



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

FILED

Feb 12, 2024, 8:41 am

OFFICE OF FAIR HEARINGS

AHCA Case No.: 23-FH2698

[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 19, 2023, at 1:00 p.m. Eastern Standard Time ("EST").

APPEARANCES

For the Petitioner:

[REDACTED]

Petitioner's Authorized Representative

For the Respondent:

Linda Latson

Registered Nurse Specialist

Agency for Health Care Administration

STATEMENT OF ISSUE

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

The second issue is whether Respondent proved by a preponderance of the evidence that Respondent's decision to reduce Petitioner's previously authorized ABA services was correct.

PRELIMINARY STATEMENT

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

Linda Latson ("Ms. Latson"), Registered Nurse Specialist and Fair Hearing Liaison 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.

Prior to the hearing, Petitioner sent to the Office of Fair Hearings and Respondent a twenty-four (24)-page evidence packet. The twenty-four (24)-page evidence packet appears in the Office of Fair Hearings' document management system as the file titles "23-FH2698 Evidence.pdf", "23-FH2698 Additional Evidence.pdf", and "23-FH2698 Additional Evidence(2).pdf". Absent an objection from the Respondent, the undersigned admitted the twenty-four (24)-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 ninety-four (94)-page evidence packet and a forty-nine (49)-page evidence packet. The ninety-four (94)-page evidence packet appears in the Office of Fair Hearings' document management system as the file title "[REDACTED] FH 12.19.2023.pdf". The forty-nine (49)-page evidence packet appears in the Office of Fair Hearings' document management system as the file title "23-FH2698 AHCA Evidence BA Services 49 Pages.pdf". Absent an objection from the Petitioner, the undersigned admitted the ninety-four (94)-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").

[REDACTED]; [REDACTED]; [REDACTED]; and [REDACTED].
[REDACTED]. *Id.* at 45.

4. As testified by Dr. Conway, in the prior authorization period Petitioner was authorized to receive the following services: 832 units of code 97153; 186 units of code 97155; and 208 units of code 97156. Petitioner requested continuation of BA services; specifically, 832 units of code 97153; 520 units of code 97155; and 208 units of code 97156, which is an increase in code 97155. In a Notice of Outcome (“NOO”), dated September 25, 2023, Respondent terminated Petitioner’s ABA services. *Id.* at 21. The NOO explained the basis for the termination as follows:

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

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

The NOO further provided:

PR Clinical Rationale – Denial: The definitions of behaviors under treatment must be written according to generally accepted practice within the field of ABA and according to AHCA standards of care (the Florida Behavior Analysis Services Coverage Policy, page 6, 9.2.i). The behavioral definitions must be clear, complete, objective and free of unobservable intentional states. The behaviors should have clear boundaries, definite on-sets and off-sets, should not overlap with other target behaviors definitions, and not be a listing of behaviors that the recipient does not engaging in. The behavior definitions in this treatment plan do not conform to generally accepted standards of care within the field of applied behavior analysis. The provider was requested to review and amend the definitions and the provider did not respond to the request. This request is denied.
...

Pages 21 – 22 of RCE 1.

5. Petitioner requested reconsideration of the Respondent’s decision. In a Notice of Reconsideration Determination (“NRD”), dated October 25, 2023, Respondent partially reversed and modified its decision. *Id.* at 32. Respondent reinstated the 832 units of code 97153 and 208

units of code 97156; however, Respondent reduced the units of code 97156 from 186 to 104.

The NRD explained the basis for the decision as follows:

The reason for the denial is that the services are not medically necessary as defined in 59G-1.010, Florida Administrative Code. Specifically the services must be:

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

The NRD further provided:

PR Recon Determination: At reconsideration, all documents were carefully reviewed. The provider submitted 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. The current request is in excess of medically necessary BA services, but BA services are approved at a lower level than requested.

...

Pages 32 – 33 of RCE 1.

6. On October 23, 2023, Petitioner requested a Fair Hearing to challenge the denial and reduction of ABA services. *Id.* at 8. On November 20, 2023, the undersigned issued an Order Scheduling Fair Hearing by Telephone and Prehearing Instructions, setting the hearing for December 19, 2023, at 1:00 p.m. EST. *Id.*

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

- a. Petitioner's neurologists and providers have determined that a minimum of twenty (20) hours of ABA therapy is medically necessary. Petitioner has not requested twenty (20) hours, but rather fourteen (14) hours. eQHealth asserted

that Petitioner’s behaviors were not severe enough to warrant the additional three (3) hours per week of services requested with the BCBA, and that the request was in excess of medical necessity. [REDACTED] stated the BCBA needs time to devise strategies to improve Petitioner’s behavior.

b. [REDACTED] stated Petitioner’s maladaptive behaviors are very intense, severe, and frequent, and [REDACTED] is concerned for Petitioner’s safety [REDACTED]

[REDACTED]
[REDACTED]
[REDACTED]

[REDACTED] [REDACTED] stated there has been regression and increases in certain behaviors since the decrease in hours.

c. Petitioner experiences [REDACTED]

[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]

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

a. The treatment plan has been reviewed by three (3) qualified Board Certified Behavior Analysts at the Masters and Doctoral levels to determine medical necessity. Petitioner has been in services with this provider since [REDACTED]. The

request for service 97155 was an increase from the previous authorization, and the service was partially denied and reduced by forty-five (45) minutes. The treatment does not meet medical necessity criteria.

- b. The provider requested an increase in service 97155 to five (5) hours per week. Petitioner receives eight (8) hours per week of direct services. Any direct services should be requested through the 97153 code, independent of the one who is providing those services. Code 97153 is the code for direct, one-to-one services. The provider has not requested an increase in direct services, and the need for direct service hours is not reason to authorize additional BCBA protocol modification hours (code 97155). The Behavior Analysis Certification Board indicates a minimum of five percent (5%) supervision for the RBT providing the direct services, and this provider was authorized for one (1) hour per week of 97155, which is over twelve percent (12%) of the eight (8) hours requested.
- c. The graph for the problem behaviors of [REDACTED] and [REDACTED] shows low levels from [REDACTED]. See page 46 of RCE 1. The graph for [REDACTED] behaviors shows level trends from [REDACTED] with significant decreases at the beginning of [REDACTED] and some increases near the end of [REDACTED]. *Id.* The graph for [REDACTED] shows low levels and increases in behavior around the beginning of school. *Id.* at 47.
- d. The provider indicates that minimal protocol modification has occurred, which is the purpose of the 97155 code. The graphs do not contain protocol modifications

indicated by phase change lines, per standards of care of ABA. The provider describes minimal changes in the plan made throughout the authorization. Many goals regard academic work, and these goals require minimal intervention from a BCBA to implement. Therefore, protocol modification services at one (1) hour per week, which is over ten percent (10%), should meet Petitioner's needs, in addition to two (2) hours per week of caregiver training and eight (8) hours of direct service.

CONCLUSIONS OF LAW

9. 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).

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

11. Because Petitioner is requesting a new service, Fla. Admin. Code R. 59G-1.100(17)(g) assigns the burden of proof to the Petitioner. Furthermore, because Respondent reduced 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.)

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

1.0 Introduction

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

...

1.4.5 Medically Necessary/Medical Necessity

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

...

4.0 Coverage Information

4.1 General Criteria

Florida Medicaid covers services that meet all of the following:

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

4.2 Specific Criteria

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

4.2.1 Behavior Assessment

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

4.2.2 Behavior Analysis

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

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

...

4.3 Early and Periodic Screening, Diagnosis, and Treatment

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

13. 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

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

15. 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.

16. 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.

17. 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.

A. Respondent’s Denial of Additional ABA Services

18. In the instant case, Petitioner requested continuation and an increase in ABA services. See ¶ 4. Respondent approved 832 units of code 97153 and 208 units of code 97156, as requested, but denied the increase of 334 units of code 97155. See ¶ 5. In the NRD dated October 25, 2023, Respondent explained that additional services were not medically necessary,

specifically, that it did not meet the requirement that services must be “individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness under treatment, and not in excess of the patient’s needs.” Respondent further explained that “although the recipient is engaging in topographies of maladaptive behaviors, the frequency and intensity of the maladaptive do not support the request for services. The current request is in excess of medically necessary BA services.” *Id.*

19. 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, a component of medical necessity is that services must be “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, Respondent denied Petitioner’s request for additional units of code 97155 protocol modification. See ¶ 4. Petitioner bears the burden of proof regarding this issue. See ¶ 11. [REDACTED] asserted that the Petitioner’s maladaptive behaviors are [REDACTED] with Petitioner’s daily functioning. See ¶ 7. As explained by Dr. Conway, code 97155 is not for direct therapy – rather it is for protocol modification. See ¶ 8. Dr. Conway asserted during testimony that the additional protocol modification units are excessive and not medically necessary due to the provider’s lack of protocol modification and phase change lines in the present treatment plan, the nature of the goals requiring little intervention from the provider, and the fact that the one (1) hour authorized exceeds the Behavior Analysis Certification Board’s five percent (5%) standard of supervision. *Id.* Dr. Conway also testified that the proper service code through which to request direct services is code 97153, and the provider did not request any additional direct service units. *Id.* Respondent

explained that the need for direct service hours does not justify the authorization of additional BCBA protocol modification hours. *Id.* Petitioner further testified and submitted evidence of medical issues which impact the maladaptive behaviors. *See* ¶ 7. However, these medical issues, in and of themselves, do not explain the need for increased protocol modification units, specifically. As such, the requested protocol modification units are “in excess of the patient’s needs.” Petitioner has not demonstrated that it is medically necessary to receive 520 units of code 97155 protocol modification services.

20. Further, Petitioner testified and submitted evidence indicating that Petitioner’s healthcare providers have determined that a minimum of twenty (20) hours of ABA therapy is medically necessary. *See* ¶ 7. However, as provided in the Definitions Policy, “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* ¶ 15. Lastly, As QIO for the Agency, eQHealth is authorized to deny services when “the reviewing physician determines the recipient will not gain any additional benefit by continuing services at the current level.” *See* ¶ 17. As discussed, *supra* ¶ 19, Respondent has authorized protocol modification services above the standard set forth by the Behavior Analysis Certification Board, and has explained why the approved protocol modification units are sufficient to meet Petitioner’s treatment needs.

21. Upon consideration of the testimony provided, evidence submitted, and applicable polices, the undersigned concludes that Petitioner did not prove by a preponderance of the evidence that the denial of ABA services was incorrect. Looking at all the evidence relevant to the particular needs of Petitioner, Petitioner has not demonstrated that the additional services,

based on the treatment plan at issue in this case, 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.

B. Respondent's Reduction of Previously Authorized ABA Services

22. In the instant case, Respondent reduced Petitioner's ABA services. *See* ¶ 5. In the NRD dated October 25, 2023, Respondent explained that continuing services at the prior level was not medically necessary, specifically, that it did not meet the requirement that services must be "individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness under treatment, and not in excess of the patient's needs." Respondent further explained that "although the recipient is engaging in topographies of maladaptive behaviors, the frequency and intensity of the maladaptive do not support the request for services. The current request is in excess of medically necessary BA services." *Id.*

23. 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, a component of medical necessity is that services must be "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, Respondent reduced Petitioner's 97155 protocol modification units. *See* ¶ 5. Respondent bears the burden of proof regarding this issue. *See* ¶ 11. As discussed *supra* ¶ 19, Respondent testified and provided evidence that the provider's treatment plan includes minimal protocol modification and phase change lines, as well as goals which require little intervention from the provider. *See* ¶ 8. The absence of sufficient protocol modification and phase change lines does not meet standards of care within the field of ABA. *Id.*

Respondent has also authorized protocol modification units in excess of the Behavior Analysis Certification Board's five percent (5%) standard. *Id.* As the provider is not providing protocol modification services in compliance with the standards of ABA, the treatment plan is not "consistent with generally accepted professional medical standards," and is not "individualized, specific, and consistent" with Petitioner's treatment needs. As such, Respondent has demonstrated that it is not medically necessary to continue services at the previous level.

24. As QIO for the Agency, eQHealth is authorized to reduce services when "the reviewing physician determines the recipient will not gain any additional benefit by continuing services at the current level." *See* ¶ 17. As discussed, *supra* ¶ 23, the provider's implementation of the authorized protocol modification units falls below the standards of ABA.


25. 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 reduction 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 reduction of ABA services was correct.

IT IS HEREBY ORDERED AND ADJUDGED THAT:

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

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

DONE and ORDERED this 12th 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:



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