

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

FILED

MAY 31 2023

Agency For Health  
Care Administration

[REDACTED]

PETITIONER,

AHCA Case No.: 23-FH0206

vs.

AGENCY FOR HEALTH CARE  
ADMINISTRATION,

RESPONDENT.

\_\_\_\_\_

**FINAL ORDER**

Pursuant to notice, the undersigned Hearing Officer convened a telephonic Fair Hearing on the instant case on April 21, 2023, at 12:15 p.m. Eastern Standard Time ("EST").

**APPEARANCES**

For the Petitioner:

[REDACTED]

Petitioner's Authorized Representative

For the Respondent:

Sandra Durden  
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 Petitioner's request for additional Behavior Analysis ("BA") services (716 units of code 97155 and 203 units of code 97156) was incorrect.

**PRELIMINARY STATEMENT**

03/14  
All parties appeared for the Fair Hearing telephonically. [REDACTED] (" [REDACTED] ),  
Petitioner's Authorized Representative and BA provider at [REDACTED] appeared for  
the Fair Hearing to provide testimony on behalf of Petitioner.

Sandra Durden, Medical Health Care Program Analyst for the Agency for Health Care Administration ("Agency" or "AHCA"), appeared for the Fair Hearing as a 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 for the Fair Hearing as a witness for Respondent. Izzie Sizemore, Director of Training and Education with eQHealth, appeared as an observer for Respondent and did not testify.

Petitioner introduced a sixteen (16)-page evidence packet at the Fair Hearing. The evidence packet appears in the Office of Fair Hearings' case management system as "23-FH0206 Hearing Evidence.pdf." Absent an objection from Respondent, the evidence packet was admitted into evidence as Petitioner's Composite Exhibit 1.

Respondent introduced a one hundred and forty-three (143)-page evidence packet. The evidence packet appears in the Office of Fair Hearings' case management system as [REDACTED] FH 03.31.2023.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 "23-FH0206\_ AHCA Evidence.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 the 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. As of the date of the Fair Hearing, Petitioner is a [REDACTED] ([REDACTED]-old [REDACTED] diagnosed with [REDACTED]. See Respondent's Composite Exhibit 1 at page 16. Petitioner's BA provider, [REDACTED] identified the following maladaptive behaviors in the Behavior Plan/Assessment, signed [REDACTED], ("Treatment Plan"): [REDACTED]

[REDACTED] *Id.* at 96-97. The parties agree that Petitioner engages in maladaptive behaviors that threaten access to typical environments and negatively affect [REDACTED] activities of daily living. *Id.* at 34.

4. As Dr. Bicard testified, the most recent data graphs for Petitioner's maladaptive behaviors show progress overall since the treatment Plan was submitted. Dr. Bicard compared the data graphs submitted by Petitioner for hearing to the Treatment Plan data graphs and established the following: [REDACTED] are occurring infrequently or not at all; [REDACTED] occur at between [REDACTED] and [REDACTED] times per week with a slight increase overall; [REDACTED] is no longer being collected because it is occurring at such a low level or not at all; [REDACTED] occur at a low level or not at all; [REDACTED] occur at between [REDACTED] and [REDACTED] times per week with a slight increase overall; [REDACTED] occur at between [REDACTED] and [REDACTED] times per week or not at all; [REDACTED] occur at between [REDACTED] to [REDACTED] times per week; [REDACTED]

██████████ occur at between ██████ and ██████ times per week; ████████████████████ occur at between ██████ to ██████ times per week; and ████████████████████ occur at between ██████ to ██████ times per week ██████ but overall at a low level. See Petitioner’s Composite Exhibit 1 at pages 8-11 and Respondent’s Composite Exhibit 1 at pages 98-116.

5. As Dr. Bicard testified, the most recent data graphs for Petitioner’s replacement behaviors show overall improvement during the authorization period and since the Treatment Plan was submitted for review. ████████████████████ occurs at a high level of approximately ██████ ████████████████████ occurs at approximately ████████████████████ occurs at approximately ████████████████████ occurs at approximately ██████ to ██████ ████████████████████ occurs at around ██████ ████████████████████ and ████████████████████ occur at approximately ██████ to ██████ See Petitioner’s Composite Exhibit 1 at pages 12-16 and Respondent’s Composite Exhibit 1 at pages 116-126.

6. On February 2, 2023, Respondent issued a Notice of Outcome (“NOO”) approving a portion of Petitioner’s request for additional BA services and denying the balance of the request. *Id.* at 33-35. The NOO states as follows:

Code: 97153 Intervention without protocol modification, per 15 minutes, Lead Analyst, BCaBA, or RBT  
From: 12/19/22  
Thru: 6/16/23  
Total Units Denied – 996  
Total Units Approved – 2,600

Code: 97155 Intervention with protocol modification, per 15 minutes  
From: 12/19/22  
Thru: 6/16/23  
Total Units Denied – 718  
Total Units Approved - 312

Code: 97156 Family training, per 15 minutes, Lead Analyst  
From: 12/19/22  
Thru: 6/16/23  
Total Units Denied – 203  
Total Units Approved - 208

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.

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: 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.

*Id.*

7. On January 12, 2023, Petitioner requested reconsideration. *Id.* at 46. On February 2, 2023, Respondent issued a Notice of Reconsideration Determination ("NRD") upholding the denial of additional BA services based on medical necessity. *Id.* at 46-48. 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 submit 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. The current request is in excess of medically necessary BA services, but BA services are approved at a lower level than requested.

*Id.* at 47.

8. On February 1, 2022, ██████████ requested a Fair Hearing on Respondent's determination.

*Id.* at 8. After granting Petitioner's request for a continuance, the Office of Fair Hearings issued an order rescheduling the Fair Hearing for April 21, 2023, at 12:00 a.m.

9. Dr. Bicard testified that Petitioner requested an increase in BA services over the last authorization period. During the last authorization period, old codes were in use and Petitioner received 2,288 units of code H2019. This authorization period, new codes are in use and Petitioner received approval for 2,600 units of code 97153, 312 units of code 97155, and 208 units of code 97156. The total approved units represents an increase in BA services over the last authorization period. Petitioner requested an additional 716 units of code 97155 and 203 units of code 97156, which are the subject of this Fair Hearing.

10. Dr. Bicard testified that Petitioner has received BA services from this provider for ██████████

██████████ Dr. Bicard established that 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. 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. Based on the data graphs submitted by the provider for the hearing, Dr. Bicard concluded that Petitioner is responding well to treatment and has continued to improve, since the Treatment Plan was submitted, with the number of units approved for this authorization period. He concluded that based on the number of behaviors treated and the intensity of the behaviors, the request for additional services is in excess of Petitioner's needs.

11. [REDACTED] testified that the requested additional hours are medically necessary based on the intensity of Petitioner's behaviors. [REDACTED] testified that Petitioner's maladaptive behaviors of [REDACTED] or [REDACTED] create dangerous situations. Further, [REDACTED] asserted Petitioner's maladaptive behaviors increased with the introduction of a new speech therapist.

#### 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. Because Petitioner requested additional services in this case, the burden of proof is on the Petitioner. 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 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.

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### **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:

- 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.;
- 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.

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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.

...

**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 denied Petitioner's request for additional BA services because the submitted documentation did not establish the medical necessity of the requested level of 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. These medical necessity standards are expressly outlined in section 2.83 of the Definitions Policy and a critical element for behavior analysis services reassessments. *See supra* ¶ 17, 20, 21. The BA Policy mandates that the treatment plan must be detailed enough to warrant the requested services and include mechanisms to monitor and evaluate its effectiveness. *See supra* ¶ 17.

24. Dr. Bicard provided credible and persuasive testimony that the additional BA services at issue 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.

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. *See supra* ¶ 10. 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* ¶ 10. Comparing the data graphs Petitioner submitted for the hearing to

the data graphs in the Treatment Plan, Dr. Bicard demonstrated that Petitioner has improved maladaptive behaviors and replacement behaviors over the course of treatment and that Petitioner has continued to show improvement with the approved level of BA services. He concluded that the data demonstrate that treatment can be effectively delivered with the number and type of units that have been approved in this case. *See supra* ¶ 4, 5, 9-10.

26. Based on Dr. Bicard's professional opinion that the approved number of units is sufficient to treat Petitioner based on Petitioner's progress on maladaptive behaviors and replacement behaviors over the course of treatment is persuasive in this case. Thus, the record reflects that the additional services at issue are not individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and are in excess of the patient's needs.

27. In this case, Petitioner's provider recommended additional units of code 97155 and units 97156. 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. *See supra* ¶ 20.

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

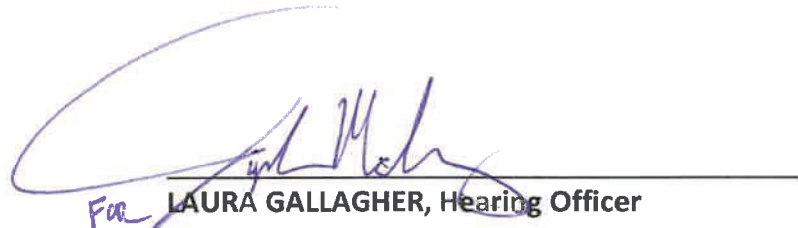
29. Accordingly, upon consideration of Petitioner's Composite Exhibit 1, Respondent's Composite Exhibit 1, Respondent's Composite Exhibit 2, the testimony, and the applicable laws

and policies, the undersigned concludes that Petitioner did not prove by a preponderance of the evidence that Respondent's denial of additional BA services at issue was incorrect.

**DECISION**

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

**DONE and ORDERED** this 31st day of May 2023, in Tallahassee, Leon County, Florida.

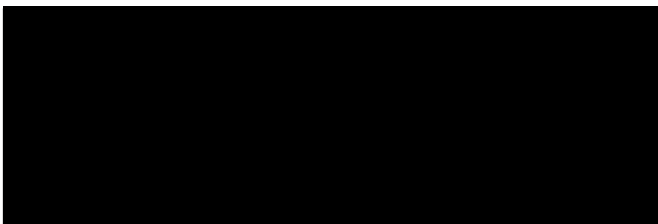


**For** LAURA GALLAGHER, Hearing Officer  
Agency for Health Care Administration  
Office of Fair Hearings  
2727 Mahan Drive, Mail Stop # 11  
Tallahassee, FL 32308-5407

**NOTICE OF A RIGHT TO JUDICIAL REVIEW**

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

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**MedicaidHearingUnit@ahca.myflorida.com**