



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

FILED

Jul 16, 2024, 4:50 pm

OFFICE OF FAIR HEARINGS

[REDACTED]

PETITIONER,

AHCA Case No.: 24-FH1290

vs.

AGENCY FOR HEALTH CARE
ADMINISTRATION,

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic Fair Hearing on the instant case on July 2, 2024, at 1:01 p.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 request for additional 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.

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. David Bicard ("Dr. Bicard"), BCBA and Director of Clinical Operations for eQHealth Solutions Inc. ("eQHealth"), appeared as a witness for Respondent.

Prior to the hearing, Petitioner sent to the Office of Fair Hearings and Respondent a twenty (20)-page evidence packet. The twenty (20)-page evidence packet appears in the Office of Fair Hearings' document management system as the file titles "24-FH1290 Correspondence.pdf" and "24-FH1290 Evidence.pdf". Absent an objection from the Respondent, the undersigned admitted the twenty (20)-page evidence packet into evidence as Petitioner's Composite Exhibit 1 ("PCE 1").

Prior to the hearing, Respondent sent to the Office of Fair Hearings and Petitioner a one-hundred and sixty-six (166)-page evidence packet and a forty-nine (49)-page evidence packet. The one-hundred and sixty-six (166)-page evidence packet appears in the Office of Fair Hearings' document management system as the file titles "[REDACTED] FH 06.10.2024 1-98.pdf" and "[REDACTED] FH 06.10.2024 99-166.pdf". The forty-nine (49)-page evidence packet appears in the Office of Fair Hearings' document management system as the file title "24-FH1290 AHCA Evidence BA Services 49 Pages.pdf". Absent an objection from the Petitioner, the undersigned admitted the one-hundred and sixty-six (166)-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 the following: [REDACTED]
[REDACTED]
[REDACTED] *Id.*

3. As testified to by Dr. Bicard, in the prior authorization, Petitioner requested and was approved for the following ABA services: 1,768 units of code 97153; 208 units of code 97155; 208 units of code 97155(HN); 52 units of code 97156; and 52 units of code 97156 (HN).

4. Petitioner requested continuation of BA services; specifically, 3,120 units of code 97153; 416 units of code 97155; 416 units of code 97155 (HN); 104 units of code 97156; and 104 units of code 97156 (HN). In a Notice of Outcome ("NOO"), dated February 8, 2024, Respondent approved 2,080 units of code 97153; 208 units of code 97155; 208 units of code 97155 (HN); 104 units of 97156; and 104 units of 97156 (HN), but denied the remaining units. 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.

The NOO further provided:

PR Clinical Rationale – Denial: According to The Behavior Analysis Services Coverage Policy, (page 3, 2.2) the recipient of ABA therapy services must engage in maladaptive behavior that interferes with the recipient’s daily functioning. Although the recipient is engaging in topographies of maladaptive behaviors, the frequency and/or intensity of the maladaptive behaviors do not support the request for services. The current request is in excess of medically necessary BA services, BA services are approved at a lower level than requested.

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Pages 23 – 24 of RCE 1.

5. Petitioner requested reconsideration of the Respondent’s decision. In a Notice of Reconsideration Determination (“NRD”), dated February 15, 2024, Respondent upheld its decision. *Id.* at 36. The NRD explained the basis for the decision as follows:

PR Recon Determination: At reconsideration all documents were carefully reviewed. The provider did not submit any new documentation that supports the medical necessity of this request. According to The Behavior Analysis Services Coverage Policy, (page 3, 2.2) the recipient of ABA therapy services must engage in maladaptive behavior that interferes with the recipient’s daily functioning. Although the recipient is engaging in topographies of maladaptive behaviors, the frequency and intensity of the maladaptive do not support the request for services. This reconsideration request has been reviewed, reconsidered and the partial denial is upheld.

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Page 36 of RCE 1.

6. On April 19, 2024, Petitioner requested a Fair Hearing to challenge the denial of ABA services. *Id.* at 8. On June 17, 2024, the undersigned issued an Order Scheduling Fair Hearing by Telephone and Prehearing Instructions, setting the hearing for July 2, 2024, at 1:00 p.m. EST.

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

- a. [REDACTED] stated the hours were requested due to an increase in behavioral concerns. [REDACTED] stated Petitioner has increased in behaviors, and the provider has had to write incident reports of Petitioner being [REDACTED]. [REDACTED] See page 2 of PCE 1. Petitioner's provider has prescribed medication. *Id.* at 17, 20. Petitioner's parents cannot go into the community. Petitioner's maladaptive behavior data is becoming variable and increasing in some instances. *Id.* at 18. [REDACTED] stated it is difficult to get Petitioner back into the routine of therapy after a break, so more services were requested to provide a consistent week for Petitioner. Petitioner now has four five-hour days of service, and the provider wants to add another day. Petitioner is making progress, but with variable data. [REDACTED] stated the graphs from [REDACTED] are no longer relevant, and that Petitioner has twenty other goals not depicted in these graphs.

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

- a. The first level reviewer determined that the allocation of units exceeds the standard two to ten ratio, which is two hours of case management for every ten hours of therapy. See page 18 of RCE 1. The provider has requested eight hours of case management and thirty hours of therapy, which exceeds recommendations from the [REDACTED]. It was determined that these services should not exceed recommendations. Services were approved within the two to ten ratio.

- b. A BCBA at the doctoral level reviewed the case at second level, and services were approved, but not at the provider's requested level. Three hours per week of additional services were approved. The reconsideration reviewer agreed with the previous reviewer.
- c. [REDACTED] data show variability and the frequency is slightly decreasing throughout the authorization, showing progress with the units approved in the last authorization. *Id.* at 57. [REDACTED] worsens throughout the authorization, and the increase in frequency is not explained in the plan. *Id.* at 59. This appears to be a short term instance of higher frequencies, as the behavior decreases in the last weeks of the authorization. *Id.* [REDACTED] shows variability with no clear trend. *Id.* at 60. [REDACTED] shows high variability. *Id.* at 62. [REDACTED] shows variability, and the behavior is at a low frequency level between zero and nine. *Id.* at 63. [REDACTED] is not occurring at all, showing improvement. *Id.* at 65. The data support continuation of ABA services, and services were approved at a higher level than the last observation period.
- d. There is a limited number of skill acquisition goals, and some of the goals Petitioner can already do. Petitioner can [REDACTED]. *Id.* at 77. [REDACTED] is improving. *Id.* at 79. [REDACTED] is progressing very well. *Id.* [REDACTED]. *Id.* at 80, 81. [REDACTED] is progressing well. *Id.* at 83. [REDACTED]
[REDACTED]
[REDACTED]



CONCLUSIONS OF LAW

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

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

11. Because Petitioner is requesting a new service, Fla. Admin. Code R. 59G-1.100(17)(g) assigns the burden of proof to the Petitioner. 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 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
 - o 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
 - o 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
 - o Maximum group size is six recipients
 - o 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
 - o Maximum group size is six recipients
 - o 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
 - o The recipient may or may not be present depending upon clinical appropriateness.
 - o Services may be provided by Lead Analyst or BCaBA
 - o 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.

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 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.

15. 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.

16. 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.

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Page 3 of Authorization Policy.

17. In the instant case, Respondent denied Petitioner's request for additional ABA services. See ¶ 4. In the NOO dated February 8, 2024, Respondent explained that continuing services at the prior level was not medically necessary, specifically, that it did not meet the requirement that services must be "individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness under treatment, and not in excess of the patient's needs." *Id.* Respondent further explained that "the current request is in excess of medically necessary BA services." *Id.*

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. As provided in section 2.83 of the Definitions Policy, a component of medical necessity is that services must be "individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness under treatment, and not in excess of the patient's needs." As shown by the record, Petitioner's maladaptive behaviors show progress and variability, and Petitioner has made progress regarding ■ replacement behavior goals. See ¶ 8. Dr. Bicard provided credible testimony, based on the treatment plan submitted by the provider, that some of Petitioner's maladaptive behaviors are decreasing, occurring at low frequencies, or not occurring at all, while others show variability and increases in frequency. *Id.* Petitioner can also perform most of ■ replacement skills, and there is a limited number of these

skills. *Id.* Dr. Bicard asserted that Petitioner’s progress supports the continuation of ABA services, and services were approved at a higher level than in the last authorization period. *Id.* While [REDACTED] testified that Petitioner requires additional services and that there are other goals not included in the graphs, [REDACTED]’s evidence did not contain these additional goals. *Id.* As some maladaptive behavior goals and several replacement goals show progress, as Petitioner is working on a limited number of goals, and as services were approved at a higher level than in the last authorization, 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.


19. As QIO for the Agency, eQHealth is authorized to deny services when “there is a documented improvement in the recipient’s medical condition.” See ¶ 16. As discussed, *supra* ¶ 18, Petitioner’s behaviors exhibit progress across some maladaptive and several replacement behavior goals, and services were increased from the prior authorization. Here, the additionally requested services exceed medical necessity.

20. 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 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 16th day of July, 2024, in Tallahassee, Leon County, Florida.

 Laura Gallagher
for Alani Day 24-FH1290
2024.07.16 08:03:36
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ALANI DAY, 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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