

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



FILED

Jan 30, 2023, 10:33 am

OFFICE OF FAIR HEARINGS

[REDACTED]

PETITIONER,

AHCA Case No.: [REDACTED]

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 7, 2022, at 9:34 a.m. Eastern Standard Time (“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 first issue is whether Respondent proved by a preponderance of the evidence that Respondent’s reduction of Petitioner’s [REDACTED] services was correct.

The second issue is whether Petitioner proved by a preponderance of the evidence that Respondent’s denial of Petitioner’s request for additional [REDACTED] services was incorrect.

**PRELIMINARY STATEMENT**

All parties appeared for the Fair Hearing telephonically. [REDACTED] Petitioner's Authorized Representative and [REDACTED], provided testimony on behalf of Petitioner. Marisa Burnham, Board Certified Behavior Analyst ("BCBA"), Natalie Houser, BCaBA, Darian Boyden, BCBA appeared as witnesses for Petitioner.

Linda Latson, Registered Nurse Specialist for the Agency for Health Care Administration ("Agency" or "AHCA"), appeared for the Fair Hearing as the representative for Respondent. Dr. David Bicard ("Dr. Bicard"), Board-Certified Behavior Analyst at the doctoral level ("BCBA-D") and Director of Clinical Operations for eQHealth, appeared as a witness for Respondent. Caylen Darbouze, Hearing Officer with AHCA, appeared as an observer.

Respondent introduced a seventy-seven (77)-page evidence packet. The evidence packet appears in the Office of Fair Hearings' case management system as "[REDACTED] FH 11.07.2022.pdf." Without objection the evidence packet was admitted into evidence as Respondent's Composite Exhibit 1. Respondent also introduced a forty-nine (49)-page evidence packet, which appears in the Office of Fair Hearings' case management system as "22-FH1558 AHCA Evidence BA Services 49 pgs.pdf." Without objection, the evidence packet was admitted into evidence as Respondent's Composite Exhibit 2.

### **FINDINGS OF FACT**

1. Petitioner receives Medicaid services on a fee-for-service basis through the Agency. See Respondent's Composite Exhibit 1 at page 16.
2. eQHealth is a Quality Improvement Organization ("QIO") contracted by Respondent to review prior authorization requests for services. See Respondent's Composite Exhibit 2 at page

2. Respondent, through contractual agreement, authorizes eQHealth to make medical necessity determinations for services requiring prior authorization, including BA services. *Id.*

3. Petitioner is a [REDACTED] diagnosed with [REDACTED]. See Respondent's Composite Exhibit 1 at page 16. Petitioner's BA provider identified the following maladaptive behaviors in the Individualized Treatment Plan ("Treatment Plan") at issue: [REDACTED] [REDACTED]. *Id.* at 49-53. The parties agree that Petitioner engages in [REDACTED] that threaten access to typical environments and negatively affect [REDACTED] activities of daily living. *Id.* at 22.

4. With regard to the maladaptive behavior, Dr. Bicard testified that the data graphs show improvement. Dr. Bicard established that Petitioner's incidents of [REDACTED] [REDACTED] are decreasing and occurring at a relatively low level. *Id.* at 49, 51, 53. Only Petitioner's incidents of [REDACTED] have increased during the course of treatment. *Id.* at 52.

5. With regard to the replacement behavior, Dr. Bicard testified that the data graphs show improvement. Dr. Bicard established that Petitioner's skill of [REDACTED] shows little progress. *Id.* at 55. However, Petitioner's other replacement behaviors show progress: [REDACTED] targets have been met for ACC Mands, LR 2M: [REDACTED] is almost mastered, VBMAPP Listener Responding 3M is close to mastered, Listener Responding 4M is close to mastered, and Track moving stimuli shows progress with three goals met. *Id.* at 55-59.

6. On July 22, 2022, Respondent issued a Notice of Outcome ("NOO") reducing Petitioner's BA services based on medical necessity. *Id.* at 21-22. The NOO states as follows:

Code: H2014 Behavior Analysis – Technician  
From: [REDACTED]

Thru: 7/31/2022  
Total Units Denied – [REDACTED]  
Total Units Approved – [REDACTED]

CodeH2012 Behavior Analysis-Assistant Analyst  
From: 7/9/2022  
Thru: 7/31/2022  
Total Units Approved - [REDACTED]

Code: H2019 Behavior Analysis – Lead Analyst  
From: 7/9/2022  
Thru: 7/31/2022  
Total Units Approved - [REDACTED]

The request for services is denied in whole or in part because they are not medically necessary as defined in Rule 59G-1.010, Florida Administrative Code. Specifically, the 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.

...

PR Principal Reason - Denial:

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

PR Clinical Rationale – Denial: According to the Florida Behavior Analysis Services Coverage Policy requests for services must be based on the medical necessity of the recipient’s maladaptive behaviors. The recipient is engaging in problem behaviors that threaten access to typical environments and negatively affects activities of daily living. However, the intensity of the recipient’s maladaptive behaviors does not justify the intensity of services requested. The provider is using a tiered service delivery model and has not made a compelling justification for services at the intensity requested. The requested hours of BA services are in excess of medical necessity.

*Id.*

7. On July 25, 2022, Respondent issued a Notice of Reconsideration Determination (“NRD”) upholding the reduction of BA services based on medical necessity. *Id.* at 32-33. The NRD states as follows:

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:

Individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness 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. The provider did not submit any new documentation that supports the medical necessity of this request. According to the Behavior Analysis Services Coverage Policy, (page6, 9.0.c-d) 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.

*Id.*

8. On August 18, 2022, [REDACTED] requested a Fair Hearing on Respondent's denial of additional BA services and reduction in BA services. *Id.* at 8. On September 29, 2022, the Office of Fair Hearings issued an order scheduling the Fair Hearing for November 7, 2022, at 9:30 a.m. Petitioner's previously approved BA services were continued pending the outcome of the Fair Hearing.

9. Dr. Bicard established that a BCBA and two BCBA's at the doctoral level reviewed the Treatment Plan and determined that the reduced services are sufficient to provide effective treatment to Petitioner. Further, 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. The effectiveness of a treatment plan is determined by reference to data, which is visually depicted in graphs showing a recipient's progress through treatment.

10. Dr. Bicard testified that he reviewed all documentation submitted by Petitioner. He agreed with the previous eQHealth reviewers that BA services are medically necessary for Petitioner; however, he asserted that the requested amount of BA services is not “individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness under treatment” and is “in excess of the patient’s needs” due to the amount of progress Petitioner has made over the course of treatment and [redacted] existing skills. On reconsideration, Petitioner’s provider did not submit any new documentation for consideration. Dr. Bicard stated that the authorized BA services are sufficient to effectively implement the Treatment Plan.

11. [redacted] testimony provided context regarding Petitioner’s treatment plan. [redacted] indicated that while data is collected daily and evaluated weekly, they observed monthly trends and that is why the monthly trends were reported. [redacted] indicated that lack of progress is attributable to staffing changes and time spent [redacted] Petitioner. [redacted] asserted that although Petitioner has had progress, [redacted] skills are comparable to that of a 2-4 year old.

#### **CONCLUSIONS OF LAW**

12. Pursuant to section 409.285(2), Florida Statutes (2019), the Agency’s Office of Fair Hearings has jurisdiction over the subject matter of this proceeding and the parties. This Final Order is the final administrative decision of AHCA.

13. Pursuant to Fla. Admin. Code R. 59G-1.100(17)(b), this hearing was held as a *de novo* proceeding.

14. Pursuant to Fla. Admin. Code R. 59G-1.100(17)(g), the burden of proof is 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 reduction 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.

15. With regard to issue one, because Respondent reduced an existing service, the burden of proof is on the Respondent as to the reduction in BA services. With regard to issue two, the burden of proof is on the Petitioner with regard to Petitioner's request for additional BA services. See Fla. Admin. Code R. 59G-1.100(17)(g). The standard of proof in an administrative hearing is a preponderance of the evidence. *Id.* The preponderance of the evidence standard requires proof by "the greater weight of the evidence" (Black's Law Dictionary at 1201, 7th Ed.).

16. The Behavior Analysis Coverage Policy ("BA Policy"), incorporated by reference in Fla. Admin. Code R. 59G-4.125, governs Behavior Analysis services available to Medicaid recipients in the State of Florida. See Respondent's Composite Exhibit 2 at pages 40 - 44. The BA Policy states as follows:

**1.0 Introduction**

Behavior analysis (BA) services are highly structured interventions, strategies, and approaches provided to decrease maladaptive behaviors and increase or reinforce appropriate behaviors.

**1.1 Florida Medicaid Policies**

This policy is intended for use by providers that render BA services to eligible Florida Medicaid recipients. It must be used in conjunction with Florida Medicaid's General Policies (as defined in section 1.3) and any applicable service-specific and claim reimbursement policies with which providers must comply.

Note: All Florida Medicaid policies are promulgated in Rule Division 59G, Florida Administrative Code (F.A.C.). Coverage policies are available on the Agency Web site at <http://ahca.myflorida.com/Medicaid/review/index.shtml>.

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**1.4 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.

#### **1.4.4 Lead Analyst**

Practitioner responsible for the implementation of BA services including: the completion and review of behavior assessments, reassessments, behavior plans, and behavior plan reviews.

#### **1.4.5 Medically Necessary/Medical Necessity**

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

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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:

##### **4.2.2 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 possible 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 eligible recipients under the age of 21 years, if such services are medically necessary to correct or ameliorate a defect, a condition, or a physical or mental illness. Included are diagnostic services, treatment, equipment, supplies, and other measures described in section 1905(a) of the Social Security Act, codified in Title 42 of the United States Code 1396d(a). As such, services for recipients under the age of 21 years exceeding the coverage described within this policy or the associated fee

schedule may be approved, if medically necessary. For more information, please refer to Florida Medicaid's General Policies on authorization requirements.

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## **6.0 Documentation**

### **6.1 General Criteria**

For information on general documentation requirements, please refer to Florida Medicaid's General Policies on recordkeeping and documentation.

...

### **6.2 Specific Criteria**

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

- Behavior assessment, and assessment review that must be reviewed and signed by a lead analyst;
- Behavior plan, and behavior plan review that must be reviewed and signed by a lead analyst;
- Notations when the recipient's family or caregiver is not able to participate in BA services, and instances when it was clinically inappropriate for the recipient to be present during training services; and
- Written physician's order.

...

## **7.0 Authorization**

### **7.1 General Criteria**

The authorization information described below is applicable to the fee-for-service delivery system. For more information on general authorization requirements, please refer to Florida Medicaid's General Policies on authorization requirements.

### **7.2 Specific Criteria**

Providers must obtain authorization from the quality improvement organization (QIO) prior to the initiation of BA services and at least every 180 days thereafter.

Providers may request authorization more frequently upon a change in the recipient's condition requiring an increase or decrease in services.

The QIO uses the review criteria specified in section 9.0 for the first level review. For more information on how the QIO uses the criteria in the review process, please refer to Florida Medicaid's General Policies on authorization requirements.

*Id.*

17. The BA Policy's Appendix states the following review criteria:

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 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 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.

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**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 behavior(s)
  - v. Identification of the functional consequences of the maladaptive behavior(s)
  - vi. Development of hypotheses and summary statements that describe the maladaptive behavior(s) and its(their) functions
  - vii. Summary and recommendations
- 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.

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**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 treatment 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

Respondent's Composite Exhibit 2 at pages 45-47.

18. 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.

19. Petitioner is under age 21, and therefore eligible for EPSDT services. However, a state may place appropriate limits on a service based on such criteria as medical necessity. *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.

20. The Florida Medicaid Definitions Policy (“Definitions Policy”) (August 2017), which is incorporated by reference in Fla. Admin. Code R. 59G-1.010, defines Medical Necessity as:

**2.83 Medically Necessary or Medical Necessity**

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 severe 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.

Definitions Policy at page 7.

21. The Florida Medicaid Authorization Requirements Policy (“Authorization Requirements Policy”) (June 2016), incorporated by reference in Fla. Admin. Code R. 59G-1.053, provides general requirements for providers to obtain authorization to render Florida Medicaid services.

The Authorization Requirements Policy states:

## **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.

Florida Medicaid Authorization Requirements Policy at pages 1-3.

22. Petitioner is under the age of 21 years and diagnosed with [REDACTED]. See supra ¶

3. The parties agree that Petitioner currently engages in maladaptive behaviors that interfere with [REDACTED] daily functioning. See supra ¶ 3. Respondent agreed that BA services are medically necessary for Petitioner, but Respondent determined that the BA provider submitted insufficient documentation to justify the level of BA services requested. See supra ¶ 6, 7.

23. Respondent reduced Petitioner’s BA services because the submitted documentation did not establish the medical necessity of the requested services. See supra ¶ 6, 7. Based on the record, Respondent determined that the documentation did not meet the following medical necessity standard: 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. See supra ¶ 6-7. This medical necessity standard is expressly outlined in section 2.83 of the Definitions Policy and a critical element for behavior analysis services reassessments. See supra ¶ 20. The BA Policy Appendix mandates that the treatment plan behavior plan is the cornerstone of the delivery of behavior analysis services, and the plan must be detailed enough to warrant the requested services and include mechanisms to monitor and evaluate its effectiveness. See supra ¶ 17. The Authorization Policy states that the QIO may deny a portion of the requested units of service if it cannot substantiate medical necessity based upon the information submitted. See supra ¶ 21.

24. Dr. Bicard, a BCBA-D provided credible and persuasive testimony that the requested BA services are not “individualized, specific, and consistent with symptoms or confirmed diagnosis

of the illness or injury under treatment,” and are “in excess of Petitioner’s needs.” *See supra* ¶ 4, 5, 9-10. The documentation in this case was also reviewed by two other BCBA-D’s at eQHealth who agreed that Petitioner’s provider did not provide sufficient justification for the requested number of BA service units. *See supra* ¶ 9.

25. The record demonstrates that the reduction in BA services is warranted in this case. 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. *See supra* ¶ 9. Further, the effectiveness of a treatment plan is determined by reference to data graphs, which visually depict a recipient’s progress over the course of treatment. *See supra* ¶ 9.

26. As the Treatment Plan and Dr. Bicard’s testimony reflect, the data graphs for maladaptive behaviors show improvement. Dr. Bicard established that Petitioner’s incidents of physical aggression, elopement, and property destruction are decreasing and occurring at a relatively low level. *See supra* ¶ 4. Only the data graph for Petitioner’s incidents of spitting show an increase during the course of treatment. *See supra* ¶ 4. Similarly, the data graphs show improvement on replacement behaviors. *See supra* ¶ 5. Petitioner’s replacement behaviors show progress as follows: three targets have been met for ACC Mands, LR 2M: Respond to Name is almost mastered, VBMAPP Listener Responding 3M is close to mastered, Listener Responding 4M is close to mastered, and Track moving stimuli shows progress with three goals met. *See supra* ¶ 5. Only the data graph for Petitioner’s replacement skill of Intraverbal: Yes shows little progress. *See supra* ¶ 5.

27. Dr. Bicard’s professional opinion, that the approved number of units is sufficient to treat Petitioner based on the Treatment Plan and Petitioner’s progress during treatment, is persuasive

in this case. Thus, the Respondent proved by a preponderance of the evidence that the Treatment Plan does *not* meet the following medical necessity criteria: 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.

28. Pursuant the Section 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 the reviewing physician determines the recipient will not gain any additional benefit by continuing services at the current level." *See supra* ¶ 21. As Dr. Bicard established that the reduced services are sufficient to provide effective treatment to Petitioner based on the Treatment Plan submitted, the record demonstrates that Petitioner would not benefit from continuing BA services at the current level and that the authorized reduction in the number of units are adequate to meet Petitioner's needs.

29. Accordingly, although Petitioner continues to need BA services, Respondent has met their burden of proof to show that continuation of the current level of BA services is not medically necessary. Looking at all the evidence relevant to the particular needs of Petitioner, the currently authorized level of BA services at issue is not necessary to correct or ameliorate a defect or a physical and mental illness or condition.

30. Accordingly, upon consideration of Respondent's Composite Exhibit 1, Respondent's Composite Exhibit 2, the testimony, and the applicable laws and policies, the undersigned concludes that Respondent proved by a preponderance of the evidence that the reduction of the BA services at issue was correct.

31. With regard to the second issue identified for resolution in this case, because Respondent demonstrated by a preponderance of the evidence that the reduction in BA services was correct, the record does not show that an increase in BA services was warranted. Therefore, Petitioner did not prove by a preponderance of the evidence that Respondent's denial of the requested additional BA services was incorrect.

**DECISION**

Respondent's reduction of Behavior Analysis services is **AFFIRMED**. Petitioner's appeal based on Respondent's reduction of Behavior Analysis services is **DENIED**.

Respondent's denial of additional Behavior Analysis services is **AFFIRMED**. Petitioner's appeal based on Respondent's denial is **DENIED**.

**DONE and ORDERED** this 30th day of January 2023, in Tallahassee, Leon County, Florida.



Laura Gallagher  
22-FH1558  
2023.01.30 06:51:17  
-05'00'

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**LAURA GALLAGHER, Hearing Officer**  
**Agency for Health Care Administration**  
**Office of Fair Hearings**  
**2727 Mahan Drive, Mail Stop # 11**  
**Tallahassee, FL 32308-5407**  
**Office: (850) 412-3649**  
**Fax: (850) 487-1423**  
**E-mail: OfficeOfFairHearings@ahca.myflorida.com**

**NOTICE OF A RIGHT TO JUDICIAL REVIEW**

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

ACCORDANCE WITH THE FLORIDA APPELLATE RULES. THE NOTICE OF APPEAL MUST BE FILED WITHIN 30 DAYS OF THE RENDITION OF THE ORDER TO BE REVIEWED.

**COPIES FURNISHED TO:**

[REDACTED]  
[REDACTED]  
[REDACTED]  
[REDACTED]

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