on the instant case on July 25, 2023, at 1:00 p.m. EST.

APPEARANCES

For the Petitioner:

[REDACTED]

Petitioner's Authorized Representative

For the Respondent:

Suzanne Chillari
Medical Health Care Program Analyst
Agency for Health Care Administration

STATEMENT OF ISSUE

The issue is whether Respondent proved by a preponderance of the evidence that Respondent's decision to terminate Petitioner's behavior analysis ("BA") services was correct.

PRELIMINARY STATEMENT

All parties and witnesses appeared telephonically. Petitioner's Authorized Representative and [REDACTED], [REDACTED] ("[REDACTED]"), appeared on behalf of the Petitioner. Jovanka Garcia ("Ms. Garcia"), owner of [REDACTED], appeared as a witness for Petitioner. Alethea Swearine ("Ms. Swearine"), Board Certified Behavior Analyst ("BCBA") with [REDACTED], appeared as a witness for Petitioner. [REDACTED] ("[REDACTED]") appeared as a witness for Petitioner.

Suzanne Chillari, 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"), BCBA at the Doctoral Level ("BCBA-D") and Director of Clinical Operations for eQHealth Solutions, Inc. ("eQHealth"), attended as a witness for Respondent.

Spanish interpreters Diego, ID No. 379861, and Leo, ID No. 250478, with Global Interpreting Network, provided translation services for Petitioner.

Petitioner did not introduce any exhibits at the Fair Hearing.

Prior to the hearing, Respondent sent to the Office of Fair Hearings and Petitioner a two hundred and fifty-one (251)-page evidence packet. The packet appears in the Office of Fair Hearings' case management system as "[REDACTED] FH 07.25.2023 1-198.pdf" and "[REDACTED] FH 07.25.2023 199-251.pdf." Absent an objection from the Petitioner, the undersigned admitted the evidence packet into evidence as Respondent's Composite Exhibit 1.

Prior to the hearing, Respondent sent to the Office of Fair Hearings and Petitioner a forty-nine (49)-page evidence packet. The packet appears in the Office of Fair Hearings' case management system as "Agency Evidence Legal Authorities 23-FH1207.pdf." Absent an objection from the Petitioner, the undersigned admitted the evidence packet into evidence as Respondent's Composite Exhibit 2.

FINDINGS OF FACT

1. Petitioner receives Medicaid services on a fee-for-service basis from the Agency. eQHealth is a Quality Improvement Organization contracted by the Agency to review prior authorization requests for services. *See* Respondent’s Composite Exhibit 2 at page 2.
2. As of the date of the hearing, Petitioner is [REDACTED]. *See* Respondent’s Composite Exhibit 1 at page 21. Petitioner is diagnosed with [REDACTED]. *Id.* at 203. Dr. Bicard established that Petitioner has participated in BA services with the current provider, [REDACTED], for approximately [REDACTED]. The Reassessment, signed May 12, 2023, (“Treatment Plan”) identified the following maladaptive behaviors for treatment: [REDACTED], [REDACTED], [REDACTED], and [REDACTED] (“[REDACTED]”). *Id.* at 204.
3. Petitioner requested the continuation of the following BA services: 3,640 units of code 97153, 312 units of code 97155, and 48 units of code 97156 for the certification period of April 24, 2023, through October 20, 2023. *Id.* at 33.
4. As Dr. Bicard testified, the Treatment Plan data graphs for maladaptive behaviors show the following: [REDACTED] increased from [REDACTED] over the last authorization period; the data points for [REDACTED] are variable, there is no progress shown, and the incidents are occurring at a relatively low level; [REDACTED] [REDACTED] increased from [REDACTED] during the last authorization period, and no interventions were made to address the lack of progress; and Petitioner does not appear to engage in [REDACTED] based on the data graph. *Id.* at 209 – 214.
5. As Dr. Bicard testified, the Treatment Plan data graphs for skill acquisition goals show the following:

- a. [REDACTED]: Petitioner has been working on the skill of being able to point to each of these numbers for approximately [REDACTED]. The data graphs are variable and show that Petitioner is not making any progress, and no interventions were made to address the lack of progress. This skill is considered to be relatively easy to teach in a matter of days or weeks.
- b. [REDACTED]: Petitioner has been working on this skill for approximately [REDACTED]. A majority of the data points are [REDACTED], and no interventions were made to address the lack of progress. In the field of ABA, multiple interventions are readily available to teach this skill.
- c. [REDACTED]: the data for this goal are no longer meaningful because the skill has been learned according to the graph.
- d. [REDACTED]: Petitioner has been working on the skill since [REDACTED]. A majority of the data points are [REDACTED], and no interventions were made to address the lack of progress. This skill should have been mastered by this time.
- e. [REDACTED]: the percentage of opportunities decreased from [REDACTED] in the last authorization period. There was no improvement, and no interventions were made to address the lack of improvement.
- f. [REDACTED]: the percentage of opportunities decreased over the last authorization period and no interventions were made to address the lack of progress.
- g. [REDACTED]: Petitioner has been working on the skill for approximately [REDACTED], no progress has been made, and no interventions were made to address the lack of progress.

h. [REDACTED]: The data for [REDACTED] clearly show no making progress is being made. The percentage of opportunities for “more” decreased from [REDACTED]. The percentage of opportunities for “[REDACTED]” and “[REDACTED]” started and ended [REDACTED]. The percentage of opportunities for “[REDACTED]” increased from [REDACTED]. No interventions were made to address the lack of progress.

i. [REDACTED]: In Florida, these skills can be taught by non-ABA provider and are not related to the confirmed diagnosis of [REDACTED].

j. [REDACTED]: The percentage of opportunities decreased from [REDACTED], and no interventions were made to address the lack of progress.

k. [REDACTED]: The data is variable showing no meaningful progress over the last authorization period. Petitioner has been working on this skill for approximately [REDACTED] and is still unable to reliably [REDACTED].

l. [REDACTED]: The data for [REDACTED], [REDACTED], and [REDACTED] are variable and show no progress is being made over the last authorization period. No interventions were made to address the lack of progress. In the field of ABA, multiple interventions are readily available to teach these skills.

m. [REDACTED]: After approximately [REDACTED], no progress has been made and no interventions were made to address the lack of progress. The skill of [REDACTED] can be taught in a matter of days even with a low functioning child and Petitioner has been working on the skill unsuccessfully for [REDACTED].

n. [REDACTED]: The majority of data points are [REDACTED] showing that Petitioner has not acquired [REDACTED], and no interventions were made to address the lack of progress.

o. [REDACTED]: After approximately [REDACTED] of treatment, the majority of data points are [REDACTED] showing that Petitioner has not acquired this skill, and no interventions were made to address the lack of progress. Dr. Bicard testified that this is a relatively easy skill that should have been learned within days or a few weeks.

Id. at 217-239.

5. On April 24, 2023, Respondent issued a Notice of Outcome (“NOO”), terminating Petitioner’s BA services. *Id.* at 33-35. The NOO explained the basis for the termination as follows:

[T]he requested services are not medically necessary under the following standard(s):

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

...

The NOO further provided:

Submitted information does not support the medical necessity for requested frequency and/or duration.

Requested services are denied because documentation is neither showing [i]mprovement nor support for maintenance.

PR Clinical Rationale – Denial: Provider was requested to submit a comprehensive diagnostic evaluation completed by a qualified health professional. The provider did not respond to the request.

Additionally, the provider was requested to submit modifications for lack of progress within the current authorization. **The provider submitted the same treatment plan without modifications and stated there was progress.** The individual has been in services with this provider since [REDACTED] with variable data this authorization indicating no progress and minimal progress in skill

acquisition goals according to the graphs included. 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 you will address human error. **The provider has not addressed the lack of progress during the last observation period and did not amend the treatment plan in relation to the lack of progress. The information submitted does not meet standards of care within the field of behavior analysis.** This request is denied. (emphasis added)

Id.

6. Petitioner requested reconsideration of the Respondent’s decision. On May 20, 2023, Respondent issued a Notice of Reconsideration Determination (“NRD”) upholding its decision. *Id.* at 45-46. The NRD states, in pertinent part as follows:

Specifically the services must be:

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

...

At reconsideration all documents were carefully reviewed. According to the Florida Medicaid State Plan (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 or reinforcement schedules, switch to a different decelerative procedure), or if lack or 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.

Id.

7. Dr. Bicard established that eQHealth reviews behavior analysis cases to ensure that providers are giving quality care consistent with the standards enumerated in the BA Policy as well as professional medical standards of applied behavior analysis (“ABA”). eQHealth reviewed the Treatment Plan submitted in this case to determine whether all five (5) conditions of medical necessity are met. Dr. Bicard asserted that Petitioner’s services were terminated because the treatment plan does not meet the following medical necessity criteria: the Treatment Plan is not “[i]ndividualized, specific, and consistent with symptoms or confirmed diagnosis of the illness under treatment, and [is] in excess of patient’s needs,” and it is not “consistent with generally accepted professional medical standards as determined by the Medicaid program.”

8. Dr. Bicard established that, according to standard of care in the field of ABA, an effective treatment plan is built around maladaptive behaviors (which decrease in frequency) and skills to be acquired (which increase in frequency) over the course of treatment. The effectiveness of a treatment plan is determined by reference to data, which is visually depicted in graphs showing a recipient’s progress through treatment. Further, standards of care in ABA call for an intervention or modification of the treatment plan to be made if there is no progress on a treatment goal.

9. Referring to the data graphs in the Treatment Plan, Dr. Bicard provided credible and persuasive testimony that the Petitioner has made no progress toward identified goals in the

past approximately twelve months and, based on the data, would not benefit from continuing treatment under the plan at issue.

10. Ms. Swearine testified that Petitioner’s Vineland assessment, Social Responsiveness Scale (“SRS-2”) assessment, and Gilliam Autism Rating Scale – Third Edition (“GARS-3”) summary report, reflect that [REDACTED] requires substantial support in almost all subskills. *Id.* at 71-128, 195-202. She testified that Petitioner has made slow improvement with maladaptive behaviors of [REDACTED], [REDACTED], and [REDACTED]. She asserted that [REDACTED] has improved with [REDACTED], [REDACTED], [REDACTED], [REDACTED], and [REDACTED]. However, she argued that Petitioner’s rate of improvement is slow due to having had [REDACTED], [REDACTED], and [REDACTED]. [REDACTED], [REDACTED] and [REDACTED] testified that Petitioner will be starting school in August and would benefit from continuing in ABA therapy.

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. 59-1.100(17)(g) assigns the burden of proof to the Respondent. The standard of proof in an administrative hearing is a preponderance of the evidence. The preponderance of the evidence standard requires proof by “the greater weight of the evidence” (Black’s Law Dictionary at 1201, 7th Ed.).

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).

15. 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.

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

17. 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.

18. The Florida Medicaid Definitions Policy, incorporated by reference in Fla. Admin. Code R. 59G-1.010, defines “Medically Necessary” or “Medical Necessity” as follows:

The medical or allied care, goods, or services furnished or ordered must meet the following conditions:

- Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate pain
- Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient’s needs

- Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational
- Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available statewide
- Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient’s caretaker, or the provider

The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services does not, in itself, make such care, goods or services medically necessary or a medical necessity or a covered service.

Respondent’s Composite Exhibit 2 at page 23.

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

1.0 Introduction

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

...

4.0 Coverage Information

4.1 General Criteria

Florida Medicaid covers services that meet all of the following:

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

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

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

These Review Criteria state as follows:

Review Criteria for Behavior Analysis Services

Behavior analysis (BA) services are considered as either the treatment of choice or as an adjunct treatment modality for a variety of conditions and disorders where maladaptive behaviors are part of the recipient’s clinical presentation,

including behavioral manifestations of diagnoses such as Autism Spectrum Disorder and other behavioral health conditions.

Critical Elements Necessary for ANY Type of Behavior Analysis Service:

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

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

...

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

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

- iv. Written detailed description of when, where, and how often these goals will be addressed and proposed strategies will be implemented
- v. System for monitoring and evaluating the effectiveness of the plan
- vi. Safety and crisis plan, if applicable
- vii. Summary and recommendations
- viii. Discharge criteria
- ix. Transition plan (if applicable)

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

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

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

...

5. Criteria for Discharge from Behavior Analysis Services – ONE or MORE of the following MUST be satisfied:

- a. The critical elements are no longer met.
- b. The data provided show that the frequency and severity of the maladaptive behavior has declined to the point that they no longer pose a barrier to the child's ability to function in his/her environment.

- c. The data provided shows the recipient has made no progress toward any goals in the last 12 months.
- d. The level of functional impairment as expressed through behaviors no longer justifies continued BA services.
- e. Parent/guardian withdraws consent for treatment.

...

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

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, in pertinent part:

3.0 Determination Process

3.1 Review Criteria

The QIO may use a national standardized set of criteria, or other set of criteria, approved by AHCA, as a guide for authorizations performed at the first review level. If services cannot be approved at the first level review, the QIO's physician peer reviewer will determine medical necessity using his or her clinical judgment, acceptable standards of care, state and federal laws, and AHCA's medical necessity definition.

3.2 Review Process

The QIO will review each authorization request and will approve, deny, or request additional information. The QIO may deny a portion of the requested units of service if it cannot substantiate medical necessity based upon the information submitted.

3.2.1 Continued Authorization Requests

The QIO shall not deny or reduce the amount, frequency, or duration of a service that is already being provided, unless:

- The reduction is to correct for factual errors or omissions in prior certifications.
- There is a documented improvement in the recipient's medical condition.
- There is a documented change in the recipient's circumstances.
- The reviewing physician determines the recipient will not gain any additional benefit by continuing services at the current level.

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

22. In this case, Respondent terminated Petitioner’s BA services. The NOO and NRD explained that Petitioner’s request for continuation of services did not meet medical necessity as the treatment plan was not “[i]ndividualized, specific, and consistent with symptoms or confirmed diagnosis of the illness under treatment, and not in excess of patient’s needs” and was not “[c]onsistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational.” See supra ¶ 5-6.

23. As provided in the BA policy (Appendix 9.0, section (a)), and the EPSDT requirements, the recipient must meet the meet all five of the medical necessity criteria as outlined in Fla. Admin. Code R. 59G-1.010. Two of these criteria 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 “consistent with generally accepted professional medical standards.” See supra ¶ 18.

24. As outlined above, Dr. Bicard identified several instances where the revised Treatment Plan was not individualized, specific, and consistent with symptoms or confirmed diagnoses. For example, the data graphs show that, under this Treatment Plan, Petitioner made no progress over the last authorization period for maladaptive behaviors [REDACTED] and [REDACTED], and [REDACTED] [REDACTED] increased. See supra ¶ 4 and 9. Petitioner also made no progress on multiple skill acquisition goals, including “[REDACTED]” despite working on this skill for approximately [REDACTED], “[REDACTED]” despite the availability of multiple interventions to teach these skills, and “[REDACTED]” when this should be taught in a matter of days or weeks. See supra ¶ 5 and 9. Moreover, the treatment Plan appears to be in excess of Petitioner’s need in that [REDACTED] does not appear to engage in [REDACTED] based on the data

graph provided. *See supra* ¶ 4 and 9. Also, [REDACTED] [REDACTED] are all skills can be taught by non-ABA provider and are not related to the confirmed diagnosis of [REDACTED]. *See supra* ¶ 5 and 9.

25. As outlined above, Dr. Bicard identified several instances where the revised Treatment Plan was not consistent with standards of care in ABA. As Dr. Bicard established, standards of care in ABA call for an intervention or modification of the treatment plan to be made if there is no progress on a treatment goal. *See supra* ¶ 8. The record demonstrates that Petitioner did not make progress on maladaptive behaviors and skill acquisition goals under the Treatment Plan at issue. *See supra* ¶ 4 and 5. Despite the lack of progress, the Treatment Plan does not contain any interventions to address the lack of progress. *See supra* ¶ 4 and 5. The provider had an opportunity to provide the necessary information upon request of eQHealth and on reconsideration but failed to do so. *See supra* ¶ 5.

26. For the foregoing reasons, the Treatment Plan at issue is not “[c]onsistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational” and is not “consistent with generally accepted professional medical standards.” *See supra* ¶ 18. Therefore, the critical elements required by the BA Policy for continuation of BA services are no longer met.

27. Petitioner’s provider recommended and testified in support of the continuation of BA services. *See supra* ¶ 10. However, the fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services does not, in itself, make such care, goods or services medically necessary or a medical necessity or a covered service. *See supra* ¶ 18.

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

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

DECISION

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

DONE and ORDERED this 5th day of September 2023, in Tallahassee, Leon County, Florida.

Laura Gallagher

23-FH1207



2023.09.05 08:32:59

~~04:00~~

LAURA GALLAGHER, 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]
[REDACTED]

AHCA Medicaid Hearing Unit
MedicaidHearingUnit@ahca.myflorida.com