



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

**FILED**

Dec 20, 2023, 12:14 pm  
OFFICE OF FAIR HEARINGS

[REDACTED]

PETITIONER,

AHCA Case No.: 23-FH2373

vs.

AGENCY FOR HEALTH CARE  
ADMINISTRATION,

RESPONDENT.

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**FINAL ORDER**

Pursuant to notice, the undersigned Hearing Officer convened a telephonic Fair Hearing on the instant case on October 31, 2023, at 9:40 a.m. Eastern Standard Time (“EST”).

**APPEARANCES**

For the Petitioner:

[REDACTED]

Petitioner’s Authorized Representative

For the Respondent:

Linda Latson  
Registered Nurse Specialist  
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 request for behavior analysis (“BA” or “ABA”) services was incorrect.

**PRELIMINARY STATEMENT**

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

Zapata, Board Certified Behavior Analyst (“BCBA”) and Clinical Director for [REDACTED] (“Provider”), appeared at the hearing as a witness for Petitioner.

Linda Latson, Registered Nurse Specialist and Fair Hearing Liaison for the Agency for Health Care Administration (“Agency” or “AHCA”), appeared on behalf of Respondent. Dr. Kathy Hurley (“Dr. Hurley”), BCBA at the doctoral level, Florida state licensed mental health counselor, and a Second Level Reviewer in the Department of Utilization Management for eQHealth Solutions Inc. (“eQHealth”), appeared as a witness for Respondent.

Petitioner did not introduce any exhibits at the Fair Hearing.

Prior to the Fair Hearing, Respondent sent to the Office of Fair Hearings and Petitioner a one hundred and twenty-four (124)-page evidence packet and a forty-nine (49)-page evidence packet. The one hundred and twenty-four (124)-page packet appears in the Office of Fair Hearings’ document management system as the file titled “[REDACTED] FH 10.31.2023.pdf”. The forty-nine (49)-page packet appears in the Office of Fair Hearings’ document management system as the file titled “23-FH2373 AHCA Evidence BA Svcs 49 Pages.pdf”. Absent any objections from Petitioner, the undersigned admitted the one hundred and twenty-four (124)-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”).

#### **FINDINGS OF FACT**

1. Petitioner receives Medicaid services on a fee-for-service basis through the Agency. See RCE 1 at page 16. eQHealth is a Quality Improvement Organization contracted by the Agency to review prior authorization requests for services. See RCE 2 at page 2.

2. Petitioner is [REDACTED]. See RCE 1 at page 21. Petitioner is diagnosed with [REDACTED]. *Id.*

3. As provided in the Behavior Analysis Re-Assessment (“Re-Assessment”, “treatment plan” or “behavior plan”) dated June 18, 2023, Petitioner is engaging in the following maladaptive behaviors: [REDACTED], [REDACTED], [REDACTED], [REDACTED], [REDACTED], [REDACTED], and [REDACTED]. *Id.* at 56 – 58. As provided in the Re-Assessment, Petitioner is learning the following replacement behaviors: [REDACTED], [REDACTED], [REDACTED], [REDACTED], [REDACTED], [REDACTED], [REDACTED], [REDACTED], [REDACTED], and [REDACTED]. *Id.* at 64 – 73.

4. As provided in the Re-Assessment, for the period from April of 2023 through June of 2023, Petitioner has made the following progress in reducing [REDACTED] maladaptive behaviors: for [REDACTED], Petitioner’s incidents decreased from [REDACTED]; for [REDACTED], Petitioner’s incidents decreased from [REDACTED]; for [REDACTED], Petitioner’s incidents decreased from [REDACTED]. *Id.* at 59 – 61. The maladaptive behaviors of [REDACTED], [REDACTED], and [REDACTED] are new behaviors and lack data. *Id.* at 62 – 64.

5. As provided in the Re-Assessment, Petitioner’s replacement behaviors showed the following: for [REDACTED], Petitioner improved from [REDACTED] for [REDACTED], Petitioner decreased from [REDACTED] for [REDACTED], Petitioner improved from [REDACTED] for [REDACTED], Petitioner improved from [REDACTED] for [REDACTED], and for [REDACTED], Petitioner improved from [REDACTED]. *Id.* at 65 – 69.

6. On June 27, 2023, Petitioner requested BA services; specifically, 3,120 units of code 97153; 104 units of code 97155; 208 units of code 97155 HN; 52 units of code 97156; and 104 units of code 97156 HN. See RCE 1 at 29. In a Notice of Outcome – Partial Denial (“NOO”), dated July 6, 2023, Respondent approved 2,288 units of code 97153; 104 units of code 97155; 208 units of code 97155 HN; 78 units of code 97156 HN; and 52 units of code 97156. *Id.* at 29 – 33. Respondent denied 832 units of code 97153 and 26 units of code 97156 HN. *Id.* at 29. The NOO states as follows:

Code: 97153

Description: Intervention without protocol modification, per 15 minutes, Lead Analyst, BCaBA or RBT

From: 7/6/23

Thru: 12/30/23

Total Units: Denied 832

Approved 2,288

Code: 97155

Description: Intervention with protocol modification, per 15 minutes

From: 7/6/23

Thru: 12/30/23

Total Units: Approved 104

Code: 97155 HN

Description: Intervention with protocol modification, per 15 minutes

From: 7/6/23

Thru: 12/30/23

Total Units: Approved 208

Code: 97156

Description: Family training, per 15 minutes, Lead Analyst

From: 7/6/23

Thru: 12/30/23

Total Units: Approved 52

Code: 97156 HN

Description: Family training, per 15 minutes, Lead Analyst

From: 7/6/23

Thru: 12/30/23

Total Units: Denied 26  
Approved 78

The NOO explained the basis for the partial denial 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: 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.

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RCE 1 at 29 – 30.

7. Petitioner requested reconsideration of the Respondent’s decision. In a Notice of Reconsideration Determination (“NRD”), dated August 7, 2023, Respondent upheld its decision.

*Id.* at 41 – 45. The NRD explained the basis for the decision 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 or injury under treatment, and not in excess of the patient’s needs.

PR Recon Determination: At reconsideration all documents were carefully reviewed. The provider did not submit any new documentation that supports the medical necessity of this request. According to The Behavior Analysis Services Coverage Policy, (page 6. 9.0.c-d) the recipient of ABA therapy services must engage in maladaptive behavior that interferes with the recipient's daily functioning. Although the recipient is engaging in topographies of maladaptive behaviors, the frequency and intensity of the maladaptive do not support the request for services. This reconsideration request has been reviewed, reconsidered and the partial denial is upheld.

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RCE 1 at 41 – 42.

8. On September 20, 2023, Petitioner requested a Fair Hearing to challenge the partial denial of BA services. On October 5, 2023, the undersigned issued an Order Scheduling Fair Hearing and Prehearing Instructions, setting the hearing for October 31, 2023, at 9:30 a.m. EST.

9. [REDACTED] is Petitioner's [REDACTED] and Authorized Representative. [REDACTED] testified to the following:

- a. [REDACTED] likes the school Petitioner is attending. Petitioner's teacher advised [REDACTED] to ask for more help because of Petitioner's behavior in the classroom.
- b. Petitioner's medication dosage increased in [REDACTED]. The increase has not helped Petitioner.
- c. Petitioner changed schools at the beginning of the school year due to [REDACTED] behaviors.

10. Ms. Arcos-Zapata is a BCBA with Petitioner's provider. Ms. Arcos-Zapata testified to the following:

- a. Petitioner was received as a transfer from another agency.
- b. Petitioner's behaviors inhibited [REDACTED] in the classroom.

- c. Petitioner's medication is not impacting [REDACTED] at all.
- d. Petitioner's behaviors increase when the registered behavior technician ("RBT") or lead analyst is not in the classroom.
- e. There have been multiple modifications to the treatment plan. The goals have not changed. Petitioner has a total of [REDACTED] goals.
- f. The changes happened past the data points in the Re-Assessment's graph.

11. Dr. Hurley is a BCBA at the doctoral level with eQHealth. Dr. Hurley testified to the following:

- a. There are procedures a provider is supposed to follow to document changes when they occur during treatment. eQHealth uses a two-level review system. The first level of review is a BCBA who has a master's degree and cannot deny services; they can only fully approve services or ask for more information. The second level of review is a BCBA at the doctoral level; this reviewer can approve or deny services. Here, the services were partially denied based on information submitted by the provider's Treatment Plan.
- b. Dr. Hurley reviewed the medical necessity criteria. See RCE 2 at 7. The treatment for Petitioner must:
  - 1. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
  - 2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and
  - 3. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;

4. 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; and

5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.

\* \* \*

(c) 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.

- c. What is in question is that the services are in excess of Petitioner's needs.
- d. Respondent's decisions are for the time reviewed, not anything that came before or after the review period.
- e. There were no extraordinary changes marked in the treatment plan that warranted the increase of services under code 97153 from the last period of 2,288 units to the requested 3,120 units.
- f. Respondent made its determination that the services were in excess of medical necessity at the time the treatment plan was sent in. Dr. Hurley agrees with the determination based on the information Respondent had at the time, and agrees that things have changed now and Petitioner needs a modification now.
- g. Regarding the maladaptive behavior of [REDACTED], Petitioner's incidents decreased from a baseline of [REDACTED] incidents to an average [REDACTED] incidents. *Id.* at 56. This is progress.
- h. Regarding the maladaptive behavior of [REDACTED], Petitioner's incidents increased from a baseline of [REDACTED] incidents to an average [REDACTED] incidents. *Id.* at

56. Respondent expects an increase in behavior when there is a change in provider.

i. Regarding the maladaptive behavior of [REDACTED] Petitioner's incidents increased from a baseline of [REDACTED] incidents.

j. Regarding the maladaptive behavior of [REDACTED], Petitioner's incidents decreased from a baseline of [REDACTED] incidents.

*Id.* at 56. There was progress.

k. Regarding the maladaptive behavior of [REDACTED], Petitioner's incidents increased from a baseline of [REDACTED] incidents. *Id.* at 57.

l. The graph for [REDACTED] shows a decrease in incidents. *Id.* at 59. Respondent can tell there is progress here.

m. The graph for [REDACTED] shows a decrease in incidents. *Id.* at 60. There is also progress here.

n. The graph for [REDACTED] toward orders shows a decrease in incidents. *Id.* at 61. There is also progress here.

o. The graph for the new maladaptive behaviors of [REDACTED] [REDACTED], and [REDACTED] only have two data points. *Id.* at 62 – 63.

p. The graph for the replacement behavior of [REDACTED] shows progress. *Id.* at 65.

q. The graph for the replacement behavior of [REDACTED] shows progress. *Id.* at 66.

- r. The graph for the replacement behavior of [REDACTED] shows a decrease. *Id.* at 67.
  - s. The last data point for [REDACTED] is [REDACTED].
  - t. The graphs did not show any intensity or magnitude.
12. [REDACTED] submitted two (2) letters from Petitioner’s doctors, [REDACTED]  
[REDACTED], recommending thirty (30) hours per week of ABA services. *Id.* at 87 – 88.

### CONCLUSIONS OF LAW

13. 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).
14. This hearing was held as a *de novo* proceeding pursuant to Fla. Admin. Code R. 59G-1.100(17)(b).
15. Because Petitioner is requesting a new service, Fla. Admin. Code R. 59G-1.100(17)(g) assigns the burden of proof to the Petitioner. The standard of proof in an administrative hearing is a preponderance of the evidence. The preponderance of the evidence standard requires proof by “the greater weight of the evidence” (Black’s Law Dictionary at 1201, 7th Ed.)
16. 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.

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#### **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 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 sectioned 1905(a) of the Social Security Act, codified in Title 42 of the United States Code 1396d(a). As such, services for recipients under the age of 21 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.

...  
RCE 2 at 40 – 42.

17. 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

...

RCE 2 at 45 – 47.

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

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

RCE 2 at 4 – 5.

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

RCE 2 at 6.

20. 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.

21. In the instant case, Petitioner requested the following ABA services: 3,120 units of code 97153; 104 units of code 97155; 208 units of code 97155 HN; 52 units of code 97156; and 104 units of code 97156 HN. See ¶ 6. In the NOO, dated July 6, 2023, Respondent explained that the request for services did not meet the following criteria: “[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 ¶ 6. Respondent further explained that the “submitted information does not support the medical necessity for requested frequency and/or duration” and that “the frequency, intensity, or severity of [Petitioner’s] maladaptive behaviors does not justify the requested units of services.” *Id.*

22. 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 ¶ 19. As provided in section 2.83 of the Definitions Policy, a component of medical necessity is that services must be “[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 ¶ 20. This component was identified as not being met in the NOO and NRD. See ¶ 6 – 7. As shown by the record, Petitioner’s maladaptive behaviors have decreased slightly. See ¶ 4, 11. For example, the maladaptive behaviors of [REDACTED], [REDACTED], and [REDACTED] have all decreased in frequency. See ¶ 4. As testified by [REDACTED] and Ms. Arcos-Zapata, Petitioner’s medication increase has not helped and is not impacting [REDACTED] at all. See ¶ 10 - 11. Further, Ms. Arcos-Zapata testified that Petitioner’s behaviors increase when the registered behavior technician (RBT) or lead analyst is not in the classroom. See ¶ 10. Dr. Hurley reviewed the graphs for Petitioner’s maladaptive behaviors noting that there were no extraordinary changes marked in the treatment plan that warranted the increase of services under code 97153 from the last period of 2,288 units to the requested 3,120 units. See ¶ 11. Further, Dr. Hurley testified that when a change occurs, there are procedures a provider is supposed to follow, and that Respondent made its determination that the services were in excess of medical necessity at the time the treatment plan was sent in. *Id.* Petitioner has failed to identify where the current approved hours of service are lacking. As such, Petitioner did not demonstrate that the denied service hours are “not in excess of the patient's needs.”

23. Lastly, although the record reflects that Petitioner’s provider recommended the additional 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 ¶ 20. Coupled with the graphs demonstrating an overall downward trend of maladaptive behaviors, Petitioner has failed to demonstrate that additional behavioral analysis services are medically necessary.

24. Upon consideration of the testimony provided, Respondent’s Composite Exhibit 1, Respondent’s Composite Exhibit 2, the EPSDT policy, and other applicable polices and laws, the undersigned concludes that Petitioner did not prove by a preponderance of the evidence that the denied units of BA services are medically necessary. Looking at all the evidence relevant to the particular needs of Petitioner, Petitioner has not demonstrated that the additional services based on this treatment plan, are necessary to correct or ameliorate a defect or a physical and mental illness or condition. Accordingly, Petitioner did not prove by a preponderance of the evidence that Respondent’s partial denial of additional BA 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 is **DENIED**.

**DONE** and **ORDERED** this 20th day of December 2023, in Tallahassee, Leon County, Florida.

 Kameisha Presley  
23-FH2373  
2023.12.20  
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**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:**

[REDACTED]  
[REDACTED]  
[REDACTED]

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