



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

**FILED**

Jul 30, 2024, 3:35 pm

OFFICE OF FAIR HEARINGS

[REDACTED]

PETITIONER,

AHCA Case No.: 24-FH1054

vs.

AGENCY FOR HEALTH CARE  
ADMINISTRATION,

RESPONDENT.

\_\_\_\_\_ /

**FINAL ORDER**

Pursuant to notice, the undersigned convened a telephonic Fair Hearing on the instant case on May 24, 2024, at 10:08 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 decision to deny Behavior Analysis (“BA” or “ABA”) services was incorrect.

**PRELIMINARY STATEMENT**

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

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

Freddy, interpreter number 371696 of Language Line Solutions, appeared for Fair Hearing to provide translation services for Petitioner.

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 eighty-eight (188)-page evidence packet and a forty-nine (49)-page evidence packet. The one hundred eighty-eight (188)-page packet appears in the Office of Fair Hearings document management system as the file title “[REDACTED] FH 05.24.2024.pdf.” The forty-nine (49)-page evidence packet appears in the Office of Fair Hearings document management system as the file title “24-FH1054- AHCA evidence 49 pgs.pdf.” Absent an objection from the Petitioner, the undersigned admitted the one hundred eighty-eight (188)-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 new requests for services. See RCE 2 at page 2.

2. Petitioner is [REDACTED]. See RCE 1 at 22. Petitioner is diagnosed with [REDACTED]. *Id.* Petitioner is [REDACTED]. *Id.* at 147-148. Petitioner receives physical therapy (“PT”). *Id.* at 147.

3. As provided in the Behavior Analysis Assessment (“Treatment Plan”) submitted by Miami Center for Cognitive Therapy, Petitioner is engaging in the following maladaptive behaviors: [REDACTED], [REDACTED], [REDACTED], [REDACTED], [REDACTED], [REDACTED], [REDACTED], [REDACTED], [REDACTED], and [REDACTED]. *Id.* at 161-169.

4. Petitioner requested ABA services for the certification period of February 29, 2024, to August 26, 2024; specifically, 2,600 units of code 97153; 312 units of code 97155; and 312 units of code 97156. *Id.* at 1, 25-26. In a Notice of Outcome (“NOO”), dated March 5, 2024, Respondent denied Petitioner’s requested ABA services. *Id.* at 29-31. The NOO explained the basis for the denial as follows:

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

The NOO further provided:

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. The behavior definitions ( [REDACTED] and [REDACTED] ) in this treatment plan do not conform to generally accepted standards of care within the field of applied behavior analysis. The provider has listed goals in this treatment plan (pg 17-18 [REDACTED] ) that do not meet medical necessity criteria. According to the Behavior Analysis Services Coverage Policy (page 4, 4.1), these goals are not covered. The goals must be necessary to protect life, to prevent significant illness, significant disability, or to alleviate severe pain and be consistent with the symptoms of any diagnosis for which ABA is medically necessary. These are skills that do not require a behavior analyst to teach. They can be learned in a less costly and equally effective manner by someone not specifically trained in ABA. They are furnished in a manner primarily intended for the convenience of recipient, the recipient's caretaker, or the provider. Further, 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. Specifically, the provider has failed to write an intervention plan that upholds the standards of care of applied behavior analysis. The plan lists procedures that include punishment (pg 21) and has not exhausted reinforcement-based strategies. There is no procedural safeguard or fading plan. Further, the information submitted does not meet standards of care within the field of behavior analysis. According to the Florida Medicaid State Plan (page 7, 6.2.2), assessment results must be present in the plan. The provider has included data and graphs for skill acquisition goals and maladaptive behaviors that were based on parent report, estimated or extrapolated average and sourced from indirect interview; and were not directly observed and measured as standards of care within the field of behavior analysis. This request is denied.

*Id.* at 29-30.

5. Petitioner requested reconsideration of the Respondent's decision. In a Notice of Reconsideration Determination ("NRD"), dated March 20, 2024, Respondent upheld its decision.

*Id.* at 41-42. The NRD explained the basis for the decision as follows:

PR Recon Determination: At reconsideration all documents were carefully reviewed. The punishment procedure is still within the plan ( [REDACTED] - [REDACTED] ). Additionally, the provider includes data labeled as weekly. The information submitted does not meet standards of care within the field of behavior analysis. According to the Florida

Medicaid State Plan (page 7, 6.2.2), assessment results must be present in the plan. The provider has included data and graphs for skill acquisition goals and maladaptive behaviors that were based on parent report, estimated or extrapolated average and sourced from indirect interview; and were not directly observed or measured as standards of care within the field of behavior analysis. 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. Specifically, the provider has failed to write an intervention plan that upholds the standards of care of applied behavior analysis. The plan lists procedures that include punishment and has not exhausted reinforcement-based strategies. There is no procedural safeguard or fading plan. This request is denied.

*Id.* at 42.

6. On April 2, 2024, Petitioner requested a Fair Hearing to challenge the denial of ABA services. On April 24, 2024, the undersigned issued an Order Scheduling Fair Hearing and Prehearing Instructions, setting the hearing for May 24, 2024, at 10:00 a.m. EST.

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

a. Petitioner has [REDACTED]  
[REDACTED]

b. [REDACTED]  
[REDACTED]  
[REDACTED]  
[REDACTED]

c. At home, Petitioner also engages in maladaptive behaviors such as [REDACTED]  
[REDACTED] against [REDACTED].

d. Petitioner needs [REDACTED]  
[REDACTED]

- e. [REDACTED] believes ABA therapy will help provide strategies to deal with Petitioner's behaviors.

8. Dr. Darling is a BCBA at the Doctoral level and Second Level Reviewer for eQHealth. Dr. Darling 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. As Dr. Darling testified, eQHealth uses a multi-level peer review process to determine if the requested ABA services meets the medically necessary criteria. See RCE 1 at 26.
- b. Three eQHealth reviewers agreed that Petitioner's provider submitted a Treatment Plan that did not meet the second, third, or fourth criteria for medical necessity. See RCE 2 at 7.
- c. Dr. Darling argued that the Treatment Plan does not meet standards of care in the field of ABA because it did not identify effective methods to meet Petitioner's needs and the procedures have no details on how to use them. See ¶ 12.
- d. The provider included a punishment procedure of "[REDACTED]" but did not have any safeguards prior to exhausting positive reinforcements, especially for an initial Treatment Plan, and is not an accepted ABA treatment. See RCE 1 at 177.
- e. The procedure of "[REDACTED]" is unclear and the remaining procedures have no explained purpose, or indicate when or how to implement them. *Id.*

- f. Dr. Darling explained that maladaptive behaviors are to be measured and tracked throughout the treatment plan with the author completing an assessment of each behavior to know why they are occurring.
- g. None except two of the replacement behaviors – i.e. “[REDACTED]” and “[REDACTED]” – are related to treating symptoms of [REDACTED], and have no function related to reducing Petitioner’s maladaptive behaviors. *Id.* at 169-175.
- h. Dr. Darling argued that the Treatment Plan teaches little on [REDACTED] and not likely to have any effect to decrease Petitioner’s maladaptive behaviors and to respond to prompt.

**CONCLUSIONS OF LAW**

- 9. The Agency’s Office of Fair Hearings has jurisdiction over the subject matter of this proceeding and the parties pursuant to section 409.285(2), Florida Statutes (2019). This order is the final administrative decision of AHCA under section 409.285(2)(a).
- 10. This hearing was held as a *de novo* proceeding pursuant to Florida Administrative Code Rule (“Fla. Admin. Code R. 59G-1.100(17)(b)”).
- 11. Because Petitioner requested 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.)

12. 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.)

...

#### **4.3 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.

...

#### **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, mechanical, 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

...

### **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 41-44.

13. 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.

14. 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.

15. 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.

16. 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.

*Id.* at 34.

17. In the instant case, Petitioner is under 21 years of age and is diagnosed with [REDACTED]. See ¶ 2. Petitioner requested ABA services. See ¶ 4-5. In a NOO, dated March 5, 2024, Respondent denied the services. See ¶ 4. Respondent cited to the lack of medical necessity as the basis for their decision, specifically that the requested ABA services must be "consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational." See ¶ 4-5. In addition, Respondent determined that the requested services were not "individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness under treatment, and not in excess of the patient's needs." See ¶ 4-5. The Definitions Policy defines a component of medical necessity as "consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational." See ¶ 15. 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 ¶ 13-14. Petitioner has the burden of proof to show by a preponderance of evidence that the Respondent's determination was incorrect. See ¶ 11.

18. Using a two-level review process, Respondent reviews behavior analysis requests to ensure ABA services are consistent with the standards enumerated in the Behavior Analysis

Coverage Policy as well as generally accepted professional medical standards in the field of behavior analysis. See ¶ 4-5, 8. The record shows that Petitioner engages in maladaptive behaviors that qualify for ABA services. See ¶ 3, 7-8. The Petitioner's maladaptive behaviors as indicated in the Treatment Plan include [REDACTED], [REDACTED], [REDACTED], [REDACTED], [REDACTED], [REDACTED], [REDACTED], [REDACTED], [REDACTED], and [REDACTED]. See ¶ 3. According to [REDACTED], Petitioner also engages in maladaptive behaviors such as [REDACTED] and [REDACTED] at home and against [REDACTED]. See ¶ 7.

19. The BA Policy maintains that the “[behavior] 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 ¶ 12.

20. At Fair Hearing, Dr. Darling contended that Petitioner's provider submitted a Treatment Plan that did not meet generally accepted professional standards. See ¶ 8. According to Dr. Darling's testimony, the Treatment Plan included an unacceptable punishment procedure, did not identify effective methods to meet Petitioner's needs, and the procedures have no details on how to use them, as written. See ¶ 8. Specifically, the provider's included punishment procedure of “[REDACTED]” is not an accepted ABA treatment where there are no safeguards prior to exhausting positive reinforcements, especially for an initial Treatment Plan. See ¶ 8, 12. Dr. Darling also explained that maladaptive behaviors are measured and tracked throughout the treatment plan with the author completing an assessment of each behavior to know why they are occurring. See ¶ 8, 12. The procedure of “[REDACTED]


██████████” is unclear and the remaining procedures have no explained purpose, or indicate when or how to implement them. See ¶ 8. Further, Dr. Darling argued that only two of the replacement behaviors (i.e. “██████████” and “██████████”) are related to treating symptoms of ██████████, and the remaining replacement behaviors have no function related to reducing Petitioner’s maladaptive behaviors. See ¶ 8. Overall, the Treatment Plan does not clearly address any of the issues presented by ██████████ such as Petitioner’s ██████████, decreasing Petitioner’s maladaptive behaviors, and responding to prompts. See ¶ 4-5, 7-8. The undersigned finds Dr. Darling’s testimony persuasive and consistent with the record to demonstrate that the Treatment Plan was not consistent with generally accepted professional medical standards within the field of behavior analysis. See ¶ 8, 12, 16. Based on these discrepancies, the undersigned finds that the Treatment Plan does not justify the requested services to implement ABA therapy effectively. See ¶ 3-5, 8, 12-16. All in all, the undersigned concludes that the request for ABA services was not supported by the documentation in the submitted Treatment Plan. See ¶ 3-5, 8, 12, 16.

21. 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 ABA services, with the treatment plan 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 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 30th day of July, 2024 in Tallahassee, Leon County, Florida.

 Kimberly Roche  
24-FH1054  
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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.

**COPIES FURNISHED TO:**



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