



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

**FILED**

Jul 11, 2024, 1:18 pm  
OFFICE OF FAIR HEARINGS

[REDACTED],

PETITIONER,

AHCA Case No.: 24-FH1662

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 9:03 a.m. Eastern Standard Time ("EST").

**APPEARANCES**

For the Petitioner:

[REDACTED]

Petitioner's Authorized Representative

For the Respondent:

Doris Rivera

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 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 on behalf of Petitioner.

Doris Rivera (“Ms. Rivera”), Medical/Health Care Program Analyst for the Agency for Health Care Administration (“Agency” or “AHCA”), appeared on behalf of Respondent. Dr. Melissa Switzer (“Dr. Switzer”), Board Certified Behavior Analyst (“BCBA”) Doctoral Level and Second Level Reviewer 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 two-hundred and twenty (220)-page evidence packet and a forty-nine (49)-page evidence packet. The two-hundred and twenty (220)-page evidence packet appears in the Office of Fair Hearings’ document management system as the file titles: “[REDACTED] FH 07.02.2024 1-126.pdf”; “[REDACTED] FH 07.02.2024 127-179.pdf”; and “[REDACTED] FH 07.02.2024 180-220.pdf”. The forty-nine (49)-page evidence packet appears in the Office of Fair Hearings’ document management system as the file title “24-FH1662- AHCA Ev BA 49 pgs.pdf”. Absent an objection from the Petitioner, the undersigned admitted the two-hundred and twenty (220)-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]  
[REDACTED]. *Id.*

3. Petitioner requested BA services; specifically, 3,120 units of code 97153; 312 units of code 97155; and 208 units of code 97156. In a Notice of Outcome (“NOO”), dated May 8, 2024, Respondent denied Petitioner’s ABA services. *Id.* at 24. 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:

PR Clinical Rationale – Denial: According to the Behavior Analysis Services Coverage Policy (page 5, 4.2.2), treatment for behaviors must be tied to the function of maladaptive behaviors. The treatment must be individualized, specific, and meet generally accepted standards of care within the field of behavior analysis. The provider’s treatment plan includes a general listing of procedures for treatment plan that is not tied to behavioral function. The interventions cannot be implemented simultaneously. The treatment plan is not individualized for the recipient and does not meet generally accepted standards of care within the field of behavior analysis.

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. This request is denied.

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Pages 24 – 25 of RCE 1.

4. Petitioner requested reconsideration of the Respondent’s decision. In a Notice of Reconsideration Determination (“NRD”), dated May 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 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. This denial is upheld.

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Pages 36 – 37 of RCE 1.

5. On May 21, 2024, Petitioner requested a Fair Hearing to challenge the denial of ABA services. *Id.* at 8. On June 13, 2024, the undersigned issued an Order Scheduling Fair Hearing by Telephone and Prehearing Instructions, setting the hearing for July 2, 2024, at 9:00 a.m. EST. *Id.*

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

a. [REDACTED]  
[REDACTED] Petitioner went to another school, which complained of the same thing. [REDACTED] stated Petitioner’s school asked that [REDACTED] pick [REDACTED] up from school due to [REDACTED] behavior. Petitioner was out of school for two weeks. [REDACTED] stated that was when [REDACTED] sought behavioral services. [REDACTED] stated Petitioner had a [REDACTED]  
[REDACTED]

b. [REDACTED] stated Petitioner [REDACTED]  
[REDACTED]  
[REDACTED]  
[REDACTED] stated the principal provided a number for ABA services, as that was the

only way Petitioner would be accepted back to school. The neurologist provided a referral.

c. [REDACTED] stated Petitioner started therapy for one week and was able to return to school, but the therapist stopped coming and [REDACTED] received the denial.

[REDACTED] stated Petitioner is returning to school, but the school is asking if he has a therapist. [REDACTED] stated Petitioner's behaviors occur daily, and [REDACTED]

[REDACTED].

[REDACTED].

d. [REDACTED] stated the therapist went to the school twice and did the assessment.

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

a. The initial request for services was denied because the provider's documentation and data do not meet medical necessity and are outside of the standards of care of accepted medical practices. This treatment plan has been reviewed by three BCBA's at the Masters and Doctoral levels to determine medical necessity. This is an initial service request. The provider was authorized for an assessment.

b. The treatment plan is not individualized nor specific to the described symptoms, and is inconsistent with accepted medical practices. See page 20 of RCE 1. The professional code of ABA requires interventions to be based on direct observational assessment results. A comprehensive assessment describes specific levels of behaviors at baseline, which inform treatment goals. Measurement of behavior should be conducted through direct observation across repeated and

frequent direct observations. Multiple observational data points are crucial in ABA to determine the factors relevant to treatment. A single data point is not sufficient, nor consistent with accepted standards of care in ABA.

- c. The most recent plan submitted at reconsideration indicates that there was one date for observation conducted by the lead analyst in the school on [REDACTED], for two hours. *Id.* at 144. A single observation data point is insufficient in the scientific practices of ABA and is not consistent with standards of care. The plan lists other dates, but it is not clear what the dates refer to, and the dates do not have any data. *Id.* at 145. It does not appear that there were multiple repeated observations, as is consistent with standards of care.
- d. The single baseline data point for [REDACTED] is dated April 24, 2024, [REDACTED] occurrences per week. *Id.* at 146. The direct observation date earlier in the plan is [REDACTED]. *Id.* at 144. It seems the data collected on [REDACTED], were used to estimate a weekly value. The estimation does not meet medical necessity and is not individualized or consistent with symptoms or standards of care, as the behaviors occur daily. The weekly estimation for [REDACTED] is not individualized or specific to daily symptoms. *Id.* at 147. The same pattern of a weekly estimated baseline occurs for the remaining maladaptive behaviors. *Id.* at 148-152.
- e. The summary table for replacement skills shows multiple dates with no data, and it does not appear that multiple observations occurred. *Id.* at 153. A typical trial count in ABA is ten trials per day. [REDACTED] shows baseline [REDACTED] per week,

representative of a single day's worth of assessment for two hours, and the number of trials is unspecified. *Id.* The percentage was extrapolated from the single assessment to an overall weekly performance, which is presumptuous and does not meet standards of care. *Id.* The same weekly estimation is found for the remaining goals. *Id.* at 155-167. There should not be assumptions about skill performance.

### **CONCLUSIONS OF LAW**

8. 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).

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

10. 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.)

11. 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.

12. 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.

13. 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.

14. 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.

15. 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.

16. In the instant case, Respondent denied Petitioner’s request for ABA services. See ¶ 3. In the NOO dated May 8, 2024, Respondent explained that continuing services at the prior level was not medically necessary, specifically, that it did not meet the requirements that services must be “consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational”, as well as “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 treatment plan is not individualized for the recipient and does not meet generally accepted standards of care within the field of behavior analysis.” *Id.*

17. 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, two components of medical necessity are that services must be “consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational”, as well as “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, the provider's assessment did not meet medical necessity criteria, nor did it conform to standards of care within the field of ABA. See ¶ 7. Dr. Switzer provided credible testimony, based on the treatment plan submitted by the provider, that the baseline data were based on a single date of observation, which does not meet ABA standards. *Id.* Dr. Switzer also noted that the baseline data were estimations extrapolated from the single date of observation, which also falls below ABA standards. *Id.* The assessment also lacks multiple repeated observations, which are consistent with ABA standards of care. *Id.* While [REDACTED] testified to Petitioner's need for services to return to school *supra* ¶ 6, the information submitted by the provider does not meet medical necessity criteria. Furthermore, Petitioner bears the burden of proof in this case and did not submit any evidence to support the request for services. As the provider's treatment plan lacks multiple repeated observations consistent with Petitioner's daily symptoms, the treatment plan is not "individualized, specific, and consistent" with the Petitioner's treatment needs. Furthermore, as the treatment plan contains speculative, extrapolated data and indicates only one single date of direct observation, the treatment plan is not "consistent with generally accepted professional medical standards" in the field of ABA. As such, Petitioner has not demonstrated that the requested services are medically necessary.

18. As QIO for the Agency, eQHealth is authorized to deny services when "the reviewing physician determines the recipient will not gain any additional benefit by continuing services at the current level." See ¶ 15. As discussed, *supra* ¶ 17, the provider's treatment plan falls below

standards of care within the field of ABA. Here, the insufficiencies of the treatment plan are well documented.

19. 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 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 11th day of July, 2024, in Tallahassee, Leon County, Florida.



Alani Day  
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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:**



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