



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

FILED

Nov 27, 2023, 11:32 am
OFFICE OF FAIR HEARINGS

[REDACTED]

PETITIONER,

AHCA Case No.: 23-FH2095

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 October 6, 2023, at 9:22 a.m. Eastern Standard Time (“EST”).

APPEARANCES

For the Petitioner:

[REDACTED]

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 decision to deny Petitioner’s behavior analysis (“ABA” or “BA”) services was incorrect.

PRELIMINARY STATEMENT

All parties and witnesses appeared telephonically. [REDACTED] (“[REDACTED]”), Petitioner’s Authorized Representative and [REDACTED], appeared on behalf of Petitioner. Anouk

Herrera (“Ms. Herrera”), Lead Analyst with [REDACTED] (“provider” or “Petitioner’s provider”), appeared as a witness for Petitioner.

Linda Latson, Registered Nurse Specialist for the Agency for Health Care Administration (“Agency” or “AHCA”), appeared for the Fair Hearing as a representative for Respondent. Dr. Alissa Conway (“Dr. Conway”), Board-Certified Behavior Analyst at the Doctoral Level (“BCBA-D”) and Second Level Reviewer for eQHealth Solutions (“eQHealth”), appeared for the Fair Hearing as a witness for Respondent.

Migdalia, translator number 404579, and Mayra, translator number 401920, provided Spanish translation services during the hearing.

Prior to the Fair Hearing, Petitioner sent to the Office of Fair Hearings and Respondent a seven (7)-page evidence packet and a two (2)-page evidence packet. The seven (7)-page packet appears in the Office of Fair Hearings’ document management system as the file titled “23-FH2095 Evidence.pdf”. The two (2)-page packet appears in the Office of Fair Hearings’ document management system as the file titled “23-FH2095 Evidence(2).pdf”. Absent any objections from Respondent, the undersigned admitted the seven (7)-page evidence packet and the two (2)-page evidence packet as Petitioner’s Composite Exhibit 1 (“PCE 1”) and Petitioner’s Composite Exhibit 2 (“PCE 2”), respectively.

Prior to the Fair Hearing, Respondent sent to the Office of Fair Hearings and Petitioner a one hundred and forty-seven (147)-page evidence packet and a forty-nine (49)-page evidence packet. The one hundred and forty-seven (147)-page packet appears in the Office of Fair Hearings’ document management system as the file titled “[REDACTED] FH 10.06.2023.pdf”. The forty-nine (49)-page packet appears in the Office of Fair Hearings’ document management

system as the file titled "23-FH2095 AHCA Evidence BA Services 49 Pages.pdf". Absent any objections from Petitioner, the undersigned admitted the one hundred and forty-seven (147)-page evidence packet as Respondent's Composite Exhibit 1 ("RCE 1") and the forty-nine (49)-page evidence packet as Respondent's Composite Exhibit 2 ("RCE 2"), respectively.

FINDINGS OF FACT

1. Petitioner receives Medicaid services on a fee-for-service basis through the Agency. See RCE 1 at 21. eQHealth is a Quality Improvement Organization contracted by the Agency to review prior authorization requests for services. See RCE 2 at 2.

2. At the time of the hearing, Petitioner is [REDACTED]. See RCE 1 at 21. Petitioner is diagnosed with [REDACTED], [REDACTED], [REDACTED], [REDACTED], [REDACTED], and [REDACTED]. *Id.* at 21, 49.

3. As provided in the provider's Behavior Analysis Assessment ("Assessment"), dated [REDACTED], Petitioner is engaging in the following maladaptive behaviors: [REDACTED], [REDACTED], [REDACTED], [REDACTED], [REDACTED], [REDACTED], and [REDACTED]. *Id.* at 53 – 55.

4. As provided in the Assessment, Petitioner has made the following progress regarding [REDACTED] maladaptive behaviors, between [REDACTED]: for [REDACTED], Petitioner's incidents remained consistent at [REDACTED]; for [REDACTED], Petitioner's incidents remained consistent at [REDACTED]; for [REDACTED], Petitioner's incidents remained consistent at [REDACTED]; for [REDACTED], Petitioner's incidents increased remained consistent at [REDACTED]; for [REDACTED], Petitioner's incidents increased from approximately [REDACTED]; for [REDACTED],

Petitioner’s incidents increased from approximately [REDACTED]; for [REDACTED], space, Petitioner’s incidents remained consistent at [REDACTED]; and for [REDACTED], Petitioner’s incidents remained consistent at [REDACTED]. *Id.* at 61 – 65.

5. On August 4, 2023, Petitioner requested continuation of BA services with [REDACTED] previous ABA provider; specifically, 312 units of code 97155; 104 units of code 97156; and 3,120 units of code 97153. *See* RCE 1 at 27. In a Notice of Outcome (“NOO”), dated August 7, 2023, Respondent denied Petitioner’s request. *Id.* at 27 – 30. The NOO states as follows:

Code: 97153 Intervention without protocol modification, per 15 minutes, Lead Analyst, BCaBA, or RBT
From: 7/25/23
Thru: 1/20/24
Total Units: Denied 3,120

Code: 97155 Intervention without protocol modification, per 15 minutes
From: 7/25/23
Thru: 1/20/24
Total Units: Denied 312

Code: 97156 Family training, per 15 minutes, Lead Analyst
From: 7/25/23
Thru: 1/20/24
Total Units: Denied 104

The NOO explained the basis for the termination as follows:

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. Specially, 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 NOO further provided:

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: This request for services is denied. The previous Behavior Analysis services with this provider for this recipient were denied and updated at a Fair Hearing.

...

RCE 1 at 27 – 28.

6. In a Notice of Reconsideration Determination (“NRD”), dated August 29, 2023, Respondent upheld its decision. *Id.* at 38 – 41. The NRD explained the basis for the decision as follows:

PR Principal Reason – Denial

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

PR Clinical Rationale – Denial: This request for services is denied. The previous Behavior Analysis services with this provider for this recipient were denied and updated at a Fair Hearing.

...

RCE 1 at 39.

7. On August 28, 2023, Petitioner requested a Fair Hearing to challenge the termination BA services. On September 8, 2023, the Office of Fair Hearings issued an Order Scheduling Fair Hearing and Prehearing Instructions, setting the hearing for October 6, 2023, at 9:00 a.m. EST.

8. During the hearing, both parties agreed that the issue was the termination of behavior analysis services for Petitioner. However, upon review of the record and submitted evidence, Respondent denied Petitioner’s *new* request for BA services. As such, the Petitioner, not the Respondent, has the burden of proof regarding the *denial* of BA services.

9. [REDACTED], Petitioner’s [REDACTED], testified to the following:

- a. [REDACTED] referred to the photos [REDACTED] submitted regarding injuries [REDACTED] received from Petitioner and [REDACTED] caused by Petitioner. See PCE 1 at 1 – 7 and PCE 2 at 1 – 2.
- b. Petitioner has not received services since [REDACTED].
- c. The new behavioral analyst with the new plan was unable to prove the effectiveness of provider’s treatment because the benefits were cut off. The new analyst visited the house two (2) times for observation in [REDACTED].
- d. Petitioner has not demonstrated any improvement in behavior. Petitioner’s behaviors are increasing.

10. Ms. Herrera, Lead Analyst with Petitioner’s provider, testified as follows:

- a. Ms. Herrera only visited with Petitioner twice, only [REDACTED], and again the following week.
- b. Ms. Herrera collected data on the behaviors that Petitioner demonstrated.
- c. Ms. Herrera submitted the Assessment that has data collection from [REDACTED], to [REDACTED].
- d. The data in the Assessment graphs was collected by both Ms. Herrera and [REDACTED].
- e. There are no replacement behaviors in place at this time.

11. Dr. Conway is a BCBA and a Second Level Reviewer for eQHealth. Dr. Conway testified as follows:

- a. eQHealth is the quality improvement organization contracted by Florida Medicaid to review requests for BA services for medical necessity. Medical necessity means

that the medical or allied cares, goods, or services must meet the medical necessity criteria. Dr. Conway read the five (5) medical necessity criteria into the record.

- b. Dr. Conway reviewed the Criteria for Discharge from Behavior Analysis Services as stated in the Behavior Analysis Services Coverage Policy, *see* RCE 2 at 47, noting that a recipient of BA services can be discharged from BA services if the data provided shows the recipient has made no progress toward any goals in the last twelve (12) consecutive months. The provider's plan met criteria for discharge from behavior analysis services.
- c. Petitioner received services from this provider from [REDACTED] [REDACTED] for over [REDACTED]. The provider originally submitted a request for reauthorization dates of [REDACTED]. The request for services was denied, upheld at reconsideration, and the denial was affirmed at a hearing held on March 29, 2023, case number 23-FH0253. The provider submitted a new request for services between [REDACTED].
- d. Petitioner may qualify for behavior analysis services based on [REDACTED] maladaptive behaviors and skill deficits. The issue today is that the current provider was given over [REDACTED] to provide quality services. The provider did not do so by failing to address the lack of progress with sufficient modifications.
- e. Petitioner can see behavior analysis services from a different provider.
- f. The provider submitted data as new baseline levels. *See* RCE 1 at 119 – 121. This data was not collected by the provider. The data was collected by Petitioner's

caregiver, [REDACTED]. This does not meet the standard of care in the field of behavior analysis. The provider has removed all progress data throughout services and submitted data not collected by the provider.

- g. The provider was providing services to Petitioner for over [REDACTED] and was denied services. The provider has not submitted a new request without any previous progress data. The provider still has not addressed the lack of progress with sufficient modification.
- h. The treatment plan does not include data collected by the provider. The data is pertinent to collect and provide prior to creating treatment plans and implementing interventions. The current treatment plan does not meet the standard of care in the field of applied behavior analysis.

CONCLUSIONS OF LAW

12. 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 (2019). This order is the final administrative decision of AHCA under section 409.285(2)(a).

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

14. Because Petitioner requested a new service, Fla. Admin. Code R. 59G-1.100(17)(b) 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.).

15. The Florida Medicaid Behavior Analysis Services Coverage Policy (October 2017) (“BA Policy”), incorporated by reference in Fla. Admin. Code R. 59G-4.125, governs BA services available under Florida Medicaid. The BA Policy provides 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.

...

1.4.5 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:

4.2.1 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 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.

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

These 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)
- ...
- 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:

- vi. i. Safety - aggression, self-injury, property destruction, elopement
- vii. ii. Communication - problems with expressive/receptive language, poor understanding or use of
- viii. non-verbal communications, stereotyped, repetitive language
- ix. iii. Self-stimulating, abnormal, inflexible, or intense preoccupations
- x. iv. Self-care - difficulty recognizing risks or danger, grooming, eating, or toileting
- xi. 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.

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

When applicable, the recipient would be transitioned to other appropriate services.

...

RCE 2 at 45 – 47.

17. 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.

18. Petitioner is under age 21, and therefore EPSDT applies to 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.

19. Section 2.83 of the Definitions Policy, incorporated by reference in Fla. Admin. Code R. 59G-1.010, defines “Medically Necessary” or “Medical Necessity” as follows:

The medical or allied care, goods, or services furnished or ordered must meet the following conditions:

- Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate pain
- Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient’s needs
- Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational
- Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available statewide
- Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient’s caretaker, or the provider

The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services does not, in itself, make such care, goods or services medically necessary or a medical necessity or a covered service.

...

RCE 2 at 23.

20. The Florida Medicaid Authorization Requirements Policy (“Authorization Requirements Policy”) incorporated by reference in Fla. Admin. Code R. 59G-1.053, provides as follows:

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.

...

RCE 2 at 34.

21. In the instant case, Petitioner submitted a request for new BA services. *See* ¶ 5. In the NOO dated August 7, 2023, Respondent denied Petitioner's request. *See* ¶ 5. Respondent determined that Petitioner's request was not medically necessary, specifically, the request was not "[i]ndividualized, specific, and consistent with symptoms or confirmed diagnosis of the illness under treatment, and not in excess of the patient's needs". *See* ¶ 5, 6. Respondent further explained that "[s]ubmitted information does not support the medical necessity for requested frequency and/or duration" and that "previous Behavior Analysis services with this provider for this recipient were denied and upheld at a Fair Hearing." *See* ¶ 5, 6.

22. As Petitioner bears the burden of proof, Petitioner must show that is medically necessary for Petitioner to receive the requested service. As explained in Appendix 9.0 of the BA Policy, BA services may be discharged if the data provided shows the recipient has made no progress toward any goals in the last twelve (12) consecutive months. *See* ¶ 11, 16. Here, Dr. Conway provided uncontested testimony that Petitioner received services from this provider for over [REDACTED] and that the provider still has not addressed the lack of progress with sufficient modification. *See* ¶ 11. In fact, [REDACTED], Petitioner's [REDACTED], testified that Petitioner has not demonstrated any improvement in behavior and that Petitioner's behaviors are increasing. *See* ¶ 9. Regarding the new baseline data collected from [REDACTED], to [REDACTED] for the

new Assessment, Ms. Herrera testified that [REDACTED] and [REDACTED] both collected the data. However, Dr. Conway provided credible and persuasive testimony that data collected by the caregiver ([REDACTED]) and not collected by the provider (Ms. Herrera) does not meet the standard of care in the field of behavior analysis. See ¶ 10, 11.

23. As provided by the EPSDT requirements, the recipient must meet the medical necessity criteria as outlined in Fla. Admin. Code R. 59G-1.010. See ¶ 18, 19. As provided in section 2.83 of the Definitions Policy, a component of medical necessity is that services must be “consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational”. See ¶ 17. As shown by the record, Petitioner’s submitted assessment includes data that was collected by Petitioner’s [REDACTED] and caregiver, [REDACTED]. See ¶ 10, 11. Also, the record shows that Petitioner’s maladaptive behaviors have not improved in the last twelve (12) months. See ¶ 4, 9, and 11. Further, Ms. Herrera testified that there are no replacement behaviors currently in place for Petitioner. Dr. Conway explained that the provider has failed to address the lack of progress with sufficient modifications to its treatment plan and/or assessment. See ¶ 11. In all, based on Dr. Conway’s credible and convincing testimony, the lack of progress in Petitioner’s maladaptive behaviors, and Ms. Gonzale’s admissions, Petitioner has failed to demonstrate that the requested services are medically necessary.

24. Lastly, although the record reflects that Petitioner’s provider recommended the ABA services, the recommendation does not make the service a covered service. Section 2.83 of the Definitions Policy mandates that “[t]he 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 ¶ 19.

25. Upon consideration of the testimony provided, Petitioner’s Composite Exhibit 1, Petitioner’s Composite Exhibit 2, Respondent’s Composite Exhibit 1, Respondent’s Composite Exhibit 2, the EPSDT policy, and all other applicable polices, the undersigned concludes that Petitioner has not demonstrated that the requested behavior analysis services are necessary to correct or ameliorate a defect or a physical and mental illness or condition. Accordingly, Petitioner did not show that Respondent’s denial of behavioral analysis services was incorrect.

IT IS HEREBY ORDERED AND ADJUDGED THAT:

Respondent’s denial of BA services is **AFFIRMED**. Petitioner’s appeal based on Respondent’s denial of BA services is **DENIED**.

DONE AND ORDERED this 27th day of November, 2023 in Tallahassee, Leon County, Florida.

 Kameisha Presley
23-FH2095
2023.11.27
08:40:29 -05'00'

KAMEISHA PRESLEY, 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.

COPIES FURNISHED TO:



AHCA Medicaid Hearing Unit
MedicaidHearingUnit@ahca.myflorida.com