



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

FILED

Mar 26, 2024, 9:33 am

OFFICE OF FAIR HEARINGS

[REDACTED]

PETITIONER,

AHCA Case No.: 23-FH3123

vs.

AGENCY FOR HEALTH CARE
ADMINISTRATION,

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic Fair Hearing on the instant case on January 31, 2024, at 10:03 a.m. Eastern Standard Time ("EST").

APPEARANCES

For the Petitioner:

[REDACTED]

Petitioner's Authorized Representative

For the Respondent:

Marielisa Amador
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 denial of Petitioner's request for behavior analysis ("BA" or "ABA") services was incorrect.

PRELIMINARY STATEMENT

All parties and witnesses appeared telephonically. [REDACTED] (" [REDACTED]"),
Petitioner's Authorized Representative and [REDACTED], appeared for the Fair Hearing to offer

testimony on behalf of Petitioner. [REDACTED] (“[REDACTED]”), Board Certified Behavior Analyst (“BCBA”) for [REDACTED], appeared for the Fair Hearing as a witness for Petitioner. [REDACTED] (“[REDACTED]”), BCBA for [REDACTED], appeared for the Fair Hearing as a witness for Petitioner.

Marielisa Amador, Medical/Health Care Program Analyst for the Agency for Health Care Administration (“Agency” or “AHCA”), appeared for the Fair Hearing as representative for Respondent. Dr. Kathy Hurley (“Dr. Hurley”), Board Certified Behavior Analyst (“BCBA”) at the doctoral level, Florida licensed Mental Health Counselor, and Second Level Reviewer for eQHealth Solutions Florida (“eQHealth”), appeared for the Fair Hearing as a witness for Respondent.

Prior to the hearing, the Office of Fair Hearings received a thirty-eight (38)-page evidence packet from Petitioner. The thirty-eight (38)-page evidence packet appears in the Office document management system as the file title “23-FH3123 Supporting Documents.pdf.” Absent an objection from the Respondent, the thirty-eight (38)-page evidence packet was admitted into evidence as Petitioner’s Composite Exhibit 1 (“PCE 1”).

Prior to the hearing, the Office of Fair Hearings received a one hundred and forty-three (143)-page evidence packet and a fifty (50)-page evidence packet from Respondent. The one hundred and forty-three (143)-page packet appears in the Office of Fair Hearings document management system as the file titles “[REDACTED] FH 01.31.2024 1-84.pdf” and “[REDACTED] FH 01.31.2024 85-143.pdf.” The fifty (50)-page evidence packet appears in the Office of Fair Hearings document management system as the file title “23-FH3123 AHCA Evidence (Pages 1-50 of 50).pdf.” Absent an objection from the Petitioner, the undersigned admitted the one hundred

and forty-three (143)-page evidence packet into evidence as Respondent’s Composite Exhibit 1 (“RCE 1”) and the fifty (50)-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 (“QIO”) contracted by the Agency to review authorization requests for services. See RCE 2 at page 2.

2. Petitioner is [REDACTED] old. See RCE 1 at page 16. Petitioner is diagnosed with [REDACTED].
Id.

3. As provided in the Functional Behavior Assessment and Treatment Plan (“Treatment Plan”) submitted by [REDACTED], Petitioner is engaging in the following maladaptive behaviors: [REDACTED], [REDACTED], [REDACTED], [REDACTED], [REDACTED], [REDACTED], [REDACTED], and [REDACTED]. *Id.* at 125-127.

4. Petitioner requested ABA services for the certification period of October 16, 2023, to April 12, 2024; specifically, 1,820 units of code 97153; 780 units of code 97154; 416 units of code 97155; and 208 units of code 97156. *Id.* at 21, 25. On October 11, 2023, Respondent requested additional information (“PEND”) from the ABA provider concerning the Treatment Plan. *Id.* at 19,

51. In response to the request, the provider stated as follows:

1. Just a reminder that this is a new treatment plan, so group therapy (2:1) has not been done so not graphs are available
2. Internal states and client's intentions are not anywhere in the targeted behaviors.
3. Additions of graph from assessment as well as anecdotal rate data is included.

4. Requested updates are highlighted
5. Parent goal is #10 as well as integrity measures.
6. Cannot report on goal being met, not met, or modified because this is an initial plan.

Id. at 20.

5. In a Notice of Outcome (“NOO”), dated October 30, 2023, Respondent denied all units of Petitioner’s request. *Id.* at 25-27. The NOO explained the basis for the denial as follows:

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

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

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

The NOO further provided:

Submitted information does not support the medical necessity for requested frequency and/or duration.

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 set in Florida Behavior Analysis Services Coverage Policy (page 7, 6.2.2). 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. All definitions lack clear onset/offsets. The definition for expressive language delay and social skill deficits do not conform to standards of care. Additionally, the supporting documentation does not meet generally accepted practices within the field of applied behavior analysis and standards set forth in the Florida Behavior Analysis Services Coverage Policy (Pages 8, 6.2.2). The provider was approved to complete an assessment, The provider has not submitted all graphed for skill acquisition goals and maladaptive behaviors that were to be completed during the assessment. This request for services is denied.

Id. at 25-26.

6. Petitioner requested reconsideration of the Respondent’s decision. In a Notice of Reconsideration Determination (“NRD”), dated November 2, 2023, Respondent upheld its decision. *Id.* at 37-38. The NRD explained the basis for the decision as follows:

PR Recon Determination: At reconsideration all documents were carefully reviewed. The supporting documentation does not meet generally accepted practices within the field of applied behavior analysis and standards set forth in the Florida Behavior Analysis Services Coverage Policy (Pages 8, 6.2.3). The provider was approved to complete an assessment, The provider has not submitted all graphed baseline data for skill acquisition goals and maladaptive behaviors that were to be completed during the assessment. This request for ABA treatment does not meet medical necessity criteria as the information submitted by the provider does not meet standards of care within the field of behavior analysis nor specifications from the Behavior Analysis Services Coverage Policy. This denial is upheld.

Id. at 38.

7. On December 12, 2023, Petitioner requested a Fair Hearing to challenge the denial of ABA services. On January 8, 2024, the undersigned issued, to all parties of record, an Order Scheduling Fair Hearing and Prehearing Instructions, setting the hearing for January 31, 2024, at 10:00 a.m. EST.

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

- a. [REDACTED] asserted that Petitioner needs help with [REDACTED] regressing behaviors.
- b. Petitioner engages in maladaptive behaviors while out in the community such as [REDACTED]. The school setting became a safety concern due to [REDACTED].

9. [REDACTED] is a BCBA for [REDACTED]. [REDACTED] testified to the following:

- a. [REDACTED] argued that each Treatment Plan submitted was the best attempt to meet the medically necessary criteria and it did meet criteria two and three for medical necessity.
10. [REDACTED] is a BCBA for [REDACTED]. [REDACTED] testified to the following:
- a. [REDACTED] argued that when the initial Treatment Plan was submitted no school information was provided at that time, but Petitioner’s maladaptive behaviors such as [REDACTED], [REDACTED], [REDACTED], [REDACTED], and [REDACTED] still met the medical necessity criteria.
 - b. [REDACTED] argued that at reconsideration the provider appropriately responded to the eQHealth reviewers’ requests for additional information to include school information. See ¶ 4-6.
11. Dr. Hurley is a BCBA at the doctoral level, Florida Mental Health Counselor, and Second Level Reviewer for eQHealth. Dr. Hurley established the following at Fair Hearing:
- a. eQHealth is hired by AHCA to provide assurance of quality services to Medicaid recipients by following the five (5) “medically necessary” criteria. See RCE 2 at page 7. eQHealth uses a two-level peer review process to determine if the requested ABA services meet the medically necessary criteria. See RCE 1 at 21-23.
 - b. Medical necessity criteria apply not only to the recipient and [REDACTED] diagnosis, but also every document submitted as part of the request for services. See ¶ 15.
 - c. Dr. Hurley argued that Petitioner’s provider submitted a Treatment Plan that is not consistent with generally accepted professional medical standards in the field of ABA. See RCE 2 at 28.

- d. Dr. Hurley explained that the provider submitted many updates to the Treatment Plan but contended that the final version was still outside standards of care in the field of ABA.
- e. There are no individual baseline graphs for each maladaptive behavior in the Treatment Plan. *See* RCE 1 at 81.
- f. All maladaptive behaviors data from the initial assessment are on the same graph and it contains no dates of observation. *Id.* Dr. Hurley explained that graphs with no dates are outside the generally accepted standards of care.
- g. Dr. Hurley opined that the provider did not identify specific behavior goals and intervention strategies such as what is the intensity to be measured or what is the behavior for the BCBA to observe for high severity behaviors like [REDACTED], [REDACTED], [REDACTED], or [REDACTED].
- h. None of the maladaptive behavior goals or acquisition skills include short-term objectives (“STO”) and long-term objectives (“LTO”). *Id.* at 82-89.
- i. There are no individual graphs for any acquisition skill in the Treatment Plan. *Id.*
- j. The provider indicated that “[g]roup therapy (2:1) will be implemented once [Petitioner] begins treatment. *Id.* at 116. Dr. Hurley argued that there is no accompanying justification for this request.

CONCLUSIONS OF LAW

12. 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 (2022). This order is the final administrative decision of AHCA under section 409.285(2)(a).

13. This hearing was held as a *de novo* proceeding pursuant to Rule 59G-1.100(17)(b), Florida Administrative Code Rule (“Fla. Admin. Code R.”).

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

15. The Florida Medicaid Behavior Analysis Services Coverage Policy (September 2023) (“BA Policy”), incorporated by reference in Fla. Admin. Code. R. 59G-4.125, governs ABA 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.

...

1.4.6 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 and Behavior Plan

A behavior assessment must be conducted prior to the initiation of behavior analysis interventions. The assessment must identify behavioral deficits that interfere with a major life activity including the events and subsequent interactions that elicit and sustain targeted behavior.

The initial assessment must include the administration, scoring, and reporting of two core standardized behavior instruments, as follows:

- Vineland-3 Comprehensive Parent Interview Form Including Maladaptive Behavior Domain, for all recipients
- Behavior Assessment System for Children, Third Edition, Parenting Relationship Questionnaire (BASC-3 PRQ), for all recipients 2 years old and less than 19 years old

The complete scoring report, including outcome measure scores, must be submitted with service prior authorization requests. Additional assessment tools may be used at the Lead Analyst's discretion.

The behavior plan identifies intervention strategies that are likely to eliminate, mitigate or replace the behavior to produce change sufficient to reengage the recipient in the major life activity. The plan must include specific behavior goal(s), intervention strategies for each goal, anticipated timeframes that are of sufficient duration to address the targeted behavior, and how the ongoing progress of intervention strategies will be reported.

The behavior plan must reflect the requested authorization period (up to six months).

A reassessment and updated behavior plan to renew prior authorization for continued services must be completed at least every six months. The core instruments must be included with reassessments every 12 months.

More frequent assessments must be conducted when:

- New behavior emerges that interferes with a recipient's participation in a major life activity
- Additional BA services are medically necessary and are likely to address the emergent behavior

A full assessment may be requested if there is a change in provider; however, a change of a practitioner status (e.g., an RBT becoming certified as a BCaBA) is not grounds for conducting a reassessment or updating a behavior plan.

4.2.2 Behavior Analysis Interventions

Florida Medicaid covers up to 40 hours per week of BA intervention services as indicated in the recipient's prior-authorized behavior plan. These services must be delivered to reduce maladaptive behaviors and assist the recipient reach the best possible functional level for that individual. The recipient's parent or guardian should participate in treatment when possible and clinically appropriate. The provider must make every effort to accommodate parental participation and must document those efforts in treatment plan updates. If parent or guardian participation is not possible, the treatment plan and session notes must

document the reasons for nonparticipation. Documentation should also explain potential impacts of nonparticipation and how potential impacts are being mitigated.

Services include:

- Adaptive behavior treatment by protocol – behavior analysis services provided according to the authorized treatment protocol
 - Services may be provided by Lead Analyst, BCaBA, or RBT
- Adaptive behavior treatment with protocol modification – behavior analysis services provided with modifications to the authorized treatment protocol to address behavior and/or response changes or progress
 - Services may be provided by Lead Analyst or BCaBA
- Group adaptive behavior treatment by protocol – behavior analysis services provided in a group setting according to the authorized treatment protocol
 - Maximum group size is six recipients
 - Services may be provided by Lead Analyst, BCaBA, or RBT
- Group adaptive behavior treatment with protocol modification – behavior analysis services provided in a group setting with modifications to the authorized treatment protocol to address behavior and/or response changes or progress
 - Maximum group size is six recipients
 - Services may be provided by Lead Analyst or BCaBA
- Family adaptive behavior treatment guidance – parent, guardian, and/or caregiver training on the implementation of the behavior plan and intervention strategies
 - The recipient may or may not be present depending upon clinical appropriateness
 - Services may be provided by Lead Analyst or BCaBA
 - The Lead Analyst may provide up to two hours per week of training to parents or guardians via telemedicine in accordance with Rule 59G-1.057, Florida Administrative Code (F.A.C.)

4.2.3 Supervision

Florida Medicaid requires supervision of BCaBAs and RBTs in accordance with certification board requirements and specified in the supervision plan of the approved behavior plan.

4.2.4 Discharge

Recipients receiving Florida Medicaid BA services who meet one or more of the following will be considered for discharge from services:

- The recipient is no longer eligible for BA services as outlined in the Florida Medicaid Behavior Analysis Services Coverage Policy, incorporated by reference in Rule 59G-4.125, F.A.C.
- The recipient no longer meets medical necessity criteria as defined in Rule 59G- 1.010, F.A.C.
- The recipient no longer engages in maladaptive behaviors.
- Data indicates the frequency and severity of maladaptive behavior(s) or level of functional impairment no longer poses a barrier to the recipient’s ability to function in his/her environment.
- The level of functional impairment as expressed through behaviors no longer justifies continued BA services.
- Parent or guardian withdraws consent for treatment

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 section 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 Authorization Requirements Policy.

...

6.2.2 Behavior Assessment and Behavior Plan

The behavior assessment and behavior plan must be signed by the Lead Analyst and the recipient’s parent or guardian. Each behavior assessment and behavior plan must include:

- Patient information
- Reason for referral
- Medical and developmental history, including medications prescribed to ameliorate behaviors
- Relevant family history
- Clinical interview
- Review of recent assessments/reports (file review)
- Assessment procedures and results
- Behavior plan
 - Treatment setting(s)
 - Proposed treatment targets, goals, and objectives related to medically necessary behavioral interventions
 - For each:
 - Definition in observable, measurable terms
 - Direct observation and measurement procedures
 - Current level (baseline)

- Behavior reduction or acquisition procedures
- Condition(s) under which behavior is to be demonstrated and mastery criteria
- Date of introduction
- Estimated date of mastery
- Plan for generalization
- Timely reporting of progress, including statements as to whether goal or objective is met; not met; or, modified (with explanation)
- Parent/guardian/caregiver training
 - Proposed targets, goals, and objectives (as above)
 - Training procedures
 - Date of introduction
 - Estimated date of mastery
- Number of units requested
 - Number of units for each billing code
 - Medical necessity for units requested
- Supervision plan, including name(s) of authorized supervisor(s)
- Care coordination with parents/caregivers, schools, state disability programs, and others as applicable
- Transition (fading) plan
- Crisis management plan
- Discharge plan

See RCE 2 at 41, 43-47.

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.

17. 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). Section 409.905(2), Florida Statutes, 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.

18. The Florida Medicaid Definitions Policy (August 2017) (“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.

See RCE 2 at 23.

19. The Florida Medicaid Authorization Requirements Policy (June 2016) (“Authorization Policy”), incorporated by reference in Fla. Admin. Code R. 59G-1.053, provides general

requirements for providers to obtain authorization to render Florida Medicaid services. See RCE 2 at 30-36. The Authorization Policy states as follows:

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.

See RCE 2 at 34.

20. In the instant case, Petitioner is under 21 years of age and is diagnosed with [REDACTED]. See ¶ 2. Petitioner requested ABA services. See ¶ 4. In a NOO, dated October 30, 2023, Respondent denied Petitioner's request. See ¶ 5. Respondent cited the lack of medical necessity as the basis for their decision, specifically that the requested ABA 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" and "consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational." See ¶ 5, 18. 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 ¶ 16-17. The Definitions Policy defines a component of medically necessary services as "consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or

investigational.” See ¶ 18. Petitioner has burden of proof to show by a preponderance of evidence that the Respondent’s determination was incorrect. See ¶ 14.

21. The record shows that Petitioner engages in maladaptive behaviors that qualify for ABA services. See ¶ 3, 7. The Petitioner’s maladaptive behaviors as indicated in the Treatment Plan include [REDACTED], [REDACTED], [REDACTED], [REDACTED], [REDACTED], [REDACTED], [REDACTED], and [REDACTED]. See ¶ 3.

As testified by [REDACTED], Petitioner engages in maladaptive behaviors in the community and at school such as [REDACTED]. See ¶ 7. [REDACTED] and [REDACTED] both argued that the submitted Treatment Plan was the best attempt to meet the medically necessary criteria and included the additional information requested by eQHealth reviewers. See ¶ 9-10.

22. Medical necessity criteria apply not only to the recipient and [REDACTED] diagnosis, but also to every document submitted as part of the request for services. See ¶ 11, 15, 18. The BA Policy maintains that the “plan must include specific behavior goal(s), intervention strategies for each goal, anticipated timeframes that are of sufficient duration to address the targeted behavior, and how the ongoing progress of intervention strategies will be reported.” See ¶ 15.

23. During testimony, Dr. Hurley contended that Petitioner’s provider submitted a Treatment Plan that did not meet generally accepted professional standards. See ¶ 11. Dr. Hurley pointed out that the provider submitted many updates to the Treatment Plan but contended that the final version still fell outside standards of care in the field of ABA. See ¶ 11. The record shows that there are no individual baseline graphs for each maladaptive behavior in the Treatment Plan. See ¶ 11. All maladaptive behaviors data from the initial assessment are within one graph with

no dates of observation for these behaviors. See ¶ 11. Dr. Hurley opined that the provider did not identify specific behavior goals and intervention strategies such as what is the intensity to be measured or what is the behavior for the BCBA to observe for high severity behaviors like [REDACTED], [REDACTED], [REDACTED], or [REDACTED]. See ¶ 11. None of the maladaptive behavior goals or acquisition skills include STOs and LTOs. See ¶ 11. As a similar issue for the maladaptive behaviors, the record also shows there are no individual graphs for any acquisition skill in the Treatment Plan. See ¶ 11. Further, Dr. Hurley argued that there is no accompanying justification for the requested units of code 97154 intended for group therapy (2:1). See ¶ 11. It is clear between the testimony by Dr. Hurley and the information in the Treatment Plan that the record is insufficient to support the medical necessity of the requested ABA services. See ¶ 11, 19. All in all, the undersigned finds Dr. Hurley's testimony persuasive to demonstrate that the Treatment Plan was not consistent with generally accepted professional medical standards within the field of behavior analysis. See ¶ 11. Based on these discrepancies, the undersigned concludes that the Treatment Plan appears vague and does not justify the requested services to implement ABA therapy effectively. See ¶ 11, 15, 19.


24. Upon consideration of the testimony provided, evidence submitted, and applicable policies, the undersigned concludes that Petitioner did not prove by a preponderance of the evidence that the requested ABA services at issue are medically necessary. Looking at all the evidence relevant to the particular needs of Petitioner, Petitioner has not demonstrated that the requested 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 the requested ABA services was incorrect.

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**.

DONE AND ORDERED this 26th day of March, 2024 in Tallahassee, Leon County, Florida.

 Kimberly Roche
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KIMBERLY ROCHE, 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.

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