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

FILED

Jan 12, 2024, 3:26 pm

OFFICE OF FAIR HEARINGS

[redacted],

PETITIONER, **AHCA CASE NO.: 23-FH2630**

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 12, 2023, at 1:00 p.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 additional Applied Behavior Analysis services ("BA" or "ABA") services was incorrect.

PRELIMINARY STATEMENT

All parties and witnesses appeared telephonically. Petitioner's Authorized Representative and [redacted], [redacted] ("[redacted]"), appeared on behalf of Petitioner.

Diana Hearod, Medical/Health Care Program Analyst for the Agency for Health Care Administration ("Agency" or "AHCA"), appeared on behalf of Respondent. Dr. Joseph Darling ("Dr. Darling"), BCBA at the Doctoral level for eQHealth Solutions Inc. ("eQHealth") appeared as a witness for Respondent.

Petitioner did not introduce evidence at the hearing. Prior to the hearing, Respondent sent to the Office of Fair Hearings and Petitioner a one hundred and twenty-three (123)-page evidence packet appearing in the Office of Fair Hearings' document management system as file titles "[redacted]-FH 12.12.2023.pdf," and a forty-nine (49)-page evidence packet appearing in the Office of Fair Hearings' document management system as the file title "23-FH2630_BA_AHCA Evidence_49 PGS_[PETITIONER'S NAME].pdf." Absent an objection from the Petitioner, the undersigned admitted the one hundred and twenty-three (123)-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*. Petitioner has participated in BA services with the current provider, [redacted] ("Provider"), since [redacted]. *Id.*

3. As provided in the Behavior Analysis Assessment – Behavior Plan ("treatment plan" or "behavior plan"), Petitioner engages in the following maladaptive behaviors: [redacted], [redacted], [redacted], [redacted], [redacted], [redacted], and [redacted]. *Id*. at 46. The graphs of the maladaptive behaviors are based on the initial assessment sessions with the provider, conducted on August 19, 2023, August 26, 2023, and September 2, 2023. Id. at 55 – 58. For [redacted], the graph shows a baseline of [redacted] occurrences on August 26, 2023, then [redacted] occurrences on September 2, 2023. *Id*. at 55. For [redacted], the graph shows a baseline of [redacted] occurrences on August 26, 2023, then [redacted] occurrence on September 2, 2023. *Id*. at 56. For [redacted], the graph shows a baseline of [redacted] occurrences on August 26, 2023, then [redacted] occurrences on September 2, 2023. *Id*. For [redacted], the graph shows a baseline of [redacted] occurrences on August 26, 2023, then [redacted] occurrence on September 2, 2023. *Id*. at 57. For [redacted], the graph shows a baseline of [redacted] occurrences on August 26, 2023, then [redacted] occurrences on September 2, 2023. *Id*. For [redacted], the graph shows a baseline of [redacted] occurrences, remaining at [redacted] occurrences on August 26, 2023, then [redacted] occurrences on September 2, 2023. *Id.* at 58. For [redacted], the graph shows a baseline of [redacted] occurrences, to [redacted] occurrences on August 26, 2023, then [redacted] occurrences on September 2, 2023. *Id*.

4. Regarding replacement behaviors to Petitioner's maladaptive behaviors, and skills acquisitions, the treatment plan includes [redacted], [redacted], [redacted], [redacted], [redacted], [redacted]

[redacted], and [redacted]. *Id*. at 62 – 67. The provider included in the treatment plan the skills acquisition programs: goals, current progress and graphs. *Id*. at 91 – 98. The skills acquisitions plan stated is that Petitioner will begin to achieve the goals without incidents of maladaptive behaviors, for [redacted] for 6 consecutive weeks, including comply with activities of daily living, by [redacted]; [redacted] *Id*.

5. Petitioner requested additional ABA services for the period from September 7, 2023, through March 4, 2024. *Id*. at 23. Specifically, Petitioner requested an additional 1,040 units of code 97153, intervention without protocol modification, per 15 minutes, Lead Analyst, BCaBA, or RBT. *Id*. Petitioner is currently approved for 2,080 of code 97153; 312 HN units and 24 units of code 97155, intervention with protocol modification, per 15 minutes; and 48 units of code 97156, family training, per 15 minutes, Lead Analyst. *Id*.

6. In a Notice of Outcome ("NOO"), dated September 15, 2023, Respondent denied Petitioner's request for additional ABA services. The NOO explained the basis for the termination as follows:

> The request for services is denied in whole or in part because they are not medically necessary as defined in Rule 59G-1.010, Florida Administrative Code.

> Specifically, the requested services are not medically necessary under the following standard(s):
>
> > Individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness under treatment, and not in excess of the patient's needs.
>
> The rational for our decision is as follows:
>
> PR Clinical Reason – Denial:
>
> Submitted information does not support the medical necessity for requested frequency and/or duration.
>
> 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.
> . . .

Pages 23 - 24 of RCE 1.

7. Petitioner requested reconsideration of the Respondent's decision. In a Notice of Reconsideration Determination ("NRD"), dated September 29, 2023, Respondent upheld its decision. *Id*. at 35 - 38. The NRD explained the rationale 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.
> . . .

Id. at 36.

8. On October 12, 2023, Petitioner requested a Fair Hearing to challenge the denial of additional ABA services. On November 17, 2023, the undersigned issued an Order Scheduling Fair Hearing and Prehearing Instructions, setting the hearing for December 12, 2023, at 1:00 p.m. EST. *Id.* at 8 - 12.

9. When reviewing the effectiveness of a treatment plan, what is looked at is whether maladaptive behaviors are being reduced and whether replacement behaviors are being increased. *See,* Appendix 9.0 of the BA Policy providing Review Criteria for Behavior Analysis Services, *infra* ¶ 18.

10. Dr. Darling is a Board-Certified Behavior Analyst at the doctoral level. Dr. Darling 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. The current treatment plan went through a peer review process conducted by three (3) Board Certified Behavior Analysts (BCBAs), including two at the doctoral level. The reviewing BCBAs each returned the treatment plan to the provider, requesting that the current treatment plan be revised to include additional information to show how the plan would effectively treat Petitioner to decrease [redacted] maladaptive behaviors and increase [redacted] replacement behaviors. The Provider revised the treatment plan, but each time the treatment plan was determined insufficient for effective treatment, therefore, the plan did not meet medical necessity criteria. RCE 1 at 35 - 36.

11. Dr. Darling established that, consistent with standards of care in the field of ABA, data graphs are the best way to measure progress in a recipient's ABA treatment, and that progress is

essential. Dr. Darling explained that the Agency relies on data submitted by the lead analyst in the BA plan. Dr. Darling testified that the proposed treatment plan for Petitioner shows a very slow plan to replace Petitioner's maladaptive behaviors with the replacement behaviors. For instance, the goal of [redacted] Dr. Darling explained that this step of the plan would mean that [redacted] of the time, the child is not achieving the replacement behavior, and in that case, the plan would have to modified with more effective treatment. Dr. Darling further testified that the [redacted] goal of [redacted] should also be achieved in three (3) to five (5) days. Dr. Darling explained that each step of the process should be done in three (3) to five (5) days, so that the child who is learning gets a lot of reinforcement and, if modifications are needed, they can be done very quickly. Dr. Darling testified that this plan does not support additional intensive one-on-one therapy. Dr. Darling acknowledged that the provider submitted a letter by the lead analyst to support the additional requested units, including a description of Petitioner and [redacted] needs, but that it does not give any information on how many hours per week are needed for the treatment plan to be effective: the letter does not support any additional therapy than what is already authorized.

12. Dr. Darling asserted that Petitioner's request for additional ABA services was denied because the treatment plan is not consistent with generally accepted professional medical standards, as determined by the Medicaid program. Dr. Darling's testimony established that the submitted treatment plan does not require additional applied behavior analysis services to be provided to Petitioner, because they are not individualized, specific, and consistent with

symptoms or confirmed diagnosis of the illness under treatment, and as such they are in excess of the patient's needs, and therefore, not medically necessary.

13. Petitioner's authorized representative and [redacted], [redacted], testified that Petitioner, [redacted]. [redacted] testified that Petitioner [redacted] concluded that [redacted] knows [redacted] needs more therapy, but [redacted] wants the appropriate therapy to be delivered, and that perhaps this provider is not giving the right therapy for [redacted].

CONCLUSIONS OF LAW

14. 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).

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

16. Because Respondent terminated Petitioner's ABA services, 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.)

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

> **1.0 Introduction**
> Behavior analysis (BA) services are highly structured interventions, strategies, and approaches provided to decrease maladaptive behaviors and increase or reinforce appropriate behaviors.
> . . .
> **1.4.5 Medically Necessary/Medical Necessity**
> As defined in Rule 59G-1.010, F.A.C.
> . . .
> **4.0 Coverage Information**
> **4.1 General Criteria**
> Florida Medicaid covers services that meet all of the following:
> - Are determined medically necessary
> - Do not duplicate another
> - 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 be 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 year 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.

18. 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. Provider 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 than 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 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
    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

19. 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.

20. 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.

21. The Florida Medicaid Definitions Policy, incorporated by reference in Fla. Admin. Code R. 59G-1.010, (the "Definitions Policy"), 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.

Page 23 of RCE 2.

22. 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.

Florida Medicaid Authorization Requirements Policy at pages 1-3.

23. Petitioner is under the age of 21 years and diagnosed with [redacted] *See supra* ¶ 2. The parties agree that Petitioner currently engages in maladaptive behaviors that interfere with [redacted] daily functioning. *See supra* ¶ 3. Respondent determined that Petitioner's "frequency, intensity, or severity of the recipient's maladaptive behaviors does not justify the requested units of services." *See supra* ¶ 6, 7.

24. Respondent denied Petitioner's request for additional ABA services because the submitted documentation did not establish the medical necessity of the services. *See supra* ¶ 6, 7. Based on the record, Respondent determined that the documentation did not meet the following medical necessity standard: [i]ndividualized, specific, and consistent with symptoms or

confirmed diagnosis of the illness under treatment, and not in excess of the patient's needs." *See supra* ¶ 6. The medical necessity standards are expressly outlined in section 2.83 of the Definitions Policy and a critical element for behavior analysis services reassessments. *See supra* ¶ 21. The BA Policy mandates that the treatment plan must be detailed enough to warrant the requested services and include mechanisms to monitor and evaluate its effectiveness. *See supra* ¶ 22.

25. In the instant case, Petitioner requested additional BA services for the period from September 7, 2023, through March 4, 2024. *See supra* ¶ 5. Specifically, Petitioner requested an additional 1,040 units of code 97153. In a NOO, dated September 15, 2023, and an NRD, dated September 29, 2023, Respondent denied the additional 1,040 requested units of ABA services, *supra* ¶ 6, 7, determining that Petitioner's request was not "medically necessary under the following standard: [i]ndividualized, specific, and consistent with symptoms or confirmed diagnosis of the illness under treatment, and not in excess of the patient's needs". *See supra* ¶ 6, 7.

26. As Petitioner bears the burden of proof, the Petitioner must show that the additional BA services at issue meet medical necessity criteria, *i.e.*, the additional of 1,040 units of code 97153. Here, the record shows that Petitioner engages in the following maladaptive behaviors: [redacted], [redacted], [redacted], [redacted], [redacted], [redacted], [redacted], and [redacted]. *See supra* ¶ 3. However, as shown by the record, the frequency and severity of Petitioner's maladaptive behaviors are low. *See supra* ¶ 3. For example, maladaptive behaviors such as [redacted], [redacted], [redacted], [redacted], [redacted], [redacted], and [redacted] occurred at low rates during the initial assessment period. *See*

supra ¶ 3. Moreover, Dr. Darling provided credible and persuasive testimony the treatment plan is not consistent with generally accepted professional medical standards as determined by the Medicaid program because it is ineffective in that it shows a very slow plan that would not deliver significant improvement over the course of treatment of maladaptive behaviors and replacement behaviors over the authorization period. As Dr. Darling established, based on the ineffectiveness of the treatment plan, Petitioner would not benefit from additional, intense one-on-one ABA services with this provider. See *supra* ¶ 10 - 11. In all, Petitioner did not demonstrate that additional ABA services with this provider is "individualized, and specific" as it is not providing effective treatment.

27. Lastly, the record reflects that Petitioner's provider believes that BA services are medically necessary. *See supra* ¶ 5. 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* ¶ 21.

28. Accordingly, Respondent has met their burden of proof to show that the requested ABA services are no longer medically necessary. Looking at all the evidence relevant to the particular needs of Petitioner, the BA services with this provider are not necessary to correct or ameliorate a defect or a physical and mental illness or condition. Upon consideration of the testimony provided, evidence submitted, and applicable policies, the undersigned finds that Respondent proved by a preponderance of the evidence that Respondent's termination of the BA services at issue was correct.

IT IS HEREBY ORDERED AND ADJUDGED THAT:

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 12th day of January, 2024, in Tallahassee, Leon County, Florida.

Debbie K. Winicki
23-FH2630
2024.01.12 12:47:55 -05'00'

DEBBIE WINICKI, 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
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