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OFFICE OF FAIR HEARINGS

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

[redacted],

PETITIONER, **AHCA CASE NO.: 23-FH2683**

vs.

AGENCY FOR HEALTH CARE ADMINISTRATION,

RESPONDENT.
_______________________________/

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic Fair Hearing on the instant case on December 5, 2023, at 9:00 a.m. Eastern Standard Time ("EST").

APPEARANCES

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

For the Respondent: Linda Latson
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 additional Applied Behavior Analysis services ("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. [redacted] ("[redacted]

”), BCBA of . (“Provider”), appeared as a witness for Petitioner.

Linda Latson, Registered Nurse Specialist for the Agency for Health Care Administration (“Agency” or “AHCA”), appeared on behalf of Respondent. Dr. Karen Goldberg (“Dr. Goldberg”), BCBA at the Doctoral level for eQHealth Solutions Inc. (“eQHealth”) appeared as a witness for Respondent.

Petitioner did not introduce exhibits at the hearing. Prior to the hearing, Respondent sent to the Office of Fair Hearings and Petitioner a one hundred and thirty-one (131)-page evidence packet appearing in the Office of Fair Hearings’ document management system as file title “-FH 12.05.2023.pdf,” and a forty-nine (49)-page evidence packet appearing in the Office of Fair Hearings’ document management system as the file title “23-FH2683AHCA Evidence BA Services 49 Pages.pdf.” Absent an objection from the Petitioner, the undersigned admitted the one hundred and thirty-one (131)-page evidence packet into evidence as Respondent’s Composite Exhibit 1 (“RCE 1”) and the forty-nine (49)-page evidence packet into evidence as Respondent’s Composite Exhibit 2 (“RCE 2”).

FINDINGS OF FACT

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

2. Petitioner is . *See* page 16 of RCE 1. Petitioner is diagnosed with . *Id*. Petitioner has participated in BA services with the current provider, (“Provider”), since . *Id.*

3. As provided in the Behavior Analysis Assessment – Behavior Plan ("treatment plan" or "behavior plan"), Petitioner engages in the following maladaptive behaviors: , , , , . *Id*. at 69 - 76. The graphs of the maladaptive behaviors include data from , through . *Id*. at 70 - 76. For , the graph shows a baseline of occurrence that bounced up and down from occurrences during the weeks of , spiked to occurrences during a week , then bouncing from occurrence in during the weeks of , when it spiked at occurrences towards the end of , leveled at occurrences during , then bouncing from occurrence and spiking at occurrences during the month of . *Id*. at 70. For , the graph shows a baseline of occurrences, then spiking in to occurrences, then bouncing from to occurrences, and spiking to occurrences during the weeks of , bouncing from occurrences, and spiking at occurrences during , and , then occurrences during , and . *Id*. at 71. For , the graph shows a baseline of occurrences, then spiking in to occurrences, then bouncing from occurrence, and spiking to occurrences during the weeks of , then bouncing from to occurrence, and spiking at occurrences in , then bouncing from to or occurrences during and , then occurrences during , and . *Id*. at 73. For , the graph shows a baseline of occurrences, bouncing from occurrences between and , with a spike to occurrences in , then occurrences during , with a spike to occurrences in

, then bouncing between occurrences in and . *Id*. at 74. For , the graph shows a baseline of occurrences, then occurrences one day in , then bouncing from occurrence during the weeks of through , except for occurrences one day in , and no occurrences in , , and . *Id.* at 76.

4. Petitioner initially requested additional ABA services for the period from May 9, 2023, through November 4, 2023. *Id*. at 21. Specifically, Petitioner requested an additional 384 units of code 97155 units for a total of 416 units, and a total of 104 units of code 97156. *Id*. at 17. The Provider did not submit any modifications to the treatment plan with the request, and the request for additional units was denied. *Id*. The Provider was asked to clarify the request as to whether the request is for units to be reallocated (i.e, remove the BCaBA hours or just add to the existing BCBA hours). The Provider's response was to "[p]lease add requested units to existing hours (no reallocating, add additional units). Please adjust as necessary. Thank you." *Id.* The Petitioner subsequently requested that the units be reallocated. *Id*. at 122.

5. In a Notice of Outcome ("NOO"), dated August 23, 2023, Respondent denied Petitioner's request for additional ABA services. 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. Specifically, the requested services are not medically necessary under the following standard(s):
>
>> Consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational.
>
> The rational for our decision is as follows:
>
> PR Clinical 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, all requested services must be based on maladaptive behaviors emitted by the recipient. Services cannot be approved on a speculative basis and services cannot be approved based on the convenience of the provider, the recipient, or the recipient's caretaker. The provider has not submitted any modifications to the treatment plan. The request for modification of treatment units is denied.
> . . .

Pages 21 - 24 of RCE 1.

6. Petitioner requested reconsideration of the Respondent's decision. In a Notice of Reconsideration Determination ("NRD"), dated September 26, 2023, Respondent upheld its decision. *Id*. at 32 - 35. The NRD explained the rationale for the decision 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. Specifically, the requested services are not medically necessary under the following standard(s):
>
>> Consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational.
>> Individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness under treatment. and not in excess of the patient's needs.
>
> PR Recon Determination: At reconsideration all documents were carefully reviewed. All requests for ABA services must be approved based on medical necessity to treat the recipient's presenting maladaptive behaviors. This request does not meet medical necessity requirements specified in the Behavior Analysis Services Coverage Policy. Services cannot be approved based on the convenience of the provider, the availability of the recipient, or the recipient's caretaker. The data submitted does not support the medical necessity of this request for services. This reconsideration request has been reviewed, reconsidered and the partial denial is upheld.
> . . .

Id. at 32 - 33.

7. On October 18, 2023, Petitioner requested a Fair Hearing to challenge the denial of additional ABA services. On November 15, 2023, the undersigned issued an Order Scheduling Fair Hearing and Prehearing Instructions, setting the hearing for December 5, 2023, at 9:00 a.m. EST. *Id.* at 8 - 12.

8. When reviewing the effectiveness of a treatment plan, what is looked at is whether maladaptive behaviors are being reduced and whether replacement behaviors are being increased. *See,* Appendix 9.0 of the BA Policy providing Review Criteria for Behavior Analysis Services, *infra* ¶ 18.

9. Petitioner's authorized representative and , , testified that Petitioner needs a continuity of ABA therapy service. agrees that the issue being heard does seem like it is a billing issue between the provider and the Agency. Petitioner's witness, , who is a BCBA with the provider, testified that the provider did request the units as additional services, but that if they made the request as a modification to the plan, it would have been approved. explained that the BCaBA went on maternity leave in , and that there was not a plan for another BCaBA to take place because there are no other BCaBAs in its facility. testified that a BCBA did into BCaBA role when BCaBA went on maternity leave, but that was because there was a change in Petitioner's behavior. agreed that the Petitioner's maladaptive behavior of during , , and were at higher rates than in , and that there was no request to change from BCaBA to BCBA level during those months. testified that the BCaBA returned from maternity leave in .

10. Dr. Goldberg is a Board-Certified Behavior Analyst at the doctoral level. Dr. Goldberg established that eQHealth reviews behavior analysis cases to ensure that providers are giving quality care consistent with the standards enumerated in the BA Policy as well as professional medical standards of applied behavior analysis ("ABA"). eQHealth reviewed the treatment plan submitted in this case to determine whether all five (5) conditions of medical necessity are met. Dr. Goldberg contends that Provider's request for additional ABA services at the BCBA level is not medically necessity, rather the request is for the convenience of Provider for them to bill at a higher rate because the BCaBA who was treating Petitioner went on maternity leave in [redacted], and the BCBA stepped in to replace [redacted]. Dr. Goldberg explained under the standards of BA, it is not prohibited for a BCBA to treat a child in lieu of a BCaBA, but they are not to bill at a higher rate than a BCaBA, unless there has been a dramatic change in the child's condition that warranted it. Dr. Goldberg noted that the request by the provider to add units of code 97155 (supervision and intervention by a BCBA) was submitted in [redacted], coinciding with the BCaBA's maternity leave.

11. Dr. Goldberg explained that during the Authorization Period, Petitioner had been approved for 32 units of code 97155, 416 units of code 97155 HN (supervision and intervention by a BCaBA or RBT), and 104 units of code 97156 (parent/family training). But, once the BCaBA took maternity leave, Provider requested to add 384 units to 97155, bringing it to 416 units, to keep 416 units of 97155 HN, and to add 104 units to 97156. Dr. Goldberg further explained that the first level reviewer of Provider's request asked for clarification, to which the Provider responded with please add the requested units to the existing authorized hours, no reallocating. A second level reviewer asked for further clarification to which Provider responded again that

the requested units should be added to the existing hours. The second level reviewer denied the request on the basis that the services could not be approved because they are not medically necessary as the treatment plan did not support the additional units, and the request was just for the convenience of Provider.

12. Dr. Goldberg testified that when the additional units were denied as for the convenience of Provider, it then modified the treatment plan requesting that the units be reallocated, not added; and to support reallocation, they added a statement that child is doing poorly and needs higher level of expertise from a BCBA. Dr. Goldberg noted that the modified treatment plan did not mention that the BCaBA went on maternity leave, but instead reported that Petitioner is having increased issues of , , , and . Dr. Goldberg referred to the data in the graph for , for an example, that shows a rate of occurrences in , when the additional units were requested. Yet in , , , and , there was no request made for additional or reallocation of units when the graph shows a higher rate of occurrences during those months. Dr. Goldberg contends that the only reason the provider requested a higher rate in is because the BCBA stepped in for the BCaBA on maternity leave, and they wanted to get paid at a higher rate. Dr. Goldberg agreed that there may be a spike in Petitioner's maladaptive behaviors when treatment schedule changed, but that is common and it would level out. Dr. Goldberg testified that for the current authorization period starting in November of 2023, the treatment plan includes the BCaBA doing 3 hours a week of supervision, and the BCBA doing a half-hour week, which is back to the way it was before the BCaBA went on maternity leave. Dr.

Goldberg concluded that it is very clear that Provider tried to find a way around the rules and the medical necessity criteria number five (5) regarding convenience to the provider or caretaker.

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 Respondent denied Petitioner's request for additional ABA services, 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 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
- 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 be 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 year 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.

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. Provider 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 than 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 treatment at the present level or using the current methods. **If** criteria for **3a is met**, but criteria for **3b and/or 3c are not met**, then a reduction of the treatment level and/or change of treatment methods may be warranted.

a. ALL criteria listed in 2a, 2b, and 2c regarding critical elements, assessment or reassessment, and behavior plan, are met.
b. The data provided must show evidence that the frequency of the maladaptive behavior(s) has decreased since the last review and, if not, that there is a modification of the behavior plan.
c. The level of functional impairment justifies continuation of BA services. The reviewer utilizes the information provided below as a guide as it relates to the level of functional impairment as expressed through the following behaviors:
    i. Safety – aggression, self-injury, property destruction, elopement
    ii. Communication – problems with expressive/receptive language, poor understanding or use of non-verbal communications, stereotyped, repetitive language
    iii. Self-stimulating, abnormal, inflexible, or intense preoccupations
    iv. Self-care – difficulty recognizing risks or danger, grooming, eating, or toileting
    v. Other – behaviors not identified above

18. States must provide Early and Periodic Screening, Diagnostic, and Treatment ("EPSDT") services to Medicaid-eligible children under age 21 when requested under the Medicaid state

plan. *See* 42 U.S.C. § 1396a(a)(43); 42 U.S.C. § 1396d(a)(4). According to 42 U.S.C. § 1396d(r)(5), EPSDT services mean, in relevant part, the following items and services:

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

19. Petitioner is under age 21, and therefore EPSDT applies to [redacted] 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.

20. The Florida Medicaid Definitions Policy, incorporated by reference in Fla. Admin. Code R. 59G-1.010, (the "Definitions Policy"), 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.

Page 23 of RCE 2.

21. The Florida Medicaid Authorization Requirements Policy ("Authorization Requirements Policy") (June 2016), incorporated by reference in Fla. Admin. Code R. 59G-1.053, provides general requirements for providers to obtain authorization to render Florida Medicaid services. The Authorization Requirements Policy states, in pertinent part:

> **3.0 Determination Process**
> **3.1 Review Criteria**
> The QIO may use a national standardized set of criteria, or other set of criteria, approved by AHCA, as a guide for authorizations performed at the first review level. If services cannot be approved at the first level review, the QIO's physician peer reviewer will determine medical necessity using his or her clinical judgment, acceptable standards of care, state and federal laws, and AHCA's medical necessity definition.
>
> **3.2 Review Process**
> The QIO will review each authorization request and will approve, deny, or request additional information. The QIO may deny a portion of the requested units of service if it cannot substantiate medical necessity based upon the information submitted.
>
> **3.2.1 Continued Authorization Requests**
> The QIO shall not deny or reduce the amount, frequency, or duration of a service that is already being provided, unless:
> - The reduction is to correct for factual errors or omissions in prior certifications.
> - There is a documented improvement in the recipient's medical condition.
> - There is a documented change in the recipient's circumstances.
> - The reviewing physician determines the recipient will not gain any additional benefit by continuing services at the current level.

Florida Medicaid Authorization Requirements Policy at pages 1-3.

22. Petitioner is under the age of 21 years and diagnosed with [redacted]. *See supra* ¶ 2. The parties agree that Petitioner currently engages in maladaptive behaviors that interfere with [redacted] daily functioning. *See supra* ¶ 3. Respondent determined that Petitioner's "all requested services must be based on maladaptive behaviors emitted by the recipient. Services cannot be approved on a speculative basis and services cannot be approved based on the convenience of the provider, the recipient, or the recipient's caretaker. The provider has not submitted any modifications to the treatment plan." *See supra* ¶ 5, 6.

23. Respondent denied Petitioner's request for additional ABA services because the submitted documentation did not establish the medical necessity of the services. *See supra* ¶ 5, 6. Based on the record, Respondent determined that the documentation did not meet the following medical necessity standard: [i]ndividualized, specific, and consistent with symptoms or confirmed diagnosis of the illness under treatment, and not in excess of the patient's needs," "[c]onsistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational," and "furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider." *See supra* ¶ 6. The medical necessity standards are expressly outlined in section 2.83 of the Definitions Policy and a critical element for behavior analysis services reassessments. *See supra* ¶ 20. The BA Policy mandates that the treatment plan must be detailed enough to warrant the requested services and include mechanisms to monitor and evaluate its effectiveness. *See supra* ¶ 21.

24. In the instant case, Petitioner requested additional BA services for the period from May 9, 2023, through November 4, 2023. *See supra* ¶ 4. Specifically, Petitioner requested an additional 384 units of code 97155, and 104 units of code 97156. In a NOO, dated August 23, 2023, and an NRD, dated September 25, 2023, Respondent denied the additional requested units of ABA services, *supra* ¶ 5, 6, determining that Petitioner's request was not "medically necessary under the following standard: [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 supra* ¶ 5, 6. Subsequently, Petitioner requested that the units be reallocated, and not added. *See supra* ¶ 4.

25. As Petitioner bears the burden of proof, the Petitioner must show that the additional BA services at issue meet medical necessity criteria, *i.e.*, the additional of 384 units of code 97155, and the 104 units of code 97156. Here, the record shows that Petitioner engages in the following maladaptive behaviors: , , , , and . *See supra* ¶ 3. However, as shown by the record, when the frequency and severity of Petitioner's maladaptive behaviors were mostly higher than the baseline, in , , and , a request for additional BCBA units, or a change to the treatment plan was not made; rather, the request came in , when the maladaptive behaviors were low or none. *See supra* ¶ 3. For example, the maladaptive behaviors such as , , and did not occur in . *See supra* ¶ 3. Moreover, Dr. Goldberg provided credible and persuasive testimony the request for additional services at the BCBA level was a matter of billing at a higher rate than the BCaBA level, since the BCaBA had gone on maternity leave. *See supra* ¶ 10 - 12. As Dr. Goldberg established, based on the level of

services of the treatment plan, Petitioner would not benefit from additional BCBA level of ABA services. See *supra* ¶ 10 - 12. In all, Petitioner did not demonstrate that additional ABA services are "individualized, and specific" as it is not providing effective treatment, "consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational," and "furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.

26. Lastly, the record reflects that Petitioner's provider believes that BA services are medically necessary. *See supra* ¶ 4. However, the "fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services does not, in itself, make such care, goods or services medically necessary or a medical necessity or a covered service." *See supra* ¶ 20.

27. Accordingly, Petitioner has not met [redacted] burden of proof to show that the requested ABA services are medically necessary. Looking at all the evidence relevant to the particular needs of Petitioner, the record does not reflect that the additional BA services are necessary to correct or ameliorate a defect or a physical and mental illness or condition. Upon consideration of the testimony provided, evidence submitted, and applicable policies, the undersigned finds that Petitioner has not proved by a preponderance of the evidence that Respondent's denial of additional BA services at issue was incorrect.

IT IS HEREBY ORDERED AND ADJUDGED THAT:

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

DONE and **ORDERED** this 2nd day of February 2024, in Tallahassee, Leon County, Florida.

DEBBIE WINICKI, 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
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