



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

FILED

Feb 07, 2024, 8:09 am

[REDACTED]

PETITIONER,

OFFICE OF FAIR HEARINGS
AHCA Case No.: 23-FH2625

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 14, 2023, at 9:00a.m. Eastern Standard Time ("EST").

APPEARANCES

For the Petitioner:

[REDACTED]

Petitioner's Authorized Representative

For the Respondent:

Diana Hearod
Medical/Health Care Program Analyst
Agency for Health Care Administration

STATEMENT OF ISSUE

The issue is whether Petitioner proved by a preponderance of the evidence that Respondent's decision to deny Petitioner's request for Behavior Analysis ("BA" or "ABA") services was incorrect.

PRELIMINARY STATEMENT

All parties and witnesses appeared telephonically. Petitioner's Authorized Representative and Board Certified Behavior Analyst ("BCBA"), [REDACTED] (" [REDACTED] ") appeared on behalf

of Petitioner. The following attended as witnesses for Petitioner: [REDACTED] (“[REDACTED]”), Petitioner’s [REDACTED]; [REDACTED], Regional BCBA in Florida for [REDACTED]; [REDACTED], Quality Assurance Specialist for [REDACTED]; [REDACTED], Quality Improvement Coordinator for [REDACTED].

Diana Hearod, Medical/Health Care Program Analyst for the Agency for Health Care Administration (“Agency” or “AHCA”), appeared on behalf of Respondent. Dr. Alissa Conway (“Dr. Conway”), Board Certified Behavior Analyst at the doctoral level (“BCBA-D”) for eQHealth Solutions Inc. (“eQHealth”) appeared as a witness for Respondent.

Prior to the hearing, Petitioner sent to the Office of Fair Hearings and Respondent a two hundred and eight (208)-page evidence packet. The evidence packet appears in the Office of Fair Hearings’ document management system as the file title “23-FH2625 Supporting Documents.pdf”. Absent an objection from the Respondent, the undersigned admitted the two hundred and eight (208)-page evidence packet into evidence as Petitioner’s Composite Exhibit 1 (“PCE 1”).

Prior to the hearing, Respondent sent to the Office of Fair Hearings and Petitioner a one hundred and seventy-nine (179)-page evidence packet and a forty-nine (49)-page evidence packet. The one hundred and seventy-nine (179)-page packet appears in the Office of Fair Hearings’ document management system as the file titles: “[REDACTED] FH 12.14.2023 1-98.pdf”; “[REDACTED] FH 12.14.2023 99-135.pdf”; “[REDACTED] FH 12.14.2023 136-171.pdf”; and “[REDACTED] FH 12.14.2023 172-179.pdf”. The forty-nine (49)-page evidence packet appears in the Office of Fair Hearings’ document management system as the file title “23-FH2625_B A_AHCA Evidence_49 PGS_[Petitioner Name].pdf”. Absent an objection from the Petitioner, the

undersigned admitted the one hundred and seventy-nine (179) 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 16 of RCE 1. Petitioner is diagnosed with [REDACTED].
Id.

3. As provided in Petitioner’s treatment plan, Petitioner is engaging in the following maladaptive behaviors: [REDACTED]; [REDACTED]; [REDACTED]; [REDACTED]; and [REDACTED]. *Id.* at 101 – 106. Petitioner’s treatment plan shows the following progress: for [REDACTED], Petitioner reduced [REDACTED] incidents from approximately [REDACTED]; for [REDACTED], Petitioner reduced [REDACTED] incidents from approximately [REDACTED]; for [REDACTED], Petitioner reduced [REDACTED] incidents from [REDACTED]; for [REDACTED], Petitioner reduced [REDACTED] incidents from approximately [REDACTED]; and for [REDACTED] Petitioner reduced [REDACTED] incidents from approximately [REDACTED]. *Id.* at 102 – 106.

4. As testified to by Dr. Conway, in the prior authorization period, Petitioner requested and was approved for the following ABA services: 1,680 units of 97153; 252 units of 97155; and 42 units of 97156.

5. Petitioner requested the following BA services: 3,640 units of code 97153; 416 units of code 97155; and 26 units of code 97156. In a Notice of Outcome (“NOO”), dated August 29, 2023,

Respondent approved 2,600 units of code 97153; 416 units of code 97155; and 26 units of 97156, but denied the remaining units. The NOO explained the basis of the denial 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 or injury under treatment, and not in excess of the patient's needs.

The NOO further provided:

PR Clinical Rationale – Denial: According to Behavior Analysis Services Coverage Policy requests for services must be based on the medical necessity of the recipient's maladaptive behaviors and skill deficits. The recipient is engaging in problem behaviors that threaten access to typical environments and negatively affects activities of daily living. However, the frequency, intensity, or severity of the recipient's maladaptive behaviors does not justify the requested units of services. The requested units of BA services are in excess of medical necessity.

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Pages 25 – 26 of RCE 1.

6. Petitioner requested reconsideration of the Respondent's decision. See page 49 – 50 of PCE 1.

7. In a Notice of Reconsideration Determination ("NRD"), dated September 19, 2023, Respondent upheld its decision. *Id.* at 36 – 38. The NRD explained the basis for the decision as follows:

PR Recon Determination: At reconsideration all documents were carefully reviewed. The provider did not submit any new documentation that supports the medical necessity of this request. According to The Behavior Analysis Services Coverage Policy, (page 6, 9.0 c-d) the recipient of ABA therapy services must engage in maladaptive behavior that interferes with the recipient's daily functioning. Although the recipient is engaging in topographies of maladaptive behaviors, the frequency and intensity of the maladaptive do not support the request for services. This reconsideration request has been reviewed, reconsidered and the partial denial is upheld.

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Pages 36 – 37 of RCE 1.

8. On October 11, 2023, Petitioner requested a Fair Hearing to challenge the denial of ABA services. On November 15, 2023, the undersigned issued an Order Scheduling Fair Hearing and Prehearing Instructions, setting the hearing for December 14, 2023, at 9:00 a.m. EST.

9. [REDACTED] is Petitioner's BCBA. [REDACTED] testified to the following:

- a. [REDACTED] has 13 years of experience with ABA.
- b. The rationale for the request for increased direct therapy hours comes from slow progress toward skill acquisition goals as well as increased intensity of maladaptive behaviors – despite reduction in frequency since the onset of service.
- c. After the initial assessment of Petitioner, [REDACTED] determined that a focused model of testing was necessary. Petitioner began therapy under [REDACTED], and [REDACTED] determined that an increase in therapy was warranted.
- d. Petitioner underwent the VB-MAPP and PEAK assessments.
- e. The VB-MAPP is used to assess and increase a learner's verbal behavior across several domains. The assessment places the patient under 1 of 3 developmental levels [REDACTED]
[REDACTED]
[REDACTED]. See page 99 of RCE 1.
- f. Petitioner requires support to communicate with peers. [REDACTED] has extreme difficulty [REDACTED].
These milestones are atypical of children [REDACTED] age and impede [REDACTED] ability to transition to a less restrictive environment.

g. Petitioner improved [redacted] VB-MAPP Barriers Assessment score from 79 to 48. See page 100 of RCE 1. Petitioner has improved, but still needs support across domains. [redacted] continues to have challenging behaviors daily, lacks instructional control across therapists, does not generalize skills to other situations or people, is dependent on [redacted]

[redacted]

h. [redacted], [redacted] and [redacted] are behaviors that have emerged since the start of treatment.

i. The PEAK assessment is an age reference assessment. Petitioner scored in the range [redacted]. The Vineland assessment shows that Petitioner scored below [redacted] age level across all domains.

j. [redacted] believes that the approved hours of services will not allow for sufficient time to work on all of Petitioner's treatment goals. Additional hours of services will allow for more repetition of skills. Children with [redacted] typically require more repetition than children without this diagnosis.

10. [redacted] is Petitioner's [redacted]. [redacted] testified to the following:

a. [redacted]
[redacted]
[redacted]

b. [redacted]
[redacted]

c. [redacted] tries to take other children's toys and invades their personal space.

- d. Petitioner's behavior and vocabulary have improved since starting ABA therapy.
- e. [REDACTED] does not believe that Petitioner has the social skills necessary for public school.

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

- a. Petitioner was originally approved for the following services: 1,680 units of 97153; 252 units of 97155; and 42 units of 97156. Thus, Petitioner has been approved for more services than what was previously requested in the prior authorization period. Dr. Conway opined that ABA services are medically necessary for Petitioner, but not at the level that was requested and that services hours authorized are sufficient to meet Petitioner's needs.
- b. The provider indicated that Petitioner's "behavior frequency may have decreased, however, the magnitude has increased". See page 83 of RCE 1. However, although there are ways to measure magnitude, the provider did not include a magnitude measure.
- c. Regarding the maladaptive behavior [REDACTED], Petitioner has lowered [REDACTED] incidents significantly and has maintained those levels. See page 102 of RCE 1. Regarding [REDACTED], Petitioner has significantly decreased [REDACTED] levels, with many days at [REDACTED]. See page 103 of RCE 1.
- d. Although [REDACTED] was not identified in the initial assessment, these behaviors were targeted at the beginning of the authorization period. See page 104 of RCE 1. The levels were variable at the beginning but have leveled off.

- e. Regarding [REDACTED], the graph shows there have been spikes, but the frequency has leveled off. See page 105 of RCE 1.
- f. The maladaptive behavior [REDACTED] had spikes but lowered to baseline levels. See page 106 of RCE 1. This maladaptive behavior is typical of someone Petitioner's age.
- g. Overall, Petitioner is showing low levels of behavior that are under management with the previously approved services. Although Petitioner has displayed new behaviors, additional hours were approved to address those.
- h. For the replacement skill "[REDACTED]", the graph shows variability, but also many days were Petitioner is successful [REDACTED] of the time. See page 107 of RCE 1. For "[REDACTED]", Petitioner is showing progress, and performed between [REDACTED] of the time at the end of the authorization period. *Id.* at 108. For "[REDACTED]", Petitioner is performing at [REDACTED] of the time at the end of the authorization period. *Id.* at 109. For "[REDACTED]" Petitioner was successful between [REDACTED] of the time at the end of the authorization period. *Id.* at 110. For "[REDACTED]", the graph shows variability. *Id.* at 113. For "[REDACTED]", Petitioner was successful [REDACTED] of the time at the end of the authorization period. *Id.* at 114. For "[REDACTED]", the graph shows variability, but there are instances where Petitioner is successful [REDACTED] of the time. *Id.* at 116. For "[REDACTED]", Petitioner is performing at about [REDACTED] many times. *Id.* at 117.

- i. The skill “ [REDACTED] ” can be taught through other disciplines, such as occupational therapy.
 - j. Petitioner was authorized for an increase in service due to the presence of some skill deficits.
 - k. The parent training was reduced to 15 minutes per week, which is outside the standard of care of ABA.
12. The Council of Autism Service Providers provides the following recommendations for dosage:

Treatment dosage, which is often references in the treatment literature as “intensity,” which will vary with each client and should reflect the goals of treatment, specific client needs, and response to treatment. Treatment dosage should be considered in two distinct categories: intensity and duration.

Intensity

Intensity is typically measured in terms of number of hours per week of direct treatment. Intensity often determines whether the treatment falls into the category of either Focused or Comprehensive.

Focused

Focused ABA generally ranges from **10-25 hours per week** of direct treatment (plus direct and indirect supervision and caregiver training). However, certain programs for severe destructive behavior **may require more than 25 hours per week** of direct therapy (for example, day treatment or inpatient program for severe self-injurious behavior).

Comprehensive

Treatment often involves an intensity level of **30-40 hours of 1:1 direct treatment to the client per week**, not including caregiver training, supervision, and other needed services. However, very young children may start with a few hours of therapy per day with the goal of increasing the intensity of therapy as their ability to tolerate and participate permits. Treatment hours are subsequently increased or decreased based on the client’s response to treatment and current needs. Hours may be increased to more efficiently reach treatment goals. Decreases in hours of therapy per week typically occur when a client has met a majority of the treatment goals and is moving toward discharge.

Although the recommended number of hours of therapy may seem high, this is based on research findings regarding the intensity required to produce good outcomes. It should also be noted that time spent away from therapy may result in the individual falling further behind typical developmental trajectories. Such delays will likely result in increased costs and greater dependence on more intensive services across their life span.

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Pages 90 – 91 of PCE 1.

CONCLUSIONS OF LAW

13. 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).

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

15. Because Petitioner is requesting a new service, Fla. Admin. Code R. 59G-1.100(17)(g) assigns the burden of proof to the Petitioner. The standard of proof in an administrative hearing is a preponderance of the evidence. The preponderance of the evidence standard requires proof by “the greater weight of the evidence” (Black’s Law Dictionary at 1201, 7th Ed.)

16. 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.

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Pages 1 – 3 of BA Policy.

17. 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.

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

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

19. Petitioner is under age 21, and therefore 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.

20. 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.

21. In the instant case, Petitioner requested the following BA services: 3,640 units of code 97153; 416 units of code 97155; and 26 units of code 97156. *See* ¶ 5. This is an increase from what was previously requested and approved in the prior authorization period. *See* ¶ 4. In the NOO, dated August 29, 2023, Respondent approved the following: 2,600 units of code 97153; 416 units of code 97155; and 26 units of 97156. *See* ¶ 5. Respondent explained that additional ABA services were not medically necessary, specifically that additional services were not “individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment” and were “in excess of the patient’s needs”. *Id.* Respondent further explained that “the frequency, intensity, or severity of the recipient’s maladaptive behaviors does not justify the requested units of services”. *Id.*

22. As Petitioner bears the burden of proof, Petitioner must show that additional ABA services are medically necessary. A component of medical necessity is that such services must 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.” As shown by the record,

Petitioner is diagnosed with [REDACTED] See ¶¶ 2, 9. Petitioner is engaging in the following maladaptive behaviors: [REDACTED]; [REDACTED]; [REDACTED]; and [REDACTED]. See ¶ 3. Although [REDACTED], [REDACTED], and [REDACTED] emerged after the initial assessment, the record shows that those behaviors were treated during the prior authorization period. *Id.* The record further reflects that Petitioner has reduced [REDACTED] incidents of maladaptive behaviors by a significant amount. *Id.*

23. At the Fair Hearing, [REDACTED] argued that the intensity of Petitioner’s maladaptive behaviors have increased, and that this warranted an increase in services. See ¶ 9. However, as explained by Dr. Conway, no data regarding the magnitude of those behaviors were provided. See ¶ 11. Thus, Petitioner did not show that the intensity had worsened. Here, Dr. Conway provided credible testimony that Petitioner’s behaviors have been lowered significantly, and that [REDACTED] behaviors are under management with the previously approved services. In all, Petitioner did not provide sufficient evidence to show that the currently approved services were inadequate to meet [REDACTED] needs and that the requested services were not “in excess of the patient’s needs”. As such, Petitioner did not show that the requested services were medically necessary.

24. Although [REDACTED] believes that the additional services are warranted, “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 ¶ 20.

25. Upon consideration of the testimony provided, evidence submitted, and applicable policies, the undersigned concludes that Petitioner did not prove by a preponderance of the evidence that the additional units of ABA services are medically necessary. Looking at all the


evidence relevant to the particular needs of Petitioner, Petitioner has not demonstrated that the requested units, are necessary to correct or ameliorate a defect or a physical and mental illness or condition. Accordingly, Petitioner did not prove by a preponderance of the evidence that Respondent's denial of ABA services was incorrect.

IT IS HEREBY ORDERED AND ADJUDGED THAT:

Respondent's reduction of ABA services is **AFFIRMED**. Petitioner's appeal based on Respondent's reduction is **DENIED**.

DONE and **ORDERED** this 7th day of February 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]

AHCA Medicaid Hearing Unit
MedicaidHearingUnit@ahca.myflorida.com