



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

**FILED**

Jul 12, 2024, 9:30 am

OFFICE OF FAIR HEARINGS

AHCA Case No.: 24-FH0942

[REDACTED]

PETITIONER,

vs.

AGENCY FOR HEALTH CARE  
ADMINISTRATION,

RESPONDENT.

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**FINAL ORDER**

Pursuant to notice, the undersigned convened a telephonic Fair Hearing on the instant case on April 30, 2024, at 9:00 a.m. Eastern Standard Time (“EST”).

**APPEARANCES**

For the Petitioner:

[REDACTED]

Petitioner’s Authorized Representative

For the Respondent:

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

**STATEMENT OF ISSUE**

The issue is whether Petitioner proved by a preponderance of the evidence that Respondent’s decision to deny Petitioner’s modification request for 832 additional units of code 97153 of Behavior Analysis (“BA” or “ABA”) services was incorrect.

**PRELIMINARY STATEMENT**

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

Petitioner. [REDACTED] (“[REDACTED]”), [REDACTED] of Petitioner, appeared as a witness for Petitioner.

Diana Hearod (“Ms. Hearod”), Medical/Health Care Program Analyst 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.

Petitioner did not introduce any exhibits at the hearing. Prior to the hearing, Respondent sent to the Office of Fair Hearings and Petitioner a one-hundred and ninety-nine (199)-page evidence packet and a forty-nine (49)-page evidence packet. The one-hundred and ninety-nine (199)-page evidence packet appears in the Office of Fair Hearings’ document management system as the file titles: “[REDACTED] FH 04.30.2024 1-92.pdf”; “[REDACTED] FH 04.30.2024 93-177.pdf”; and “[REDACTED] FH 04.30.2024 178-199.pdf”. The forty-nine (49)-page evidence packet appears in the Office of Fair Hearings’ document management system as the file title “24-FH0942\_Behavior Analysis\_AHCA EVIDENCE\_49 PGS\_[PETITIONER].pdf”. Absent an objection from the Petitioner, the undersigned admitted the one-hundred and ninety-nine (199)-page evidence packet into evidence as Respondent’s Composite Exhibit 1 (“RCE 1”) and the forty-nine (49)-page evidence packet into evidence as Respondent’s Composite Exhibit 2 (“RCE 2”).

### **FINDINGS OF FACT**

1. Petitioner receives Medicaid services on a fee-for-service basis from the Agency. eQHealth is a Quality Improvement Organization contracted by the Agency to review prior authorization requests for services. See page 2 of RCE 2.

2. Petitioner is [REDACTED]. See page 16 of RCE 1. Petitioner is diagnosed with [REDACTED]. *Id.*

3. As provided in Petitioner's treatment plan, Petitioner is engaging in the following maladaptive behaviors: [REDACTED]; [REDACTED]; [REDACTED]; [REDACTED]; [REDACTED]; and [REDACTED]. *Id.* at 91-101. Petitioner's treatment plan shows the following progress: for [REDACTED], Petitioner reduced [REDACTED] incidents from [REDACTED]; for [REDACTED], Petitioner reduced [REDACTED] incidents from [REDACTED]; for [REDACTED], Petitioner reduced [REDACTED] incidents from [REDACTED]; for [REDACTED], Petitioner reduced [REDACTED] incidents from [REDACTED]; for [REDACTED], Petitioner reduced [REDACTED] incidents from [REDACTED]; and for [REDACTED], Petitioner reduced [REDACTED] incidents from [REDACTED]. *Id.*

4. As testified to by Dr. Conway, in the current authorization, Petitioner requested and is approved for the following ABA services: 2,288 units of code 97153; 458 units of code 97155; and 104 units of code 97156.

5. Petitioner requested an increase in BA services; specifically, 832 units of code 97153; 416 units of code 97155; and 104 units of code 97156. In a Notice of Outcome ("NOO"), dated March 6, 2024, Respondent denied Petitioner's request for additional ABA services. *Id.* at 22. 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.  
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.

The NOO further provided:

PR Clinical Rationale – Denial: According to the Behavior Analysis Services Coverage Policy, all requested services must be based on maladaptive behaviors emitted by the recipient and the protocols necessary to render services (page 3, 2.2). Services cannot be approved on a speculative basis and services cannot be approved based on the convenience of the provider, the availability of the recipient, or the recipient’s caretaker. The information submitted by the provider do not support this request for modification of services. The request for modification of treatment units is denied.

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Pages 22 – 23 of RCE 1.

6. Petitioner requested reconsideration of the Respondent’s decision. In a Notice of Reconsideration Determination (“NRD”), dated March 8, 2024, Respondent upheld its decision.

*Id.* at 33. The NRD explained the basis for the decision as follows:

PR Recon Determination: At reconsideration all documents were carefully reviewed. According to the Behavior Analysis Services Coverage Policy, all requested services must be based on maladaptive behaviors emitted by the recipient and the protocols necessary to render services (page 3, 2.2). Services cannot be approved on a speculative basis and services cannot be approved based on the convenience of the provider, the availability of the recipient, or the recipient’s caretaker. The information submitted by the provider do not support this request for modification of services. The denial of the requested modification is upheld.

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Pages 33 – 34 of RCE 1.

7. On March 20, 2024, Petitioner requested a Fair Hearing to challenge the denial of ABA services. *Id.* at 8. On April 10, 2024, the undersigned issued an Order Scheduling Fair Hearing by Telephone and Prehearing Instructions, setting the hearing for April 30, 2024, at 9:00 a.m. EST.

*Id.*

8. [REDACTED] is a Board Certified Behavior Analyst. [REDACTED] testified to the following at the Fair Hearing:

a. Petitioner has severe skill deficits regarding [REDACTED]  
[REDACTED]  
[REDACTED]  
[REDACTED]  
[REDACTED]  
[REDACTED]  
[REDACTED]

b. Petitioner has health issues which impact [REDACTED] ability to attend therapy, and Petitioner cannot communicate [REDACTED] feeling with the therapist. The plan focuses on adaptive skills and communication. There is limited data on some graphs because there was limited time to work on those goals. Petitioner does not have health issues that impact [REDACTED] behavior. Petitioner was faded into the new agency, and the provider is seeing more of what needs treatment. The provider is seeing an increase in Petitioner [REDACTED].

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

a. Petitioner needs help, as [REDACTED] does not have daily living skills. Petitioner needs daily help with [REDACTED] needs and has [REDACTED]. Petitioner needs replacement behaviors and skills to be functional and [REDACTED]. Therapy will improve Petitioner's life. The previous agency was approved for forty hours per week, but

did not have enough availability. Petitioner had services in school, as well as community and home services.

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

- a. This treatment plan has been reviewed by three BCBA's at the Masters and Doctoral levels to determine medical necessity. Petitioner was transferred to the current provider in [REDACTED]. With the previous provider, Petitioner was authorized for 10 hours per week of code 97153. eQHealth's system shows that between ten and twelve hours were requested and approved in the past two authorizations. The provider requested a modification increase of code 97153 from ten hours to twenty-two hours, and the request was approved in the prior authorization. For the current authorization, Petitioner is approved for 2,288 units of code 97153, 458 units of code 97155, and 104 units of code 97156. The provider is requesting an additional increase of 832 units of code 97153. The provider was denied the additional increase, as the request is in excess and is for the convenience of the provider. The provider submitted documents unrelated to ABA services.
- b. Protesting shows a slight decreasing trend. *Id.* at 91. [REDACTED] shows a decreasing trend. *Id.* at 93. [REDACTED] shows a decrease. *Id.* at 95. Both levels of [REDACTED] show significant decreases. *Id.* at 98. [REDACTED] shows stability over time. *Id.* at 101. Overall, all maladaptive behaviors, except for

[REDACTED], show a decreasing trend, indicating progress. This is why services were approved at the same level as in the previous authorization.

- c. Most replacement skills have limited data points, making it difficult to determine the trend. *Id.* at 104. However, Petitioner shows stability and high levels of behaviors for each replacement skill. [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]. Overall, replacement skills show stability and progress. The current request is in excess of Petitioner’s needs as, at the current level, Petitioner is making significant progress across many skills and has decreasing maladaptive behaviors.

**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 Petitioner is requesting a modification of 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.)

14. The Florida Medicaid Behavior Analysis Services Coverage Policy (September 2023) (“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.

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**1.4.6 Medically Necessary/Medical Necessity**

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

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**2.0 Eligible Recipient**

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**2.2 Who Can Receive**

Florida Medicaid recipients under the age of 21 years requiring BA services that are medically necessary to address behavior that impairs a recipient’s ability to perform a major life activity. Such functional impairment is expressed through the following behaviors:

- Safety – aggression, self-injury, property destruction, elopement
- Communication – problems with expressive/receptive language, poor understanding or use of non-verbal communications, stereotyped, repetitive language
- Self-stimulating – abnormal, inflexible, or intense preoccupations
- Self-care – difficulty recognizing risks or danger, grooming, eating, or toileting
- Other behaviors not identified above but not limited to complexity of treatment, programming, or environmental variables

The recipient must be referred by an independent physician or practitioner qualified to assess and diagnose disorders related to functional impairment, including:

- Primary care physician with family practice, internal medicine, or pediatric specialty
- Board certified or board eligible physician with specialty in developmental behavioral pediatrics, neurodevelopmental pediatrics, pediatric neurology, adult or child psychiatry
- Child psychologist

The referral must include a comprehensive diagnostic evaluation (CDE) performed according to national evidence-based practice standards. CDEs may be performed

by a multidisciplinary team or individual practitioner. In either case, the CDE must be led by a licensed practitioner working within their scope of practice. The CDE must include assessment findings and treatment recommendations appropriate to the recipient. For example, the CDE may include data from behavioral reports by parents, guardians, and/or teachers; diagnostic testing related to recipients' development, behavior, hearing, and/or vision; genetic testing; and/or other neurological and/or medical testing.

Some services may be subject to additional coverage criteria as specified in section 4.0.

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#### **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 reassessment 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 function level for that individual. 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.)

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#### **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 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 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 Authorization Requirements Policy.

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### **5.0 Exclusion**

#### **5.1 General Non-Covered Criteria**

Services related to this policy are not covered when any of the following apply:

- The service does not meet the medical necessity criteria listed in section 1.0
- The recipient does not meet the eligibility requirements listed in section 2.0
- The service unnecessarily duplicates another provider’s service

#### **5.2 Specific Non-Covered Criteria**

Florida Medicaid does not cover the following as part of this service benefit:

- Any procedure or physical crisis management technique that involves the use of seclusion or manual, technical, or chemical restraint utilized to control behaviors
- Services for the delivery of recipient supervision, personal care assistance (e.g., acting as a 1:1 aid), companion, chaperone, or shadow regardless of activity or setting. This may include supports and services that are reimbursed through a different Florida Medicaid service benefit or are able to be provided by individuals without professional skills or training.
- Caregiver or childcare services
- Psychological testing, neuropsychology, psychotherapy, cognitive therapy, sex therapy, psychoanalysis, hypnotherapy, or long-term counseling
- Services funded under section 110 of the Rehabilitation Act of 1973
- Services not listed on the fee schedule
- Services on the same day as behavioral health overlay services\*
- Services on the same day as therapeutic behavioral on-site services\*
- Services on the same day as therapeutic group care services\*
- Services provided simultaneously by more than one BA provider, unless determined to be medically necessary, prior authorized, and indicated in the approved behavior plan
- Travel Time

\* These services include behavior analysis treatment.

Florida Medicaid may cover some services listed in this section through a different service benefit.

## **6.0 Documentation**

### **6.2 Specific Criteria**

Providers must maintain the following documentation in the recipient's file:

#### **6.2.1 Referral Information**

Original referral documentation must be maintained in the recipient's medical record.

#### **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

### **6.2.3 Assessment and Behavior Plan for Reauthorization and Continuation of Services**

In addition to the documentation requirements indicated in 6.2.2, subsequent assessments and behavior plans for reauthorization and continuation of services must include:

- Data reflecting progress of all behaviors targeted for improvement. Each behavior under treatment must have its own data table and corresponding graph.
- A narrative discussion of progress and a statement of justification for continuation of care at the intensity level requested

If significant clinical progress is not made over the course of an authorized period, the provider must explain why clinically significant progress was not made and treatment changes to promote progress.

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Pages 1 – 8 of BA Policy.

15. 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.

16. 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.

17. 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.

18. 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.

...

Page 3 of Authorization Policy.

19. In the instant case, Respondent denied Petitioner’s request for additional ABA services. See ¶ 5. In the NOO dated March 6, 2024, Respondent explained that additional services were not medically necessary, specifically, that it did not meet the requirements 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”; “consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational”; and “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”.

*Id.* Respondent further explained that “the information submitted by the provider [does] not support this request for modification of services.” *Id.*

20. 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, three components of medical necessity are 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”; “consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational”; and “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”. As shown by the record, Petitioner has made progress regarding both ■ maladaptive and replacement behavior goals. See ¶¶ 3, 10. Dr. Conway provided credible testimony, based on the treatment plan submitted by the provider, that Petitioner’s maladaptive behaviors show decreasing trends, while Petitioner’s replacement skills are stable, improving, and occurring at high levels. *Id.* While ■ ■ testified that Petitioner’s ■ warrants additional services, Dr. Conway asserted that the graphs depicting Petitioner’s ■ behaviors show significant decreases. *Id.* As Petitioner has shown significant improvement across ■ goals at the current level of services, the additionally requested services are “in excess of the patient’s needs.” As such, Petitioner has not demonstrated that the additionally requested services are medically necessary.

21. As QIO for the Agency, eQHealth is authorized to deny services when “there is a documented improvement in the recipient’s medical condition.” See ¶ 18. As discussed, *supra* ¶


20, Petitioner's behaviors exhibit progress across maladaptive and replacement behavior goals. Here, Petitioner's progress is well documented.

22. 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 additionally 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 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 12th day of July 2024, in Tallahassee, Leon County, Florida.

 Joseph Mabry  
24-FH0942  
2024.07.12  
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**JOSEPH MABRY, Hearing Officer**  
**Agency for Health Care Administration**  
**Office of Fair Hearings**  
**2727 Mahan Drive, Mail Stop # 11**  
**Tallahassee, FL 32308-5407**

**NOTICE OF A RIGHT TO JUDICIAL REVIEW**

A PARTY WHO IS ADVERSELY AFFECTED BY THIS FINAL ORDER IS ENTITLED TO JUDICIAL REVIEW, WHICH SHALL BE INSTITUTED BY FILING THE ORIGINAL NOTICE OF APPEAL WITH THE AGENCY

CLERK OF AHCA, AND A COPY, ALONG WITH THE FILING FEE PRESCRIBED BY LAW, WITH THE DISTRICT COURT OF APPEAL IN THE APPELLATE DISTRICT WHERE THE AGENCY MAINTAINS ITS HEADQUARTERS OR WHERE A PARTY RESIDES. REVIEW PROCEEDINGS SHALL BE CONDUCTED IN ACCORDANCE WITH THE FLORIDA APPELLATE RULES. THE NOTICE OF APPEAL MUST BE FILED WITHIN 30 DAYS OF THE RENDITION OF THE ORDER TO BE REVIEWED.

**Copies Furnished To:**

[REDACTED]  
[REDACTED]

**AHCA Medicaid Hearing Unit**  
**MedicaidHearingUnit@ahca.myflorida.com**