



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

FILED

Jan 26, 2024, 8:50 am

OFFICE OF FAIR HEARINGS
AHCA Case No.: 23-FH2469

[REDACTED]

PETITIONER,

vs.

AGENCY FOR HEALTH CARE
ADMINISTRATION,

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic Fair Hearing on the instant case on December 5, 2023, at 1:04 p.m. Eastern Standard Time (“EST”).

APPEARANCES

For the Petitioner:

[REDACTED]

Petitioner’s Authorized Representative

For the Respondent:

Doris Rivera
Medical/Health Care Program Analyst
Agency for Health Care Administration

STATEMENT OF ISSUE

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

PRELIMINARY STATEMENT

All parties and witnesses appeared telephonically. Petitioner’s Authorized Representative and Lead Analyst, [REDACTED] (“[REDACTED]”), appeared on behalf of Petitioner. [REDACTED] (“[REDACTED]”), [REDACTED] of Petitioner, appeared as a witness for Petitioner.

Doris Rivera (“Ms. Rivera”), Medical/Health Care Program Analyst for the Agency for Health Care Administration (“Agency” or “AHCA”), appeared on behalf of Respondent. Dr. Alyssa Conway (“Dr. Conway”), Second Level Reviewer and Board Certified Behavior Analyst for eQHealth Solutions Inc. (“eQHealth”), appeared as a witness for Respondent.

Julian, interpreter number 377285, appeared to offer translation services for the Petitioner.

Petitioner did not introduce any exhibits at the hearing. Prior to the hearing, Respondent sent to the Office of Fair Hearings and Petitioner a two-hundred and twenty-three (223)-page evidence packet and a forty-nine (49)-page evidence packet. The two-hundred and twenty-three (223)-page evidence packet appears in the Office of Fair Hearings’ document management system as the file title “[REDACTED] FH 12.5.2023.pdf”. The forty-nine (49)-page evidence packet appears in the Office of Fair Hearings’ document management system as the file title “23-FH2469- AHCA Evidence 49 pgs.pdf”. Absent an objection from the Petitioner, the undersigned admitted the two-hundred and twenty-three (223)-page evidence packet into evidence as Respondent’s Composite Exhibit 1 (“RCE 1”) and the forty-nine (49)-page evidence packet into evidence as Respondent’s Composite Exhibit 2 (“RCE 2”).

FINDINGS OF FACT

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

2. Petitioner is [REDACTED]. See page 21 of RCE 1. Petitioner is diagnosed with [REDACTED]. *Id.*

3. As provided in Petitioner’s Functional Behavior Reassessment (“treatment plan” or “behavior plan”), Petitioner is engaging in the following maladaptive behaviors: [REDACTED]; [REDACTED]; [REDACTED]; [REDACTED]; [REDACTED]; [REDACTED]; [REDACTED]; [REDACTED]; and [REDACTED].

4. Petitioner requested continuation of BA services; specifically, 3,120 units of code 97153; 520 units of code 97155; and 104 units of code 97156. In a Notice of Outcome (“NOO”), dated September 5, 2023, Respondent terminated Petitioner’s ABA services. *Id.* at 27. The NOO explained the basis for the termination as follows:

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

Consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational. Individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness under treatment, and not in excess of the patient’s needs.

The NOO further provided:

PR Clinical Rationale – Denial: There are behaviors listed for decrease and goals for increase that do not meet medical necessity criteria. All goals must significantly interfere with normal functioning by threatening access to typical environments and negatively affects activities of daily living. As written, the goals recognizing others’ snames do not meet medical necessity. Additionally, 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. Further, The information submitted does not meet standards of care within the field of behavior analysis. The provider has included treatment data and graphs for skill acquisition goals and maladaptive behaviors that were based on parent report (pg 18), extrapolated average and/or sourced from indirect interview; and were not directly observed or measured as standards of care within the field of behavior analysis. This request is denied.

...

Pages 27 – 28 of RCE 1.

5. Petitioner requested reconsideration of the Respondent’s decision. In a Notice of Reconsideration Determination (“NRD”), dated October 2, 2023, Respondent upheld its decision.

Id. at 39 – 40. The NRD explained the basis for the decision as follows:

PR Recon Determination: 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 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.

...

Pages 39 – 40 of RCE 1.

6. On September 29, 2023, Petitioner requested a Fair Hearing to challenge the termination of ABA services. *Id.* at 8. On October 25, 2023, the undersigned issued an Order Scheduling Fair Hearing by Telephone and Prehearing Instructions, setting the hearing for December 5, 2023, at 1:00 p.m. EST. *Id.*

7. Dr. Conway is a Board Certified Behavior Analyst at the doctoral level. Dr. Conway testified to the following at the Fair Hearing:

- a. This treatment plan was reviewed by three (3) qualified Board Certified Behavior Analysts at the master's and doctoral levels to determine compliance with medical necessity criteria. Petitioner has participated in ABA therapy with this provider since [REDACTED]. There has not been sufficient progress regarding maladaptive or replacement behaviors, nor sufficient modification to the plan to address the lack of progress, which does not meet medical necessity. The provider was approved for protocol modification, and modifications should have occurred weekly. Petitioner may qualify for services with a different provider. Although the current provider is a preferred provider, services must be furnished in a manner not intended for the convenience of the caretaker.
- b. In the most recent treatment plan submitted, the provider submitted new baseline data. See page 190 of RCE 1. These data are not true baseline, as there is data on each maladaptive behavior through [REDACTED], and these behaviors are in

Petitioner's repertoire. Overall, each graph depicts high variability and minimal to no changes over [REDACTED] year of services.

- c. Petitioner's [REDACTED] behavior exhibits high variability. *Id.* at 192. The levels at the end of the authorization are higher than some levels within the authorization, and maintain at about the same level as [REDACTED], demonstrating a lack of significant progress. *Id.* The [REDACTED] and [REDACTED] behavior exhibit very similar trends and variability, which is very uncommon across such different behaviors. *Id.* at 193. Both behaviors show high levels and high variability, and do not depict progress throughout the authorization. *Id.* [REDACTED] ranges from [REDACTED] occurrences, and [REDACTED] ranges from [REDACTED] occurrences. *Id.*
- d. The behaviors of [REDACTED] and [REDACTED] exhibit very similar data paths, as well as an increasing trend from [REDACTED] through [REDACTED]. *Id.* at 194. The behaviors show high variability and increases rather than the decreases expected after [REDACTED] year of service. *Id.* The behaviors of [REDACTED] and [REDACTED] also exhibit very similar data paths. *Id.* at 195. [REDACTED] exhibits a slight decreasing trend, but still occurs between [REDACTED] times per week with highly variable data. *Id.* [REDACTED] shows highly variable data and an increasing trend, and the behavior occurs between [REDACTED] times per week. *Id.* This level is the same or higher than the level in [REDACTED]. *Id.*

- e. The behavior of [REDACTED] depicts high variability, no progress, and high levels of occurrence per week. *Id.* at 196. The behavior occurs at the same level at the beginning and end of the authorization. *Id.* [REDACTED] is highly variable and still occurs at very high levels, ranging from [REDACTED] [REDACTED] per week. *Id.* [REDACTED] also shows high variability. *Id.* at 197. The behavior shows a slight decrease, but still occurs between [REDACTED] [REDACTED] times per week. *Id.* Overall, the maladaptive behaviors show high variability and many different graphs with very similar, overlapping data paths, although the behaviors are very different.
- f. The skills acquisition graphs show very similar data paths across each program, although the behaviors differ in their targets. This is uncommon. The behavior of [REDACTED] occurred at [REDACTED] at baseline, and Petitioner is still performing this skill at about [REDACTED] with prompting. *Id.* at 209. Petitioner can [REDACTED] properly only [REDACTED] [REDACTED] of the time. *Id.* at 210. It is expected that the provider would implement modifications to increase performance.
- g. [REDACTED] occurs only [REDACTED] of the time, with prompt, after [REDACTED] of services. *Id.* at 211. The graph intended to depict [REDACTED] depicts a different behavior, [REDACTED], meaning the data and the goal do not match. *Id.* at 212. The behavior shows no progress. *Id.* [REDACTED] shows no progress since baseline. *Id.* at 213. The behavior of [REDACTED] shows a decrease and level trends, with performance

around [REDACTED] *Id.* at 214. The new replacement behavior identified to target [REDACTED] will not target the function of the behavior. *Id.* at 215. There is no progress data included for caregiver training. *Id.* at 219. There is no data included for the registered behavior technicians.

8. [REDACTED] is Petitioner's Lead Analyst. [REDACTED] testified to the following at the Fair Hearing:

- a. Petitioner has severe [REDACTED] and intense, frequent, and dangerous behaviors. [REDACTED] stated Petitioner's [REDACTED] involve several different behaviors at once. [REDACTED] stated the provider could not initially collect all the data, which is why the frequencies do not appear to be improving. [REDACTED] stated the provider had to prioritize preventing Petitioner from harming [REDACTED] over data collection and teaching replacement behaviors, which is why the replacement behaviors are also low. [REDACTED] stated the graphs appear similar because all behaviors were happening at once. [REDACTED] stated Petitioner has improved, and the behaviors and intensity have reduced. [REDACTED] stated the provider can now collect data more accurately.
- b. [REDACTED] stated [REDACTED] made all changes that were requested by AHCA, but the plan was still denied. [REDACTED] stated [REDACTED] removed goals that were not medically necessary and modified the plan, highlighted in yellow. [REDACTED] stated the intervention for [REDACTED] is medically necessary.

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

- a. [REDACTED] stated Petitioner has improved and has participated in less [REDACTED] and [REDACTED]. [REDACTED] stated [REDACTED] is happy with the current agency.

CONCLUSIONS OF LAW

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

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

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

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

1.0 Introduction

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

...

1.4.5 Medically Necessary/Medical Necessity

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

...

4.0 Coverage Information

4.1 General Criteria

Florida Medicaid covers services that meet all of the following:

- Are determined medically necessary
- Do no 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.

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

These Review Criteria state as follows:

Review Criteria for Behavior Analysis Services

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

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

Critical Elements Necessary for ANY Type of Behavior Analysis Service:

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

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

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

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

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

- a. **ALL** critical elements are met
- b. An assessment or, if applicable, a reassessment, authored by a lead analyst, is provided. An assessment of the maladaptive behavior(s) is a necessary element of the process of identifying the frequency and magnitude of the behaviors as well as the variables associated with the occurrence of the maladaptive behavior(s). This helps in defining what are the functional consequences of the problem behavior(s) so 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

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

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

16. Petitioner is under age 21, and therefore EPSDT applies to [REDACTED] 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.

17. 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.

18. 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.

19. In the instant case, Respondent terminated Petitioner’s ABA services. See ¶ 4. In the NOO dated September 5, 2023, Respondent explained that continuing services at the prior level was not medically necessary, specifically, that it did not meet the requirements that services must be “consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational,” as well as “individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness under treatment, and not in excess of the patient’s needs.” *Id.* Respondent further explained that “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.” *Id.*

20. As provided by the EPSDT requirements, the recipient must meet the medical necessity criteria as outlined in Fla. Admin. Code R. 59G-1.010. As provided in section 2.83 of the Definitions Policy, two components of medical necessity are that services must be “consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational,” as well as “individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness under treatment, and not in excess of the patient’s needs.” As shown by the record, Petitioner has not made progress regarding ■■■■■■ maladaptive behaviors and replacement behaviors. See ¶ 7. Dr. Conway provided credible testimony that Petitioner’s maladaptive behavior graphs exhibit high levels of variability and minimal to no progress. *Id.* Furthermore, several of the graphs show uncommon similarities in data patterns across different behaviors. *Id.* Petitioner’s replacement behaviors are also not showing improvement, with none of the behaviors occurring above fifty percent (50%). *Id.* Dr. Conway also identified new skills that are ineffective to address the functions of the targeted behaviors. *Id.* While the provider testified to some of the reasons for the similarities and lack of progress depicted on the graphs *supra* ¶ 8, the graphs still do not show progress. See ¶ 7. The treatment plan also lacked caregiver progress data and RBT data. *Id.* As the plan did not contain adequate progress, adequate intervention, nor all necessary components, the treatment plan was not “consistent with generally accepted professional medical standards.” Furthermore, as the plan lacked intervention and modification to facilitate Petitioner’s success, the treatment plan was not “individualized, specific, and consistent” with Petitioner’s treatment needs. As such, Respondent demonstrated that it was not medically necessary to continue services with the current provider.


21. As QIO for the Agency, eQHealth is authorized to terminate services when “the reviewing physician determines the recipient will not gain any additional benefit by continuing services at the current level.” See ¶ 18. As discussed, *supra* ¶ 20, Petitioner has not made progress in reducing his maladaptive behaviors, nor in improving his replacement behaviors. Here, Petitioner’s lack of improvement is well documented.

22. Upon consideration of the testimony provided, evidence submitted, and applicable polices, the undersigned concludes that Respondent proved by a preponderance of the evidence that the termination of ABA services was necessary. Looking at all the evidence relevant to the particular needs of Petitioner, Respondent has demonstrated that the previously authorized services, based on the treatment plan at issue in this case, are not necessary to correct or ameliorate a defect or a physical and mental illness or condition. Accordingly, Respondent proved by a preponderance of the evidence that Respondent’s termination of ABA services was correct.

IT IS HEREBY ORDERED AND ADJUDGED THAT:

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

DONE and ORDERED this 26th day of January, 2024, in Tallahassee, Leon County, Florida.

 Joseph Mabry
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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]
[REDACTED]

AHCA Medicaid Hearing Unit
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