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

FILED
Dec 06, 2023, 3:59 pm
OFFICE OF FAIR HEARINGS

[redacted],

PETITIONER, **AHCA Case No.: 23-FH2281**

vs.

AGENCY FOR HEALTH CARE ADMINISTRATION,

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned Hearing Officer convened a telephonic Fair Hearing in the above-styled case on October 31, 20203, at 1:06 p.m. Eastern Standard Time (EST).

APPEARANCES

For the Petitioner: [redacted]
Petitioner's Authorized Representative

For the Respondent: Lee Ann Williams
Medical Health Care Program Analyst
Agency for Health Care Administration

STATEMENT OF ISSUE

The issue is whether Respondent proved by a preponderance of the evidence that Respondent's reduction of Petitioner's Behavior Analysis services was correct.

PRELIMINARY STATEMENT

All parties appeared for the Fair Hearing telephonically. [redacted] ("[redacted]"), Petitioner's Authorized Representative and Board Certified Behavior Analyst ("BCBA") at [redacted]., appeared for the Fair Hearing to provide testimony on behalf of Petitioner.

Lee Ann Williams, 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 and Director of Clinical Operations for eQHealth, appeared for the Fair Hearing as a witness for Respondent.

Interpreter Pedro, Spanish Interpreter number 262483 with Language Line Solutions, appeared for the hearing to provide language translation services for the Petitioner during the first half of the hearing. Interpreter Omer, Spanish Interpreter number 363258 with Language Line Solutions, appeared for the hearing to provide language translation services for the Petitioner during the second half of the hearing.

Petitioner did not introduce any exhibits at the Fair Hearing. Respondent introduced a one hundred and ninety-seven (197) page evidence packet. The evidence packet appears in the Office of Fair Hearings' case management system as "[redacted] FH 10.31.2023 1-127.pdf" and "[redacted] FH 10.31.2023 128-197.pdf." Absent an objection from Petitioner, the undersigned admitted the evidence packet into evidence as Respondent's Composite Exhibit 1.

Respondent also introduced a forty-nine (49)-page evidence packet. The evidence packet appears in the Office of Fair Hearings' case management system as "23-FH2281 Agency Evidence Legal Authorities 49 pages.pdf." Absent an objection from Petitioner, the undersigned admitted the evidence packet 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 21.

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 the Behavior Analysis ("BA") services at issue. *Id.*

3. Petitioner is [redacted] diagnosed with [redacted]. *See* Respondent's Composite Exhibit 1 at page 21. Petitioner's BA service provider, [redacted] identified the following behaviors as maladaptive: [redacted], and [redacted]. *Id*. at 140-143. As Dr. Bicard testified, Petitioner has received BA services from [redacted]. ("provider") since [redacted]. Petitioner's maladaptive behavior has improved during the course of treatment, and Respondent concluded that Petitioner would benefit from receiving BA services at a reduced level. *Id*. at 28.

4. On July 18, 2023, Respondent issued a Notice of Outcome ("NOO") reducing Petitioner's Behavior Analysis services based on medical necessity criteria. *Id.* at 28. The NOO states as follows:

> Code: 97155 Intervention with protocol modification, per 15 minutes
> From: 07/17/2023
> Thru: 1/12/2024
> Total Units: Approved – 104
>
> Code: 97156 Family training, per 15 minutes, Lead Analyst
> From: 07/17/2023
> Thru: 1/12/2024
> Total Units: Denied - 26
> Total Units: Approved – 78

Code: 97155 HN Intervention with protocol modification, per 15 minutes
From: 07/17/2023
Thru: 1/12/2024
Total Units: Approved – 312

Code: 97156 HN Family training, per 15 minutes, Lead Analyst
From: 07/17/2023
Thru: 1/12/2024
Total Units: Denied - 26
Total Units: Approved – 78

Code 97153 Intervention without protocol modification, per 15 minutes, Lead Analyst, BCaBA, or RBT
From: 07/17/2023
Thru: 1/12/2024
Total Units: Denied – 624
Total Units: Approved – 2,496

The request for services is denied in whole or in part because they are not medically necessary as defined in Fla. Admin. Code R. 59G-1.010 (166). Specifically, the requested services are not medically necessary under the following standard(s):

Individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs.

The rationale for our decision is as follows:
. . .
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 and skill deficits. The recipient is engaging in problem behaviors that threaten access to typical environments and negatively affects activities of daily living. However, the frequency, intensity, or severity of the recipient's maladaptive behaviors does not justify the requested units of services. The requested units of BA services are in excess of medical necessity.

Id. at 28 - 29.

5. Petitioner appealed the Agency's determination. On September 9, 2023, Respondent issued a Notice of Reconsideration Determination ("NRD") upholding the reduction of Behavior Analysis services based on medical necessity criteria. *Id*. at 40-42. The NRD states as follows, in pertinent part:

> The reason for the denial is that the services are not medically necessary as defined in 59G-1.010, Florida Administrative Code. Specifically the services must be:
>
> Individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness 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. Based on the information submitted for review at reconsideration, additional units of services are approved. However, although the recipient is engaging in topographies of maladaptive behaviors, the frequency and intensity of the maladaptive do not support the request for service. The current requested is in excess of medically necessary for BA services.

Id. at 40-41.

6. On September 7, 2023, Petitioner requested a Fair Hearing to contest Respondent's reduction of BA services. *Id*. at 8. Specifically, Petitioner's BA services were reduced as follows: 26 units of code 97156, 26 units of code 97156 HN, and 624 units of code 97153. *Id.* at 28, 40. The undersigned issued a Scheduling Order scheduling the hearing to be conducted by telephone on October 31, 2023, at 1:00 p.m. EST. *Id*. at 8-19. Administrative approval of BA services was granted pending the outcome of the Fair Hearing. *Id*. at 23.

7. At the Fair Hearing, Dr. Bicard testified that the previously approved level of BA services are no longer "individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment," and are "in excess of" Petitioner's needs due to [redacted]

progress achieved though treatment. As a result, approximately twenty-three (23) hours of BA services per week were authorized and 6 hours were denied. Additionally, 1.5 hours per week of caregiver training was authorized and one-half hour was denied. Dr. Bicard agreed with the three previous eQHealth reviewers that the intensity of Petitioner's maladaptive behaviors does not justify the amount of units requested in the Treatment Plan.

8. As Dr. Bicard testified, the Treatment Plan contains a table of the most recent data on Petitioner's maladaptive behaviors, which were targeted for reduction by the provider. The table describes Petitioner's progress on maladaptive behaviors as follows: [redacted] has decreased by [redacted] over baseline; [redacted] has improved by [redacted] over baseline; [redacted] has improved by [redacted] over baseline; [redacted] has improved [redacted] over baseline; [redacted] have improved by [redacted] over baseline; [redacted] has improved by [redacted] over baseline; and [redacted] has improved [redacted] over baseline. *Id*. at 140-141. Dr. Bicard asserted that it is unclear how the provider is measuring [redacted] and how it differs from [redacted], but [redacted] has improved as well. Similarly, [redacted] is overlaps with [redacted] but it has decreased as well. Finally, Dr. Bicard questioned the credibility of the two new maladaptive behaviors identified in the Treatment Plan as it is very rare for new maladaptive behaviors to emerge and occur at a high severity level after [redacted] of treatment have elapsed and when every other maladaptive behavior is declining in frequency. One example is [redacted], which is identified as a new maladaptive occurring at a rate of [redacted] times per week. Dr. Bicard also concluded that Petitioner is making progress on replacement

behaviors according to the Treatment Plan. Finally, Dr. Bicard testified that the Treatment Plan inappropriately included caregiver goals regarding data collection. *Id*. at 179. He asserted that the goal of caregiver training is to assist the caregiver in learning to better interact with the child and not collect data. Based on all of the information supplied by the provider, Petitioner's significant progress, and standards of care in the field of BA, Dr. Bicard concluded that the requested BA units at issue were in excess of Petitioner's needs.

9. [redacted] testified regarding the environmental factors that affect Petitioner's treatment. [redacted] testified that Petitioner primarily [redacted]. Petitioner lives with [redacted] parents and [redacted] who has [redacted]. [redacted] testified that Petitioner school environment does not contribute to [redacted] improvement. [redacted] asserted that the new maladaptive behaviors identified in the Treatment Plan are a result of a difficult family environment and Petitioner's limited communication skills.

CONCLUSIONS OF LAW

10. 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. This Final Order is the final administrative decision of the Agency.

11. Pursuant to Rule 59G-1.100(17)(b), Florida Administrative Code ("F.A.C."), this hearing was held as a *de novo* proceeding.

12. Pursuant to Rule 59G-1.100(17)(g), F.A.C., 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.

13. Because Respondent reduced an existing service, the burden of proof is on the Respondent. *See* Rule 59G-1.100(17)(g), F.A.C. 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.).

14. The Behavior Analysis services Coverage Policy ("BA Policy"), incorporated by reference in Rule 59G-4.125, F.A.C., governs Behavior Analysis services available to Medicaid recipients in the State of Florida. *See* Respondent's Composite Exhibit 2 at page 38. 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.

Respondent's Composite Exhibit 2 at pages 40-42.

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

Behavior analysis (BA) services are considered as either the treatment of choice or as an adjunct treatment modality for a variety of conditions and disorders where maladaptive behaviors are part of the recipient's clinical presentation, including behavioral manifestations of diagnoses such as Autism Spectrum Disorder and other behavioral health conditions.

Critical Elements Necessary for ANY Type of Behavior Analysis Service:

The following critical elements **MUST** be satisfied to qualify for BA services:

a. Eligibility – the recipient must meet all criteria for Behavior Analysis services as outlined in the Behavior Analysis Services Coverage Policy, Rule 59G-4.125, F.A.C.;
b. Medical necessity – the recipient must meet medical necessity criteria as outlined in 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 <u>evidence that the frequency of the maladaptive behavior(s) has decreased</u> since the last review and, if not, that there is <u>a modification of the behavior plan</u>.

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

Respondent's Composite Exhibit 2 at pages 45-48.

16. States must provide Early and Periodic Screening, Diagnostic, and Treatment ("EPSDT") services to Medicaid-eligible children under age 21 when requested under the Medicaid state plan. *See* 42 U.S.C. § 1396a(a)(43); 42 U.S.C. § 1396d(a)(4). According to 42 U.S.C. § 1396d(r)(5), EPSDT services mean, in relevant part, the following items and services:

> Such other necessary health care, diagnostic services, treatment, and other measures described in subsection (a) of this section to correct or ameliorate defects and physical and mental illness and conditions discovered by the screen services, whether or not such services are covered under the state plan.

17. Petitioner is under age 21, and therefore eligible for EPSDT services. However, a state may place appropriate limits on a service based on 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.

18. The Florida Medicaid Definitions Policy ("Definitions Policy") (August 2017), which is incorporated by reference in Rule 59G-1.010, F.A.C. defines Medically Necessary or 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.

19. The Florida Medicaid Authorization Requirements Policy ("Authorization Requirements Policy") (June 2016), incorporated by reference in Rule 59G-1.053, F.A.C., 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.

Respondent's Composite Exhibit 2 at pages 31-

20. Petitioner is under the age of 21 years and diagnosed with [redacted]. *See* supra ¶ 3. Petitioner currently engages in maladaptive behaviors that interfere with [redacted] daily functioning. *See* supra ¶ 3. Respondent agrees that Petitioner should receive Behavior Analysis services but argues that the Behavior Analysis provider submitted insufficient documentation to justify the level of services requested. *See* supra ¶ 4 – 5, and 9.

21. Respondent reduced Petitioner's Behavior Analysis services based on medical necessity criteria. *See* supra ¶ 4 - 5, and 7-8. Respondent determined that the submitted Treatment Plan did not meet the following medical necessity standard: services must be individualized, specific,

and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs. *See* supra ¶ 4 - 5. This medical necessity standards is expressly outlined in section 2.83 of the Definitions Policy. *See* supra ¶ 18. The BA Policy mandates that the behavior plan must be detailed enough to warrant the requested services and include mechanisms to monitor its effectiveness. *See* supra ¶ 15. Further, the Authorization Requirement Policy permits eQHealth to reduce the amount or frequency of a service when there is a documented improvement in the recipient's medical condition or the reviewing physician determines that the recipient will not gain any additional benefit by continuing services at the current level. *See* supra ¶ 19.

22. In this case, Dr. Bicard provided credible and persuasive testimony that the previously approved level of BA service is "in excess of Petitioner's needs." *See* supra ¶ 8. Dr. Bicard agreed with three eQHealth reviewers that the documentation provided shows that Petitioner has made significant progress during the course of BA treatment. For example, with regard to maladaptive behaviors targeted for reduction, the Treatment Plan contains a table of the most recent data. *See* supra ¶ 8. The table shows that [redacted] has decreased by [redacted] over baseline, [redacted] has improved by [redacted] over baseline, [redacted] has improved by [redacted] over baseline, [redacted] has improved [redacted] over baseline, [redacted] have improved by [redacted] over baseline, [redacted] has improved by [redacted] over baseline, and [redacted] has improved [redacted] over baseline. *See* supra ¶ 8. Replacement behavior similarly show improvement throughout treatment. *See* supra ¶ 8. Although new maladaptive behaviors appeared in the

Treatment Plan, Dr. Bicard effectively questioned the credibility of the new behaviors based on his experience as a BCBA at the doctoral level. *See* supra ¶ 8. Finally, a reduction was made to caregiver training to exclude data collection activity, which is a BA provider function. As Dr. Bicard testified, the goal for caregiver training should be to assist the caregiver in learning to better interact with the child and rather than data collection. *See* supra ¶ 8.

23. In this case, the BA provider recommended a continuation of the previously approved level of BA services. *See* supra ¶ 9. 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 ¶ 18.

24. Accordingly, Respondent has met their burden of proof to show that the previously approved units of BA services requested in this case are not individualized and specific to Petitioner and are in excess of Petitioner's needs. Therefore, the BA previously approved level of BA services no longer meets medical necessity criteria. Looking at all the evidence relevant to the particular needs of Petitioner, the level of BA services requested in the Treatment Plan at issue is not necessary to correct or ameliorate a defect or a physical and mental illness or condition.

25. Accordingly, upon consideration of Respondent's Composite Exhibit 1, Respondent's Composite Exhibit 2, the parties' sworn testimony, and the applicable laws and policies, the undersigned concludes that Respondent proved that the reduction of the Behavior Analysis services at issue was correct.

DECISION

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

DONE and ORDERED this 6th day of December 2023, in Tallahassee, Leon County, Florida.

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.

COPIES FURNISHED TO:

[redacted]

AHCA Medicaid Hearing Unit
MedicaidHearingUnit@ahca.myflorida.com