



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

FILED

Feb 17, 2023, 8:57 am  
OFFICE OF FAIR HEARINGS

[REDACTED]

PETITIONER,

AHCA Case No.: 22-FH1912

vs.

AGENCY FOR HEALTH CARE  
ADMINISTRATION,

RESPONDENT.

\_\_\_\_\_ /

**FINAL ORDER**

Pursuant to notice, Hearing Officer Caylen Darbouze convened a telephonic Fair Hearing in the instant case on January 6, 2023, at 8:30 a.m. Eastern Standard Time (“EST”).

**APPEARANCES**

For the Petitioner:

[REDACTED]

Authorized Representative

For the Respondent:

Lee Ann Williams  
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 denial of additional Behavior Analysis (“BA”) services was incorrect.

**PRELIMINARY STATEMENT**

All parties and witnesses appeared for the scheduled Fair Hearing telephonically. [REDACTED]

[REDACTED] (“[REDACTED]”), Petitioner’s Authorized Representative and [REDACTED], appeared for the Fair

Hearing on behalf of Petitioner, and provided testimony. Aliana Gurriss (“Ms. Gurriss”), Petitioner’s Board-Certified Behavior Analyst (“BCBA”), appeared for the Fair Hearing as a witness for Petitioner.

Les Ann Williams, a Medical Health Care Program Analyst and Fair Hearing Liaison for the Agency for Health Care Administration (“Agency” or “AHCA”), appeared for the Fair Hearing as representative for Respondent. Dr. Joseph Darling (“Dr. Darling”), Board-Certified Behavior Analyst at the doctoral level (“BCBA-D”) for eQHealth Solutions, appeared for the Fair Hearing as a witness for Respondent. Sandra Durden, Medical Health Care Program Analyst and Fair Hearing Liaison for the Agency, appeared for the Fair Hearing as an observer.

Interpreter George, ID No. 31578792 with Global Interpreting Network, provided translation services for Petitioner.

Petitioner did not introduce any exhibits at the Fair Hearing. Prior to the Fair Hearing, Respondent sent to the Office of Fair Hearings and Petitioner a 147-page evidence packet. The evidence packet appears in the Office of Fair Hearings case management system as “[REDACTED] 01.06.2023 1-74.pdf,” “[REDACTED] 01.06.2023 75-108.pdf,” and “[REDACTED] 01.06.2023 108-147.pdf.” Absent an objection, the evidence packet was admitted into evidence as Respondent’s Composite Exhibit 1.

Prior to the Fair Hearing, Respondent sent to the Office of Fair Hearings and Petitioner a 49-page evidence packet. The evidence packet appears in the Office of Fair Hearings’ case management system as “22-FH1912.pdf.” Absent an 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, pages 21, 48. eQHealth is a Quality Improvement Organization contracted by the Agency to review prior authorization requests for Medicaid services, including Behavior Analysis services, to ensure that the request meets medical necessity. See Respondent's Composite Exhibit 2, page 2.

2. As of the date of the Fair Hearing, Petitioner is [REDACTED] and diagnosed with [REDACTED]. See Respondent's Composite Exhibit 1, pages 21, 48, 49. Petitioner's BA provider is [REDACTED] ("[REDACTED]"). *Id.* at 21. As confirmed by Dr. Darling at the Fair Hearing, Petitioner began receiving BA services from [REDACTED] in October 2019. *Id.* at 49. Petitioner submitted a Behavior Analysis Reassessment ("Treatment Plan"). *Id.* at 49-145.

3. Petitioner engages in the following maladaptive behaviors: [REDACTED]; [REDACTED]; [REDACTED]; [REDACTED]; [REDACTED]; [REDACTED]; [REDACTED]; [REDACTED]; [REDACTED]; and [REDACTED]. *Id.* at 62-64. The data in the Treatment Plan indicate that Petitioner's maladaptive behaviors of [REDACTED], [REDACTED], [REDACTED], [REDACTED], [REDACTED], [REDACTED], [REDACTED], [REDACTED], and [REDACTED] have reduced in frequency (shown improvement) over the certification period. *Id.* at 42-99.

4. On October 13, 2022, Respondent issued a Notice of Outcome ("NOO") denying Petitioner's request for additional BA services. *Id.* at 26-27. In the NOO, Respondent approved the same intensity (30 hours per week) of BA services that Petitioner received in the last certification period. However, Respondent denied Petitioner's request to increase the intensity

of Registered Behavior Technician (“RBT”) services by 5 hours per week. The NOO states the following, in pertinent part:

Code: 97153  
Description: Intervention without protocol modification, per 15 minutes, Lead Analyst, BCaBA, or RBT  
From: 10/23/22  
Thru: 4/20/23  
Total Units: Denied – 520  
Approved – 2,600

Code: 97156  
Description: Family training, per 15 minutes, Lead Analyst  
From: 10/23/22  
Thru: 4/20/23  
Total Units: Approved – 104

Code: 97155  
Description: Intervention without protocol modification, per 15 minutes,  
From: 10/23/22  
Thru: 4/20/23  
Total Units: Approved – 312

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 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: PR DETERMINATION: Partial Denial

According to 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. 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 ABA services are more than medical necessity.

Respondent's Composite Exhibit 1, pages 26-27.

5. On October 17, 2022, Petitioner requested a reconsideration review. *Id.* at 37-38. On October 19, 2022, Respondent issued a Notice of Reconsideration Determination ("NRD") upholding the denial of additional BA services. *Id.* at 37-38. 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:

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. The provider did not submit any new documentation that supports the medical necessity of this request. According to The Behavior Analysis Services Coverage Policy, (page 6, 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.

Respondent's Composite Exhibit 1, pages 37-38.

6. October 14, 2022, [REDACTED] requested a Fair Hearing on behalf Petitioner concerning Respondent's denial of additional BA services. *Id.* at 19. On November 22, 2022, the undersigned Hearing Officer issued a Scheduling Order to all parties of record scheduling the Fair Hearing to be conducted by telephone on January 6, 2023, at 8:30 a.m. EST. *Id.* at 8-18.

7. Based on [REDACTED] testified that Petitioner is requesting to increase the intensity of BA services because Petitioner is growing as a teenager and need continuous assistance to reduce negative behaviors and learn positive behaviors. [REDACTED] acknowledged that the Petitioner has benefited from receiving BA services.

8. Ms. Gurriss testified that additional BA services will ensure that Petitioner continues making progress toward the goals identified in the Treatment Plan. Ms. Gurriss argued that the Treatment Plan establishes the medical necessity of the additional hours requested. Ms. Gurriss' recommendation for additional hours is based on her professional judgement and experience as Petitioner's BCBA.

9. Dr. Darling's testified that a medical necessity determination was made in this case based on eQHealth's review process and the Florida Medicaid Behavior Analysis Policy Criteria concerning the intensity of BA services. See supra ¶ 15. Dr. Darling determined that the requested additional RBT services are in excess of Petitioner's needs and not consistent with generally accepted professional medical standards established by the Florida Medicaid program. Based on Dr. Darling's review of the Treatment Plan, the Behavior Analysis provider is using the same treatment strategies it has used in the past, the data graphs for Petitioner's maladaptive behaviors show improvement through treatment, and no new treatment strategies were identified in the Treatment Plan. Dr. Darling opined that the Petitioner would not gain any additional benefit from increasing the treatment intensity from 30 hours per week of BA services to 35 hours per week of BA services considering the documented progress Petitioner has already achieved with 30 hours per week of BA services.

#### **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.

(Emphasis added).

13. In the instant case, Petitioner requested additional BA services. As such, 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.).

14. The Florida Medicaid Behavior Analysis Policy ("BA Policy"), incorporated by reference in Fla. Admin. Code. R. 59G-4.125, establishes the provision for Behavior Analysis services available

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 not 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.

See Respondent's Composite Exhibit 2, pages 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 21 years, and therefore EPSDT applies to [redacted] request for services. However, a state may place medical necessity limitations on EPSDT services. *See* 42 C.F.R. §§ 440.230(a), (b), (d). 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.

18. The Florida Medicaid Definitions Policy (“Definitions Policy”), incorporated by reference in Fla. Admin. Code R. 59G-1.010, states as follows, in pertinent part:

**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 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. See Respondent’s Composite Exhibit 2, pages 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.

20. In the instant case, Petitioner is under the age of 21 and therefore EPSDT applies to [REDACTED] request for the authorization of an additional 5 hours per week of BA services (“RBT services”) at issue. Petitioner’s BA provider submitted a request to eQHealth to increase the intensity of Petitioner’s Behavior Analysis services for the certification period of October 23, 2022, through April 20, 2023. *See supra* ¶ 4-5. As established on the record, eQHealth approved Petitioner to continue receiving BA services at the same intensity as last certification period, but denied Petitioner’s request to increase the intensity after determining that the documentation provided does not support the medical necessity for requested frequency and/or duration. *See supra* ¶ 4-5.

21. Pursuant to the BA Policy, the critical elements necessary for any type of BA service are: (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* ¶ 14-15. 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 service hours. *See supra* ¶ 15. Thus, as the frequency of maladaptive behaviors decrease, then the number of service hours would decrease. 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. *See supra* ¶ 14-15. Thus, as the recipient’s maladaptive behaviors decrease in frequency and replacement behaviors increase in frequency, there is an inference that service

hours will decrease. *See supra* ¶ 14 – 15. The Treatment Plan is the cornerstone of the delivery of BA services, and BA providers have the burden to ensure that proper justification for the requested intensity of services is adequately documented in the Treatment Plan. *See supra* ¶ 14-15. Dr. Darling, on behalf of eQHealth, provided credible and persuasive testimony that Petitioner met the criteria for continuing treatment at the present level and/or using current methods, but did not qualify for increasing the intensity of RBT services. *See supra* ¶ 9, 15. Based on Dr. Darling’s review of the Treatment Plan, the Behavior Analysis provider is using the same treatment strategies it has used in the past, the data for Petitioner’s maladaptive behaviors show improvement through treatment, and no new treatment strategies were identified in the Treatment Plan. *See supra* ¶ 9. Simply, the Behavior Analysis provider has not made a compelling justification for services at the intensity requested. *See supra* ¶ 4-5.

22. Pursuant to section 2.83 of the Florida Medicaid Definitions Policy, the five (5) conditions of Medical Necessity must be met for “medical . . . services furnished or ordered” to be determined medically necessary. *See supra* ¶ 18. Accordingly, all five (5) of the conditions must be met for eQHealth to approve requested Behavior Analysis services. In this case, Respondent determined that the request to increase the intensity of Behavior Analysis services is in excess of Petitioner’s needs based on the Treatment Plan. *See supra* ¶ 2-5, 8.

23. Based on Dr. Darling’s professional assessment that the approved treatment intensity is sufficient to treat Petitioner’s confirmed diagnoses, and Petitioner’s documented progress, the record demonstrates 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.” Ms. Gurriss testified

in support of the additional RBT hours at issue. However, “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.”

24. Accordingly, though Petitioner continues to need BA services, Petitioner *has not* met their burden of proof to show that the additional BA services are medically necessary. Looking at all the evidence relevant to the particular needs of Petitioner, the requested intensity of BA services at issue is not necessary to correct or ameliorate a defect or a physical and mental illness or condition.

25. Therefore, in light of both parties’ testimony, both parties’ admitted evidence, and the applicable laws and policies, the undersigned Hearing Officer finds that Petitioner did not prove by a preponderance of the evidence that Respondent’s denial of the additional BA services at issue was incorrect.

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

Respondent’s denial of additional Behavior Analysis services from October 23, 2022, through April 20, 2023, is hereby **AFFIRMED**. Petitioner’s request for relief is **DENIED**.

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

Laura Gallagher

22-FH1912



2023.02.17

07:51:47 -05'00'

---

**LAURA GALLAGHER, Hearing Officer**  
**Agency for Health Care Administration**  
**Office of Fair Hearings**  
**2727 Mahan Drive, Mail Stop # 11**

**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]

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