



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

FILED

Mar 25, 2024, 10:40 am

OFFICE OF FAIR HEARINGS

AHCA Case No.: 23-FH2757

[REDACTED]

PETITIONER,

vs.

AGENCY FOR HEALTH CARE
ADMINISTRATION,

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned Hearing Officer convened telephonic Fair Hearings on the instant case on December 6, 2023, at 1:07 p.m. Eastern Standard Time (“EST”), on January 26, 2024, at 9:36 a.m. EST, and on February 29, 2024, at 9:32 a.m. EST.

APPEARANCES

For the Petitioner:

[REDACTED]

Petitioner’s Authorized Representative

For the Respondent:

Linda Latson

Fair Hearing Liaison

Agency for Health Care Administration

STATEMENT OF ISSUE

The issue is whether Respondent proved by a preponderance of the evidence that Respondent’s termination of Petitioner’s behavior analysis (“BA” or “ABA”) services was correct.

PRELIMINARY STATEMENT

All parties and witnesses appeared telephonically. [REDACTED] (“[REDACTED]”), Petitioner’s Authorized Representative and [REDACTED], appeared at each Fair Hearing on behalf of Petitioner.

Yamile Gonzalez (“Ms. Gonzalez”), Board Certified Behavior Analyst (“BCBA”) and Lead Analyst appeared at each Fair Hearing as a witness for Petitioner. Sandra Gomez, Registered Behavior Analyst (RBT) appeared at the Fair Hearing on December 6, 2023, as a witness for Petitioner but did not testify. Veronica Gomez, RBT, appeared at the Fair Hearing on January 26, 2024, as a witness for Petitioner but did not testify.

Linda Latson, Fair Hearing Liaison and Registered Nurse Specialist for the Agency for Health Care Administration (“Agency” or “AHCA”), appeared for each Fair Hearing as a representative for Respondent. Dr. Joseph Darling (“Dr. Darling”), Board-Certified Behavior Analyst at the Doctoral Level (“BCBA-D”) and Second Level Reviewer for eQHealth Solutions Inc. (“eQHealth”), appeared at each Fair Hearing as a witness for Respondent.

The following Spanish translators appeared at the Fair Hearings to provide translation services: Roberto, ID Number 371644, on December 6, 2023; Carlos, ID Number 409208, on December 6, 2023; Jorge, ID Number 371940, on January 26, 2024; Maricio, ID Number 359811, on February 29, 2024; Claudia, ID Number 220319, on February 29, 2024; Koanelly, ID Number 403780, on February 29, 2024; and Larissa, ID Number 365114, on February 29, 2024.

Petitioner did not introduce any exhibits at the Fair Hearing.

Prior to the Fair Hearing, Respondent sent to the Office of Fair Hearings and Petitioner a one hundred and sixty-one (161)-page evidence packet and a forty-nine (49)-page evidence packet. The one hundred and sixty-one (161)-page packet appears in the Office of Fair Hearings’ document management system as files titled “[REDACTED] FH 12.06.2023 1 – 73.pdf”, “[REDACTED] FH 12.06.2023 74 – 107.pdf”, and “[REDACTED] FH 12.06.2023 108 – 161.pdf”. The forty-nine (49)-page packet appears in the Office of Fair Hearings’ document management system as the file

5. On September 12, 2023, Petitioner requested BA services; specifically, 3,120 units of code 97153; 260 units of code 97155; and 260 units of code 97156. See RCE 1 at 27. In a Notice of Outcome –Denial (“NOO”), dated September 20, 2023, Respondent terminated Petitioner’s BA services. *Id.* at 27 – 31. The NOO states as follows:

Code: 97155

Description: Intervention with protocol modification, per 15 minutes

From: 9/12/23

Thru: 3/9/24

Total Units: Denied 260

Code: 97156

Description: Family training, per 15 minutes, Lead Analyst

From: 9/12/23

Thru: 3/9/24

Total Units: Denied 260

Code: 97153

Description: Intervention without protocol modification, per 15 minutes, Lead Analyst, BCaBA or RBT

From: 9/12/23

Thru: 3/9/24

Total Units: Denied 3,120

The NOO explained the basis for the partial denial 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):

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

The NOO further provided:

The rationale for our decision is as follows:

PR Principal Reason – Denial:

Requested services are denied because documentation is neither showing improvement nor support for maintenance.

PR Clinical Rationale –Denial: Analysis Services Coverage Policy, page 6, 9.2i), the behavior 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 [engage] in. The behavior definitions for [REDACTED], [REDACTED] in this treatment plan do not conform to generally accepted standards of care within the field of applied behavior analysis. Additionally, According to the Florida Medicaid State Plan (Appendix 9.3.b), the data provided must show evidence that the frequency of the maladaptive behavior(s) has decreased since the last review and, if not, that there is a modification of the behavior plan. The recommendations for procedural modifications include: additions/changes to treatment plan to impact behaviors targeted for reduction. Procedural modifications should include one or more of the following: antecedent manipulation modifications, modifications of prompting procedures used in acquisition, modifications in consequence-based strategies – ones that either reduce maladaptive behavior or reinforce replacement behavior (e.g., manipulation of reinforcement schedules, switch to a different decelerative procedure), or if lack of progress was due to therapist error (e.g., poor data collection or poor training intervention methods), how you will address human error. The provider has not addressed the lack of progress during the last observation period and did not amend the treatment plan in relation to the lack of progress or the proposed changes have little chance of improving behavior. The information submitted does not meet standards of care within the field of behavior analysis. This request is denied.

...

RCE 1 at 27 – 28.

6. Petitioner requested reconsideration of Respondent’s decision. In a Notice of Reconsideration Determination (“NRD”), dated October 30, 2023, Respondent upheld its decision. *Id.* at 39 – 42. 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:

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

PR Recon Determination: At reconsideration all documents were carefully reviewed. According to the Florida Medicaid State Plan (page 8, 6.2.3), 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 to the behavior plan. The recommendations for procedural modifications include: additions/changes to treatment plan to impact behaviors targeted for reduction. Procedural modifications should include one or more of the following: antecedent manipulation modifications, modifications of prompting procedures used in acquisition, modifications in consequence-based strategies – ones that either reduce maladaptive behavior or reinforce replacement behavior (e.g., manipulation of reinforcement schedules, switch to a different decelerative procedure), or if lack of progress was due to therapist error (e.g., poor data collection or poor training intervention methods), how you will address human error. The provider has not addressed the lack of progress during the last observation period and did not amend the treatment plan in relation to the lack of progress or the proposed changes have little chance at improving behavior. The information submitted does not meet standards of care within the field of behavior analysis. This denial is upheld.

...

RCE 1 at 39 – 40.

7. On October 26, 2023, Petitioner requested a Fair Hearing to challenge the termination of BA services. On November 8, 2023, the undersigned issued an Order Scheduling Fair Hearing and Prehearing Instructions, setting the hearing for December 6, 2023, at 1:00 p.m. EST. During the December 6, 2023, hearing, Respondent requested for the hearing to be continued. Absent an objection to the request to continue, the Office of Fair Hearings issued an Order Granting Continuance on December 7, 2023, and a Second Order Scheduling Fair Hearing and Prehearing Instructions, dated December 18, 2023, setting the hearing for January 26, 2024, at 9:30 a.m. EST. During the January 26, 2024, hearing, Respondent again requested a continuance. The Office of Fair Hearings issued a Third Order Scheduling Fair Hearing and Prehearing Instructions, dated January 29, 2024, setting the hearing for February 29, 2024, at 9:30 a.m.

8. Dr. Darling, a BCBA-D and a Second Level Reviewer for eQHealth, testified to the following:

- a. eQHealth has been hired by ACHA to provide assurance of quality services to Medicaid recipients. Respondent follows the five (5) medically necessary criteria that medical or allied care, goods, or services furnished or ordered must meet. Dr. Darling read the five (5) medical necessity criteria into the record. *See* RCE 2 at 7. Based on the treatment plan submitted by the provider, criterion two was not met, specifically that the request in the treatment plan was in excess of Petitioner’s needs based, and criterion three, specifically that the treatment plan was not generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational. The requested BA services were denied because they did not meet medical necessity and because the two treatment plans did not meet the standards of ABA. The requested services are in excess of Petitioner’s needs.
- b. Petitioner has received BA services since [REDACTED].
- c. The number of hours of therapy each week for a recipient are determined by the number of hours necessary to implement the procedures for behaviors to decrease, as well as the procedures for behaviors to increase.
- d. Dr. Darling reviewed Petitioner’s maladaptive behaviors. The data graph for [REDACTED] shows the behavior was not occurring by [REDACTED]. *See* RCE 1 at 69. The data graphs for the behaviors that have been targeted to decrease overtime show there has been a decrease since treatment started. *See* RCE 1 at 70 – 79. The summary table shows that the maladaptive behaviors of [REDACTED], [REDACTED], and [REDACTED] have reduced

significantly. See RCE 1 at 68. The remaining behaviors have had some reduction in the last six months. See RCE 1 at 69.

- e. The summary table for the [REDACTED] replacement behaviors shows a slow change in each of the behaviors from month to month. See RCE 1 at 79 – 80. The requested BA services are in excess of Petitioner’s needs because some of the replacement skills are at 90% or better, which means the task has been learned and time should no longer be used to teach a skill that Petitioner has learned. The skill of [REDACTED] will take another 3 or 4 years before it is met. See RCE 1 at 79. After [REDACTED] years of treatment, there are behaviors being targeted that are no longer necessary, and other behaviors that are moving very slowly. This violates the second and third medically necessary criteria.
 - f. The initial denial was also based on the unclear definitions of maladaptive behaviors in the first treatment plan. The second treatment plan was submitted with some corrections. The treatment plans have contradictory data.
 - g. In totality, there has been some progress in Petitioner’s maladaptive behaviors over the years; the progress is slow and inconsistent.
 - h. Based on the currently targeted behavior, the request for 30 hours of intensive one-on-one therapy is not justified and not supported by the treatment plans. The submitted treatment plans show enough maladaptive behaviors to support some units of therapy for Petitioner, but not all of the requested units.
 - i. Petitioner may qualify for BA services with a different provider.
9. Ms. Gonzalez, a BCBA, testified as follows:

- a. Petitioner’s behavior has improved as follows - for [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
- b. Petitioner demonstrated an overall reduction of [REDACTED] points in maladaptive behaviors during the last authorization period.
- c. Petitioner mastered the maladaptive behavior of [REDACTED] on [REDACTED] [REDACTED]. See RCE 1 at 58.
- d. [REDACTED] decided that the offered 24 hours of BA services was not enough for Petitioner. Ms. Gonzalez informed Respondent of [REDACTED]’s decision.

10. [REDACTED], Petitioner’s Authorized Representative, testified as follows:

- a. Petitioner’s behavior has improved.

CONCLUSIONS OF LAW

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

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

13. Because Respondent terminated a previously approved service, Fla. Admin. Code R. 59G-1.100(17)(b) assigns the burden of proof to the Respondent. The standard of proof in an administrative hearing is a preponderance of the evidence. The preponderance of the evidence

standard requires proof by “the greater weight of the evidence” (Black’s Law Dictionary at 1201, 7th Ed.).

14. 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.

...

RCE 2 at 40 – 42.

15. 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

...

RCE 2 at 45 – 47.

16. 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.

RCE 2 at 4 – 5.

17. 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.

RCE 2 at 13.

18. Section 2.83 of 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.

RCE 2 at 23.

19. The Florida Medicaid Authorization Requirements Policy (“Authorization Requirements 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 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.

RCE 2 at 34.

20. In the instant case, Petitioner requested the following ABA services: 3,120 units of code 97153; 260 units of code 97155; and 260 units of code 97156. See ¶ 5. In the NOO, dated September 20, 2023, and the NRD, dated October 30, 2024, Respondent explained that the request for services did not meet the medically necessary criteria that services be “[c]onsistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational.” See ¶ 5, 6. Respondent further explained that the “[r]equested services are denied because documentation is neither showing improvement nor support for maintenance” and that the “provider has not addressed the lack of progress during the last observation period and did not amend the treatment plan in relation to the lack of progress or the proposed changes have little chance of improving behavior.” See ¶ 5.

21. As provided by the EPSDT requirements, the recipient must meet the medical necessity criteria as outlined in Fla. Admin. Code R. 59G-1.010. See ¶ 17. As provided in section 2.83 of the Definitions Policy, a component of medical necessity is that services must be “consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational.” See ¶ 18. These criteria were identified as not being met in the NOO and NRD. See ¶ 5 – 6. [REDACTED] testified that Petitioner's behavior has improved See ¶

10. Ms. Gonzalez testified that Petitioner demonstrated an overall reduction of [REDACTED] points in maladaptive behaviors during the last authorization period. See ¶ 9. These statements are corroborated by Dr. Darling’s testimony that the summary table shows that the maladaptive behaviors of [REDACTED], [REDACTED], [REDACTED], and [REDACTED] have reduced significantly. See ¶ 8. Further, Dr. Darling established that based on the currently targeted behaviors, the request for 30 hours of intensive one-on-one therapy is not justified. See ¶ 8. Dr. Darling opined that the submitted treatment plans show enough maladaptive behaviors to support some units of therapy for Petitioner, but not all of the requested units. See ¶ 8. Although Petitioner may need ABA services, the data graphs in the provider’s Reassessment demonstrate that the requested hours of BA services are in excess of Petitioner’s needs. See ¶ 3 – 6, 8. In all, based on the credible and convincing testimony of Dr. Darling, and the documented progress in the treatment plan, Respondent demonstrated that the provider’s treatment is not “consistent with generally accepted professional medical standards as determined by the Medicaid program”.

22. As QIO for the Agency, eQHealth is authorized to terminate services when “the reviewing physician determines the recipient will not gain any additional benefit by continuing services at the current level.” See ¶ 19. As discussed, supra ¶ 20 – 21, the current treatment exceeds Petitioner’s needs.


23. Upon consideration of the testimony provided, Respondent’s Composite Exhibit 1, Respondent’s Composite Exhibit 2, and the applicable polices and laws, the undersigned concludes that Respondent proved by a preponderance of the evidence that the ABA services at issue do not meet medical necessity criteria. Looking at all the evidence relevant to the particular

needs of Petitioner, Respondent has demonstrated that the previously authorized services, based on the treatment plans at issue in this case, are not necessary to correct or ameliorate a defect or a physical and mental illness or condition. Accordingly, Respondent proved by a preponderance of the evidence that Respondent's termination of BA services 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 is **DENIED**.

DONE and **ORDERED** this 25th day of March, 2024, in Tallahassee, Leon County, Florida.

 Kameisha Presley
23-FH2757
2024.03.25
10:28:06 -04'00'

KAMEISHA PRESLEY, 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:






AHCA Medicaid Hearing Unit
MedicaidHearingUnit@ahca.myflorida.com