



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

FILED

Jan 17, 2023, 8:54 am  
OFFICE OF FAIR HEARINGS

[REDACTED]

PETITIONER,

AHCA Case No.: 22-FH1549

vs.

AGENCY FOR HEALTH CARE  
ADMINISTRATION,

RESPONDENT.

\_\_\_\_\_ /

**FINAL ORDER**

Pursuant to notice, the undersigned convened a telephonic Fair Hearing on the instant case on November 4, 2022 at 9:30 a.m. EST.

**APPEARANCES**

For the Petitioner:

[REDACTED]

Petitioner's Authorized Representative

For the Respondent:

Linda Latson  
Registered Nurse Specialist  
Agency for Health Care Administration

**STATEMENT OF ISSUE**

The issue is whether Respondent proved by a preponderance of the evidence that Respondent's termination of Behavior Analysis ("BA") services was correct.

**PRELIMINARY STATEMENT**

All parties appeared telephonically. Petitioner's Authorized Representative and [REDACTED],

[REDACTED], (" [REDACTED] "), appeared on behalf of the Petitioner.

Linda Latson, Registered Nurse Specialist for the Agency for Health Care Administration (“Agency” or “AHCA”), appeared on behalf of Respondent. Dr. David Bicard (“Dr. Bicard”), a Board-Certified Behavior Analyst at the doctoral level for eQHealth Solutions, Inc. (“eQHealth”), attended as a witness for Respondent.

Prior to hearing, Petitioner sent to the Office of Fair Hearings a three hundred and two (302)-page evidence packet. The evidence packet appears in the Office of Fair Hearings’ document management system as “22-FH1549 Case Evidence.pdf.” Absent an objection from Respondent, the undersigned admitted the three hundred and two (302)-page evidence packet into evidence as Petitioner’s Composite Exhibit 1.

The Petitioner also sent to the Office of Fair Hearings a four (4)-page evidence packet. The evidence packet appears in the Office of Fair Hearings’ document management system as “22-FH1549 Letter from School.pdf.” Absent an objection from Respondent, the undersigned admitted the four (4)-page evidence packet into evidence as Petitioner’s Composite Exhibit 2.

Prior to the hearing, Respondent sent to the Office of Fair Hearings and Petitioner a one hundred and sixty-one (161)-page evidence packet. The evidence packet appears as six files maintained in the Office of Fair Hearings’ document management system as: “██████████ FH 11.04.2022 1-45.pdf,” “██████████ FH 11.04.2022 46-73.pdf,” “██████████ FH 11.04.2022 74-103.pdf,” “██████████ FH 11.04.2022 104-122.pdf,” “██████████ FH 11.04.2022 123-148.pdf,” and “██████████ FH 11.04.2022 149-161.pdf.” Absent an objection from Petitioner, the undersigned admitted the one hundred and sixty-one (161)-page evidence packet into evidence as Respondent’s Composite Exhibit 1.

The Respondent also sent to the Office of Fair Hearings and Petitioner a forty-nine (49)-page evidence packet. The evidence packet appears in the Office of Fair Hearings' document management system as "22-FH1549 AHCA Evidence BA Svcs 49 Pages.pdf." Absent an objection from Petitioner, the undersigned admitted the forty-nine (49)-page evidence packet into evidence as Respondent's Composite Exhibit 2.

### **FINDINGS OF FACT**

1. Petitioner receives Medicaid services on a fee-for-service basis from the Agency. See Respondent's Composite Exhibit 1 at page 23. eQHealth is a Quality Improvement Organization ("QIO") contracted by the Agency to review prior authorization requests for services. See Respondent's Composite Exhibit 2 at page 2.

2. Petitioner is [REDACTED]-years old and diagnosed with [REDACTED]. See Respondent's Composite Exhibit 1 at page 16.

3. Petitioner receives Behavior Analysis services from [REDACTED] ("BA provider"). *Id.* at 16. The BA provider submitted a Behavior Analysis Reassessment/Support Plan ("Treatment Plan") requesting 416 units of Behavior Analysis - Lead Analyst ("Lead Analyst") services and 3,120 units of Behavior Analysis - Technician ("RBT") services. *Id.* at 23.

4. On July 14, 2022, Respondent issued a Request for Additional Information letter, which states, in pertinent part:

Provider, the recipient has participated in BA services with your company since [REDACTED]. During that time there has been little progress on goals. According to the Florida Medicaid State Plan (Appendix 9.3.b), the data provided must show evidence that the frequency of the maladaptive behavior(s) has decreased since the last review and, if not, that there is a modification of the behavior plan . . . The treatment modifications proposed in your plan appear insufficient. Please add any additional treatment

modification you are proposing Also, please submit a rationale for this request for services units. The justification submitted with the treatment is insufficient given the requested units and the recipient’s maladaptive behaviors and skill deficits. This request for services will not be approved with the current configuration of therapy units of service. Please check the request to make sure the units are correct or review plan and submit therapy hours that reflects standards of care within the field of behavior analysis.

*Id.* at 44. As Dr. Bicard testified, the provider did not respond to the request.

5. On July 26, 2022, Respondent issued a Notice of Outcome (“NOO”) reducing Petitioner’s BA services. *Id.* at 23-24. As established through testimony, Respondent denied all hours requested. The NOO states the following, in pertinent part:

Code:	H2019
Description:	Behavior Analysis – Lead Analyst
From:	7/9/22
Thru:	1/4/23
Total Units:	Denied – 416

Code:	H2014
Description:	Behavior Analysis – Technician
From:	7/9/22
Thru:	1/4/23
Total Units:	Denied – 3210

The reason for the denial is that the services are not medically necessary as defined in 59G-1.010, Florida Administrative Code. Specifically[,] the services are not medically necessary under the following standards:

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 or injury under treatment, and not in excess of the patient’s needs

The rationale for our decision is as follows:

PR Principal Reason - Denial:

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

PR Clinical Rationale - Denial: Required documentation not submitted as requested. The request for services is denied.

*Id.* at 23.

6. On August 5, 2022, Petitioner requested reconsideration. *Id.* at 32. On August 18, 2022, Respondent issued a Notice of Reconsideration Determination (“NRD”) upholding the termination of BA services. *Id.* at 32. The NRD states the following, in pertinent part:

The reason for the denial is that the services are not medically necessary as defined in 59G-1.010, Florida Administrative Code. Specifically[,] the services must be:

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 or injury under treatment, and not in excess of the patient’s needs.

The rationale for our decision is as follows:

PR Recon Determination: At reconsideration all documents were carefully reviewed. According to the Florida Medicaid State Plan (Appendix 9.3.b), the data provided must show evidence that the frequency of the maladaptive behavior(s) has decreased since the last review and, if not, that there is a modification of the behavior plan. The recommendations for procedural modifications include: additions/changes to treatment plan to impact behaviors targeted for reduction. Procedural modifications should include one or more of the following: antecedent manipulation modifications, modifications of prompting procedures used in acquisition, modifications in consequence-based strategies-- ones that either reduce maladaptive behavior or reinforce replacement behavior (e.g., manipulation of reinforcement schedules, switch to a different decelerative procedure), or if lack of progress was due to therapist error (e.g., poor data collection or poor training on intervention methods), how the provider will address human error. The provider has not addressed the lack of progress during the last observation period and did not amend the treatment plan in relation to the lack of progress or the recommendations are insufficient to support continued care. This reconsideration request has been reviewed, reconsidered and the denial is upheld.

*Id.* at 33.

7. On August 16, 2022, ██████████ requested a Fair Hearing on behalf Petitioner to dispute the termination of BA services. *Id.* at 8. On September 27, 2022, the undersigned Hearing Officer issued an Order Scheduling Fair Hearing by Telephone and Prehearing Instructions Order to the parties of record scheduling the Fair Hearing on November 4, 2022, at 9:00 a.m. EST. *Id.*

8. Based on Dr. Bicard’s testimony presented at the Fair Hearing, the effectiveness of BA therapy is determined by a visual interpretation of data graphs. Dr. Bicard testified that the Treatment Plan and additional information provided by the provider does not meet the standard of care for behavior therapy. Dr. Bicard asserted there was no baseline data or data graphs provided and that the only progress noted by the provider was in narrative form. Dr. Bicard stated that the provider was sent a request for additional information and there was no response by the provider to this request. Dr. Bicard stated that there was no functional assessment done and there were no function-based interventions found in the Treatment Plan.

9. ██████████ stated that the Petitioner is still actively displaying severe maladaptive behaviors and that ██████ believes ██████ needs to continue ABA therapy.

#### **CONCLUSIONS OF LAW**

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

11. This hearing was held as a *de novo* proceeding pursuant to Florida Administrative Code Rule (“Fla. Admin. Code R.”) 59G-1.100(17)(b), which states “[e]ach fair hearing shall be a de

novo, evidentiary proceeding, and shall be conducted in a manner that meets the requirements of this rule.”

12. The burden of proof in this proceeding is governed by Fla. Admin. Code R. 59G-1.100(17)(g), which provides as follows:

The burden of proof is on the party asserting the affirmative of an issue, except as otherwise required by statute. The burden of proof is on the Agency or plan, whichever is applicable, when the issue presented is the suspension, reduction, or termination of a previously authorized service. The burden of proof is on the recipient or enrollee, when the issue presented is the denial or a limited authorization of a service. The party with the burden of proof shall establish its position to the satisfaction of the Hearing Officer by a preponderance of the evidence.

13. In the instant case, Respondent terminated an existing service. As such, Fla. Admin. Code R. 59G-1.100(17)(g) assigns the burden of proof to the Respondent. The standard of proof in an administrative hearing is a preponderance of the evidence. The preponderance of the evidence standard requires proof by “the greater weight of the evidence” (Black’s Law Dictionary at 1201, 7th Ed.).

14. The Florida Medicaid Behavior Analysis Services Coverage Policy (“BA Policy”) (October 2017), incorporated by reference in Fla. Admin. Code. R. 59G-4.125, establishes the provision of BA services to Medicaid recipients under the age of 21 years. See Respondent’s Composite Exhibit 2, pages 38-47. The BA Policy provides as follows, in pertinent part:

**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.

...

**1.4.5 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 no duplicate another
- 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**

One per fiscal year, per recipient, when completed within 30 days of the start of the assessment.

##### **4.2.2 Behavior Analysis**

Up to 40 hours per week, per recipient, consisting of services identified on the recipient's behavior plan in order to reduce maladaptive behaviors and to restore the recipient to his or her best functional level. Services include:

- Implementing behavior analysis interventions, and monitoring and assessing the recipient's progress towards goals in the behavior plan
- Behavior analysis interventions, for example, discrete trial teaching, task analysis training, differential reinforcement, non-contingent reinforcement, conducting task analyses of complex responses, and teaching using chaining, prompting, fading, shaping, response cost, and extinction
- Training the recipient's family, caregiver(s), and other involved persons on the implementation of the behavior plan and intervention strategies (the recipient must be present when clinically appropriate)

#### **4.3 Early and Periodic Screening, Diagnosis, and Treatment**

As required by federal law, Florida Medicaid provides services to be 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 year 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 General Policies on authorization requirements.

Respondent's Composite Exhibit 2, pages 38-47.

15. Appendix 9.0 of the BA Policy provides the Review Criteria for Behavior Analysis Services.

*Id.* at 45-47. The Review Criteria state as follows:

#### **Review Criteria for Behavior Analysis Services**

Behavior analysis (BA) services are considered as either the treatment of choice or as an adjunct treatment modality for a variety of conditions and disorders where maladaptive behaviors are part of the recipient's clinical presentation, including behavioral manifestations of diagnoses such as autism spectrum disorder and other behavioral health conditions.

**Critical Elements Necessary for ANY Type of Behavior Analysis Service:**

The following critical elements **MUST** be satisfied to qualify for BA services:

- a. Eligibility – The recipient must meet all criteria for BA services as outlined in the Behavior Analysis Services Coverage Policy, Rule 59G-4.125, F.A.C.
- b. Medical necessity – The recipient must meet medical necessity criteria as outlined in Rule 59G-1.010, F.A.C.
- c. The recipient currently engages in maladaptive behaviors
- d. These maladaptive behaviors interfere with the recipient's daily functioning

...

**1. Criteria for Initial Behavior Analysis Assessment - BOTH** of the following **MUST** be satisfied:

- a. **ALL** critical elements are met
- b. Provide submits a valid written physician's order as stipulated in the Behavior Analysis Services Coverage Policy, Rule 59G-4.125, F.A.C.

...

**2. Criteria for Behavior Analysis Services and Reassessments – ALL** of the following **MUST** be satisfied:

- a. **ALL** critical elements are met
- b. An assessment or, if applicable, a reassessment, authored by a lead analyst, is provided. An assessment of the maladaptive behavior(s) is a necessary element of the process of identifying the frequency and magnitude of the behaviors as well as the variables associated with the occurrence of the maladaptive behavior(s). This helps in defining what are the functional consequences of the problem behavior(s) so that an adequate behavior plan can be implemented. This (re)assessment **MUST** include, at a minimum, **ALL** of the following:
  - i. A clear operational description of the maladaptive behavior(s)
  - ii. Baseline and/or updated treatment data (if reassessment)
  - iii. Progress toward identified goals (if a reassessment)
  - iv. Identification of the events, times, and situations that appear to be associated to the occurrence of the maladaptive behaviors

...

- c. A behavior plan authored or updated by a lead analyst. The behavior plan is the cornerstone of the delivery of behavior analysis services and it is based on the information obtained in the assessment. It proposes

specific interventions to reduce or eliminate the maladaptive behavior. These interventions take into consideration the variables, both present before the behavior, as well as after the behavior, that influence the occurrence of the maladaptive behavior(s). This plan also includes replacement appropriate behaviors for the recipient to engage in instead of the maladaptive behaviors in order to obtain the same function. The plan must be detailed enough to warrant the requested services and include mechanisms to monitor its effectiveness. This **MUST** include, at a minimum, **ALL** of the following:

- i. Observable and measurable descriptions of the maladaptive behavior(s)
- ii. Identified function of the maladaptive behavior(s) behavior as a result of the assessment or reassessment conducted
- iii. Goals and strategies for changing the maladaptive behavior(s)
- iv. Written detailed description of when, where, and how often these goals will be addressed and proposed strategies will be implemented
- v. System for monitoring and evaluating the effectiveness of the plan
- vi. Safety and crisis plan, if applicable
- vii. Summary and recommendations
- viii. Discharge criteria
- ix. Transition plan (if applicable)

NOTE: Although the assessment and behavior plan were addressed separately in section 2, both of them can be submitted as a single document.

...

**3. Criteria for Continuation of Treatment at the Present Level and/or Using Current Methods:** Providers must ensure that ALL of the following criteria are met to request continuation of treatments at the present level or using the current methods. If criteria for 3a is met, but criteria for 3b and/or 3c are not met, then a reduction of the treatment level and/or change of treatment methods may be warranted.

- a. ALL criteria listed in 2a, 2b, and 2c regarding critical elements, assessment or reassessment, and behavior plan, are met.
- b. The data provided must show evidence that the frequency of the maladaptive behavior(s) has decreased since the last review and, if not, that there is a modification of the behavior plan.
- c. The level of functional impairment justifies continuation of BA services. The reviewer utilizes the information provided below as a guide as it relates to the level of functional impairment as expressed through the following behaviors:
  - i. Safety – aggression, self-injury, property destruction, elopement

- ii. Communication – problems with expressive/receptive language, poor understanding or use of non-verbal communications, stereotyped, repetitive language
- iii. Self-stimulating, abnormal, inflexible, or intense preoccupations
- iv. Self-care – difficulty recognizing risks or danger, grooming, eating, or toileting
- v. Other – behaviors not identified above

...

**4. Criteria to Assess the Intensity of Behavior Analysis Services:** Providers may request up to 40 hours of BA services per week, per recipient, based upon the following:

**As a rule, higher number of maladaptive behaviors, higher severity and frequency of behaviors, as well as the multiplicity of settings where the behaviors occur, would usually justify a higher number of services hours. The greater the number of goals targeted to reduce maladaptive behaviors, the more the likelihood that a higher number of services hours could also be warranted.**

Providers **MUST** ensure that proper justification for the requested hours of services is adequately documented in the behavior plan. Based on the information provided in the assessment, behavior plan, and any other supporting documentation, the reviewer utilizes the information provided below as a guide as it relates to the level of functional impairment as expressed through the following behaviors:

- i. Safety – aggression, self-injury, property destruction, elopement
- ii. Communication – problems with expressive/receptive language, poor understanding or use of non-verbal communications, stereotyped, repetitive language
- iii. Self-stimulating, abnormal, inflexible, or intense preoccupations
- iv. Self-care - difficulty recognizing risks or danger, grooming, eating, or toileting
- v. Other – behaviors not identified above

**5. Criteria for Discharge from Behavior Analysis Services - ONE or MORE** of the following **MUST** be satisfied:

- a. The critical elements are no longer met.
- b. The data provided shows that the frequency and severity of maladaptive behavior(s) has declined to the point that they no longer pose a barrier to the child's ability to function in his/her environment.
- c. The data provided shows the recipient has made no progress toward any goals in the last 12 consecutive months.
- d. The level of functional impairment as expressed through behaviors no longer justifies continued BA services.
- e. Parent/guardian withdraws consent for treatment.

Respondent's Composite Exhibit 2, pages 45-47. (Emphasis added).

16. States must provide Early and Periodic Screening, Diagnostic, and Treatment ("EPSDT") services to Medicaid-eligible children under age 21 when requested under the Medicaid state plan. *See* 42 U.S.C. § 1396a(a)(43); 42 U.S.C. § 1396d(a)(4). According to 42 U.S.C. § 1396d(r)(5), EPSDT services mean, in relevant part, the following items and services:

Such other necessary health care, diagnostic services, treatment, and other measures described in subsection (a) of this section to correct or ameliorate defects and physical and mental illness and conditions discovered by the screen services, whether or not such services are covered under the state plan.

17. Petitioner is under the age of [REDACTED] ( [REDACTED] ) years, 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). Section 409.905(2), Florida Statutes, limits EPSDT services with a medical necessity standard:

The [Agency] shall pay for early and periodic screening and diagnosis of a recipient under age 21 to ascertain physical and mental problems and conditions and all services determined by the agency to be medically necessary for the treatment, correction, or amelioration of these problems and conditions, including personal care, private duty nursing, durable medical equipment, physical therapy, occupational therapy, speech therapy, respiratory therapy, and immunizations.

18. The Florida Medicaid Definitions Policy ("Definitions Policy") (August 2017), 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.

Respondent’s Composite Exhibit 2, page 23.

19. The Authorization Requirements Policy, incorporated by Fla. Admin. Code R. 59G-1.053, provides general requirements for providers to obtain authorization to render Florida Medicaid services. *Id.* at 30-37. The Authorization Requirements Policy states the following:

**1.2 Definitions**

The following definitions are applicable to this policy. For additional definitions that are applicable to all sections of Rule Division 59G, F.A.C., please refer to the Florida Medicaid definitions policy.

...

**1.3.1 Authorization**

The process of obtaining approval for reimbursement of a service based on medical necessity.

...

**1.3.6 Provider**

The term used to describe any entity, facility, person, or group that has been approved for enrollment or registered with Florida Medicaid.

**1.3.7 Quality Improvement Organization**

Entity designated to perform utilization review, quality assurance, and quality improvement activities for Florida Medicaid-covered services rendered by fee-for-service providers (also known as the QIO).

...

**2.0 Authorization Requirements**

...

**2.4.2 Requests for Additional Information**

The QIO may request additional information, as necessary, to determine medical necessity.

...

### **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.

##### **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 errors 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.

Respondent's Composite Exhibit 2, pages 30-36. (Emphasis added).

20. In the instant case, Petitioner is under the age of [REDACTED] and therefore EPSDT applies. Petitioner's BA provider requested the continuation of treatment for the certification period of July 9, 2022, through January 4, 2023. *See supra* ¶ 5-6. As established on the record, eQHealth terminated Petitioner's BA services after determining that the submitted information does not support the medical necessity for requested frequency and/or duration. *See supra* ¶ 5-6.

21. Pursuant to the BA Policy, the critical elements necessary for any type of BA service are as follows: (a) eligibility – the recipient must meet all criteria for Behavior Analysis services as outlined in the Behavior Analysis Services Coverage Policy, Rule 59G-4.125, F.A.C; (b) medical

necessity – the recipient must meet medical necessity criteria as outlined in in Rule 59G-1.010, F.A.C; (c) the recipient currently engages in maladaptive behaviors; and (d) these maladaptive behaviors interfere with the recipient’s daily functioning. *See supra* ¶ 15.

22. Pursuant to section 2.83 of the Definitions Policy, all five (5) conditions of medical necessity must be met in order for “medical or allied care, goods, or services furnished or ordered” to be medically necessary. *See supra* ¶ 14, 18. In this case, Respondent determined that the continuation of BA services is inappropriate because the requested services are not consistent with generally accepted professional medical standards. *See supra* ¶ 5, 6, 8.

23. Respondent terminated Petitioner’s BA services because the submitted documentation did not establish the medical necessity of the requested BA services. *See supra* ¶ 4-5. Based on the record, Respondent determined that the documentation did not meet the following medical necessity standards: 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; consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational. *See supra* ¶ 4-5. This medical necessity standard is expressly outlined in § 2.83 of the Definitions Policy and a critical element for BA services reassessments. *See supra* ¶ 17. The BA Policy mandates that the behavior plan must be detailed enough to warrant the requested intensity of BA services and include mechanisms to monitor and evaluate its effectiveness. *See supra* ¶ 13-14.

24. Dr. Bicard, a Board-Certified Behavior Analyst at the Doctoral level, provided credible and persuasive testimony that the requested BA services do not meet the standard of care for ABA therapy. *See supra* ¶ 4-5, 7. The documentation from the BA provider did not provide sufficient

justification for the requested number of Behavior Analysis service units. *See supra* ¶ 4-5. Dr. Bicard and ██████████ both agree that the recipient has displayed several maladaptive behaviors. *See supra* ¶ 7-8. Dr. Bicard also asserted that the Petitioner needs BA services, but the Treatment Plan submitted by the provider does not meet the standard of care. *See supra* ¶ 7. The provider had an opportunity to correct the deficiencies in the Treatment Plan but failed to do so. *See supra* ¶ 4.

25. An effective treatment plan is built around maladaptive behaviors (which decrease in frequency) and replacement behaviors (which increase in frequency) over the course of treatment, as evidenced in data graphs. *See supra* ¶ 13-14. Further, the effectiveness of a treatment plan is determined by reference to data graphs, which visually depict a child's progress over the course of treatment. *See supra* ¶ 13-14. The BA Policy requires that the data provided must show evidence that the frequency of the maladaptive behavior(s) has decreased since the last review and, if not, that there is a modification of the behavior plan. *See supra* ¶ 13-14. In this case, there was a lack of baseline data and a lack of appropriate data graphs demonstrating the frequency of maladaptive behaviors. *See supra* ¶ 4, 6, 8. The undersigned Hearing Officer found Dr. Bicard's testimony regarding the Treatment Plan and Petitioner's condition to be credible and persuasive.

26. Based on Dr. Bicard's professional assessment of the documentation provided and the providers failure to correct the documentation, Respondent proved by a preponderance of the evidence that the Treatment Plan does **not** meet the following medical necessity criteria: [c]onsistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational; and [i]ndividualized, specific, and

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

27. Pursuant the § 3.2.1 of the Authorizations Policy, "the QIO shall not deny or reduce the amount, frequency, or duration of a service that is already being provided, unless is a documented improvement in the recipient's medical condition." See supra ¶ 18. Due to the deficiencies in the Treatment Plan, and that the plan is not consistent with generally accepted medical standards, the record demonstrates that the Petitioner will not gain any additional benefit by continuing services at the current level. See supra ¶ 2-5, 8.

28. Accordingly, Respondent has met their burden of proof to show that continuation of the current level of BA services is no longer medically necessary. Looking at all the evidence relevant to the particular needs of Petitioner, Respondent demonstrated that the BA services at issue are not necessary to correct or ameliorate a defect or a physical and mental illness or condition.

29. Therefore, in light of both parties' testimony, Petitioner's Composite Exhibit 1, Petitioner's Composite Exhibit 2, Respondent's Composite Exhibit 1, Respondent's Composite Exhibit 2, and the applicable laws and policies, the undersigned Hearing Officer finds that Respondent *has* proven by a preponderance of the evidence that Respondent's termination of Petitioner's Behavior Analysis services was correct.

**IT IS HEREBY ORDERED AND ADJUDGED THAT:**

Respondent's termination of Behavior Analysis services is hereby **AFFIRMED**. Petitioner's request for relief is **DENIED**.

**DONE AND ORDERED** this 17th day of January 2023, in Tallahassee, Leon County, Florida.



Joseph Mabry  
22-FH1549  
2023.01.17  
07:05:42 -05'00'

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*for* LAURA GALLAGHER, Hearing Officer  
Agency for Health Care Administration  
Office of Fair Hearings  
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**NOTICE OF A RIGHT TO JUDICIAL REVIEW**

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

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