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

FILED
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OFFICE OF FAIR HEARINGS

PETITIONER, **AHCA Case No.: 23-FH0291**

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 13, 2023, at 8:30 a.m. Eastern Standard Time ("EST").

APPEARANCES

For the Petitioner:
Petitioner's Authorized Representative

For the Respondent: Marielisa Amador
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 (752 units of code 97155) was incorrect.

PRELIMINARY STATEMENT

All parties appeared for the Fair Hearing telephonically. Petitioner's Authorized Representative and , appeared for the Fair Hearing to

provide testimony on behalf of Petitioner. [redacted] a Board Certified Behavior Analyst ("BCBA") with [redacted] provided testimony on behalf of Petitioner.

Marielisa Amador, 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.

Petitioner introduced an eight (8)-page evidence packet at the Fair Hearing. The evidence packet appears in the Office of Fair Hearings' case management system as "23-FH0291 Hearing Evidence.pdf." Absent an objection from Respondent, the evidence packet was admitted into evidence as Petitioner's Composite Exhibit 1.

Petitioner introduced a twenty-eight (28)-page evidence packet at the Fair Hearing. The evidence packet appears in the Office of Fair Hearings' case management system as "23-FH0291 Hearing Evidence(2).pdf." Absent an objection from Respondent, the evidence packet was admitted into evidence as Petitioner's Composite Exhibit 2.

Petitioner introduced an fifty-six (56)-page evidence packet at the Fair Hearing. The evidence packet appears in the Office of Fair Hearings' case management system as "23-FH0291 Hearing Evidence(3).pdf." Absent an objection from Respondent, the evidence packet was admitted into evidence as Petitioner's Composite Exhibit 3.

Respondent introduced an eighty-one (81)-page evidence packet. The evidence packet appears in the Office of Fair Hearings' case management system as "[redacted] FH

04.13.2023.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-FH0291 AHCA Evidence (Pages 1-49 of 49).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] diagnosed with [redacted] Disorder. *See* Respondent's Composite Exhibit 1 at page 16. Petitioner's BA provider, Adaptive LLC, identified the following maladaptive behaviors in the Functional Behavioral Assessment, signed November 16, 2022, ("Treatment Plan"): [redacted] *Id*. at 46. 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 31.

4. On January 4, 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 (752 units of code 97155). *Id.* at 30-32 The NOO states as follows:

> Code: 97155 Intervention with protocol modification, per 15 minutes
> From: 11/28/22
> Thru: 5/26/23
> Total Units Denied – 752
> Total Units Approved - 208
>
> Code: 97153 Intervention without protocol modification, per 15 minutes, Lead Analyst, BCaBA, or RBT
> From: 11/28/22
> Thru: 5/26/23
> Total Units Approved – 288
>
> 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 rational 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.

5. On December 12, 2022, Petitioner requested reconsideration. *Id.* at 41. On January 4, 2023, Respondent issued a Notice of Reconsideration Determination ("NRD") upholding the denial of additional BA services based on medical necessity. *Id*. at 41-43. 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 request does not meet medical necessity requirements and standards of care within the Behavior Analysis. All therapy hours must use the 97153-service code. Services cannot be approved based on the convivence [sic] of recipient, the provider, or the recipient's caretaker. This reconsideration request has been reviewed, and the partial denial is upheld.

Id. at 42.

6. On February 10, 2023, [redacted] requested a Fair Hearing on Respondent's determination. *Id.* at 8. On March 6, 2023, the undersigned issued an order rescheduling the Fair Hearing for April 13, 2023, at 8:30 a.m.

7. At the Fair Hearing, [redacted] testified that the additional units of BA service are medically necessary based on Petitioner's need for continuous repetition and the intensity of Petitioner's behaviors, [redacted]. [redacted] testified that Petitioner's maladaptive behaviors [redacted]. [redacted] testified that the units at issue were requested under code 97155 (case management) because the provider does not have a Registered Behavioral Technician ("RBT") who is qualified to work with Petitioner at this time.

8. Dr. Bicard testified that Petitioner requested 960 units of code 97155 case management services and 288 units of code 97153 therapy services. Dr. Bicard established that the BA standard of care is a 2 : 10 ratio of case management services to therapy services. Dr. Bicard testified that the requested units are inconsistent with this standard of care and in excess of Petitioner's need for case management. Dr. Bicard testified that the services at issue should be requested under the 97153 code for BA therapy services rather than case management.

CONCLUSIONS OF LAW

9. 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.

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

11. 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.

12. 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.).

13. The Behavior Analysis Services Coverage Policy (October 2017) ("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.
> **. . .**
> **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.
> . . .
> **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.

. . .

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.

14. The BA Policy's Appendix 9.0 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 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.

. . .

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 45-48.

15. 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.

16. 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.

17. 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.

18. 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.

19. 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 ¶ 4, 5.

20. Respondent denied Petitioner's request for additional BA case management services because the submitted documentation did not establish the medical necessity of the requested level of services. *See* supra ¶ 4, 5. Based on the record, Respondent determined that the documentation did not meet the following medical necessity standards: individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs; and consistent with generally accepted professional medical standards as determined by the Medicaid program. *See* supra ¶ 4, 5, 8, 17. 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 ¶ 14. 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 ¶ 14.

21. Dr. Bicard provided credible and persuasive testimony that the additional BA services at issue are in excess of Petitioner's case management need and not consistent with generally accepted professional standards of care in BA. *See* supra ¶ 8. Dr. Bicard established that the ratio of case management services to BA therapy services exceeds the professional standard ratio of 2 : 10 hours per week. [redacted] testified that the services at issue were requested under code 97155 because there is no RBT available to provide the therapy services and they are being provided instead by a BCBA. This testimony was not persuasive because, as Dr. Bicard testified, the BA service codes are based on what service (case management or therapy) is provided rather than who (BCBA or RBT) provides the services. [redacted] testified that in this case the Treatment Plan can be modified to correct this error and provide Petitioner with more units of BA therapy.

22. As previously stated, Petitioner's provider recommended additional 752 units of code 97155 case management services. 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 ¶17.

23. Accordingly, although Petitioner continues to need BA services, Petitioner has not met their burden of proof to show that the requested additional code 97155 case management services are medically necessary. Looking at all the evidence relevant to the particular needs of Petitioner, requested additional BA case management services at issue are not necessary to correct or ameliorate a defect or a physical and mental illness or condition.

24. Accordingly, upon consideration of Petitioner's Composite Exhibits 1-3, Respondent's Composite Exhibit 1-2, 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 1st day of June 2023, in Tallahassee, Leon County, Florida.

Joseph Mabry
23-FH0291
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***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