



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

FILED

Jun 03, 2024, 4:40 pm

OFFICE OF FAIR HEARINGS

[REDACTED]

PETITIONER,

AHCA Case No.: 24-FH0409

vs.

AGENCY FOR HEALTH CARE  
ADMINISTRATION,

RESPONDENT.

\_\_\_\_\_ /

**FINAL ORDER**

Pursuant to notice, the undersigned convened a telephonic Fair Hearing on the instant case on March 19, 2022, at 1:00 p.m. Eastern Standard Time (“EST”).

**APPEARANCES**

For the Petitioner:

[REDACTED]

Petitioner’s Authorized Representative

For the Respondent:

Marielisa Amador  
Medicaid 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 (“BA”) services was correct.

**PRELIMINARY STATEMENT**

All parties appeared for the Fair Hearing telephonically. [REDACTED] (“[REDACTED]”)

[REDACTED] Petitioner’s Authorized Representative and [REDACTED], appeared for the Fair Hearing and provided testimony on behalf of Petitioner.

Marielisa Amador, Medical Health Care Program Analyst for the Agency for Health Care Administration (“Agency” or “AHCA”), appeared for the Fair Hearing as a representative for Respondent. Dr. Joseph Darling (“Dr. Darling”), Board Certified Behavior Analyst (“BCBA”) at the doctoral level, appeared for the Fair Hearing as a witness for Respondent.

Petitioner did not introduce any exhibits at the Fair Hearing.

Respondent introduced a one hundred and forty-eight (148)-page evidence packet. The evidence packet appears in the Office of Fair Hearings’ case management system as “[REDACTED] FH 03.19.2024.pdf.” Without objection, this evidence packet was admitted into evidence as Respondent’s Composite Exhibit 1.

Respondent also introduced a forty-nine (49) page evidence packet, which appears in the Office of Fair Hearings’ case management system as “24-FH0409 AHCA Evidence (Pages 1-49 of 49).pdf.” Without objection, this evidence packet was admitted into evidence as Respondent’s Composite Exhibit 2.

### **FINDINGS OF FACT**

1. Petitioner receives Medicaid services on a fee-for-service basis through the Agency. *See* Respondent’s Composite Exhibit 1 at page 16.
2. eQHealth is a Quality Improvement Organization (“QIO”) contracted by the Respondent to review prior authorization requests for services. *See* Respondent’s Composite Exhibit 2 at page 2. Respondent, through contractual agreement, authorizes eQHealth to make medical necessity determinations for services requiring prior authorization, including BA services. *Id.*
3. As of the date of the Fair Hearing, Petitioner is an [REDACTED]. *See* Respondent’s Composite Exhibit 1 at page 16. Petitioner’s BA provider, [REDACTED].

[REDACTED], identified the following behaviors as maladaptive in the Reassessment, dated December 22, 2023, ("Treatment Plan"): [REDACTED], [REDACTED], [REDACTED], [REDACTED], [REDACTED], [REDACTED], [REDACTED], [REDACTED], and [REDACTED], *Id.* at 53 - 62. The parties agree that Petitioner engages in maladaptive behaviors that threaten access to typical environments and negatively affect [REDACTED] activities of daily living. *Id.* at 17, 27.

4. As Dr. Darling testified, the data graphs for maladaptive behaviors in the Treatment Plan show the following: [REDACTED] and [REDACTED] are new behaviors; and [REDACTED], [REDACTED], [REDACTED], [REDACTED], [REDACTED], [REDACTED], [REDACTED], and [REDACTED], show slow progress and no modifications to the Treatment Plan to timely address the lack of progress. *Id.* at 46 - 62.

5. As Dr. Darling testified, the data graphs for replacement behaviors in the Treatment Plan show very slow increases for: [REDACTED], [REDACTED], [REDACTED], [REDACTED], [REDACTED], [REDACTED], [REDACTED], [REDACTED], and [REDACTED]. *Id.* at 64-74.

The data graph for increased time on tasks shows that, after [REDACTED] of treatment, Petitioner is only able to [REDACTED]. *Id.* at 65-66.

6. On January 4, 2024, Respondent issued a Notice of Outcome ("NOO") reducing Petitioner's BA services on the basis of medical necessity for the certification period of December 27, 2023, through June 23, 2024. . *Id.* at 18-19, 21. Specifically, the NOO states that the BA

services at issue are not “[i]ndividualized, specific, and consistent with symptoms or confirmed diagnosis of the illness under treatment, and . . . in excess of the patient’s needs.” *Id.* at 21-22.

The NOO states that the submitted information does not support the medical necessity for requested frequency and/or duration. The NOO further states:

PR Clinical Rationale – Denial: According to [t]he Behavior Analysis Services Coverage Policy, (page 3, 2.2) 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 request for behavior analysis services is in excess of medical necessity. Behavior analysis services are approved, but at a lower level than what the provider requested.

*Id.* at 22.

7. On February 26, 2024, Respondent issued a Notice of Reconsideration Determination (“NRD”) upholding the reduction of BA services on the basis of medical necessity. *Id.* at 33-34. Specifically, the NRD states that the BA services at issue are not “[i]ndividualized, specific, and consistent with symptoms or confirmed diagnosis of the illness under treatment, and . . . in excess of the patient’s needs.” *Id.* at 33-34. The NRD further states:

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 [t]he behavior analysis Services Coverage Policy, (page 3, 2.2) 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.

*Id.* at 34.

8. On February 2, 2024, Petitioner requested a Fair Hearing on Respondent’s decision to reduce Petitioner’s BA services. *Id.* at 8. On February 29, 2024, the Office of Fair Hearings issued

an order scheduling the Fair Hearing for March 19, 2024, at 1:00 p.m. *Id.* at 11. The order also extended the Final Order due date pursuant to Rule 59G-1.100(18), Florida Administrative Code. *Id.* Administrative approval of services was granted pending the outcome of the Fair Hearing. *Id.* at 17.

9. At the Fair Hearing, Dr. Darling explained that Petitioner's one-on-one behavior analysis therapy (code 97153) is being reduced from approximately twenty-five (25) hours per week to approximately twenty (20) hours per week and that the protocol modification and oversight by the BCBA (code 97155) remains unchanged at approximately two (2) hours per week. *Id.* at 21. Dr. Darling explained the peer review process that the Treatment Plan underwent at eQHealth. Dr. Darling agreed with the previous three BCBA's at eQHealth who reviewed the Treatment Plan, *Id.*, and asserted that the approved level of services are sufficient to successfully implement the Treatment Plan. Dr. Darling provided credible and persuasive testimony that twenty (20) hours per week of intensive one-on-one therapy, along with two (2) hours per week of protocol modification, and one (1) hours per week of parent training were sufficient to effectively implement the Treatment Plan for the next six (6) months.

10. The provider responded with a two (2)-page letter but did not propose any additional therapy or protocol modifications to address, or "speed-up," Petitioner's progress. Far too little oversight and protocol modifications. TP modifications did not occur as they should and minimum progress over [REDACTED] The reduction brought a higher ratio of oversight.

11. Dr. Darling established that maladaptive behaviors should decrease or extinguish, and replacement behaviors should increase, throughout the course of effective treatment. Further, standards of care in the field of BA require timely and ongoing modifications to a treatment plan

to ensure that progress is continuously made on maladaptive behaviors and replacement behaviors. Progress is determined by reference to data graphs. Dr. Darling provided credible and persuasive testimony that, in this case, the data graphs show that Petitioner's progress on maladaptive and replacement behaviors was very slow after [REDACTED] of treatment and that no ongoing modifications were made during the authorization period to promote progress. *Id.* at 46-74.

12. Dr. Darling questioned the credibility of minimal modifications to the Treatment Plan that were proposed by the BA provider with the requested authorization for another six (6) months of treatment. In this case, two new maladaptive behaviors ([REDACTED] and [REDACTED]) and one replacement behavior ([REDACTED]) were added just before the authorization cycle ended. Dr. Darling testified that, in [REDACTED] experience, it is highly unusual for new maladaptive behaviors to appear after [REDACTED] of therapy and these behaviors should have been tracked all along. Moreover, Petitioner is [REDACTED]  
[REDACTED] As Dr. Darling established, there are specific BA interventions that could be effective alongside medical treatment; however, the BA provider did not propose any specific modifications to the Treatment Plan to address this.

13. [REDACTED] testified concerning Petitioner's medical issues and need for the requested BA services to protect Petitioner's life. [REDACTED] asserted that Petitioner needs constant supervision and that the requested BA services are essential to target maladaptive behaviors.

#### **CONCLUSIONS OF LAW**

14. Pursuant to section 409.285(2), Florida Statutes (2019), the Agency’s Office of Fair Hearings has jurisdiction over the subject matter of this proceeding and the parties. This Final Order is the final administrative decision of AHCA.

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

16. 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.

17. Because Respondent reduced Petitioner’s BA services, 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.).

18. The Florida Medicaid Behavior Analysis Services Coverage Policy (September 2023) (“BA Policy”), incorporated by reference in Rule 59G-4.125, F.A.C., 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.

...

**4.0 Coverage Information**

**4.1 General Criteria**

Florida Medicaid covers services that meet all of the following:

- Are determined medically necessary

- Do no duplicate another
- Meet the criteria as specified in this policy

Respondent's Composite Exhibit 2 at page 41-43.

19. The BA Policy further provides as follows:

#### **4.2.1 Behavior Assessment and Behavior Plan**

A behavior assessment must be conducted prior to the initiation of behavior analysis interventions. The assessment must identify behavioral deficits that interfere with a major life activity including the events and subsequent interactions that elicit and sustain targeted behavior.

The initial assessment must include the administration, scoring, and reporting of two core standardized behavior instruments, as follows:

- Vineland-3 Comprehensive Parent Interview Form Including Maladaptive Behavior Domain, for all recipients
- Behavior Assessment System for Children, Third Edition, Parenting Relationship Questionnaire (BASC-3 PRQ), for all recipients 2 years old and less than 19 years old

The complete scoring report, including outcome measure scores, must be submitted with service prior authorization requests. Additional assessment tools may be used at the Lead Analyst's discretion.

The behavior plan identifies intervention strategies that are likely to eliminate, mitigate or replace the behavior to produce change sufficient to reengage the recipient in the major life activity. The plan must include specific behavior goal(s), intervention strategies for each goal, anticipated timeframes that are of sufficient duration to address the targeted behavior, and how the ongoing progress of intervention strategies will be reported.

The behavior plan must reflect the requested authorization period (up to six months).

A reassessment and updated behavior plan to renew prior authorization for continued services must be completed at least every six months. The core instruments must be included with reassessments every 12 months.

More frequent assessments must be conducted when:

- New behavior emerges that interferes with a recipient's participation in a major life activity
- Additional BA services are medically necessary and are likely to address the emergent behavior

A full reassessment may be requested if there is a change in provider; however, a change of a practitioner status (e.g., an RBT becoming certified as a BCaBA) is not grounds for conducting a reassessment or updating a behavior plan.

#### **4.2.2 Behavior Analysis Interventions**

Florida Medicaid covers up to 40 hours per week of BA intervention services as indicated in the recipient's prior-authorized behavior plan. These services must be delivered to reduce maladaptive behaviors and assist the recipient reach the best possible function level for that individual. Services include:

- Adaptive behavior treatment by protocol - behavior analysis services provided according to the authorized treatment protocol
  - o Services may be provided by Lead Analyst, BCaBA, or RBT
- Adaptive behavior treatment with protocol modification – behavior analysis services provided with modifications to the authorized treatment protocol to address behavior and/or response changes or progress
  - o Services may be provided by Lead Analyst or BCaBA
- Group adaptive behavior treatment by protocol – behavior analysis services provided in a group setting according to the authorized treatment protocol
  - o Maximum group size is six recipients
  - o Services may be provided by Lead Analyst, BCaBA, or RBT
- Group adaptive behavior treatment with protocol modification – behavior analysis services provided in a group setting with modifications to the authorized treatment protocol to address behavior and/or response changes or progress
  - o Maximum group size is six recipients
  - o Services may be provided by Lead Analyst or BCaBA
- Family adaptive behavior treatment guidance – parent, guardian, and/or caregiver training on the implementation of the behavior plan and intervention strategies
  - o The recipient may or may not be present depending upon clinical appropriateness.
  - o Services may be provided by Lead Analyst or BCaBA
  - o The Lead Analyst may provide up to two hours per week of training to parents or guardians via telemedicine in accordance with Rule 59G-1.057, Florida Administrative Code (F.A.C.)

...

#### **4.2.4 Discharge**

Recipients receiving Florida Medicaid BA services who meet one or more of the following will be considered for discharge from services:

- The recipient is no longer eligible for BA services as outlined in the Florida Medicaid Behavior Analysis Services Coverage Policy, incorporated by reference in Rule 59G-4.125, F.A.C.

- The recipient no longer meets medical necessity criteria as defined in Rule 59G-1.010, F.A.C.
- The recipient no longer engages in maladaptive behaviors.
- Data indicates the frequency and severity of maladaptive behavior(s) or level functional impairment no longer poses a barrier to the recipient's ability to function in his/her environment.
- The level of functional impairment as expressed through behaviors no longer justifies continued BA services.
- Parent or guardian withdraws consent for treatment

#### **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 Authorization Requirements Policy.

...

### **5.0 Exclusion**

#### **5.1 General Non-Covered Criteria**

Services related to this policy are not covered when any of the following apply:

- The service does not meet the medical necessity criteria listed in section 1.0
- The recipient does not meet the eligibility requirements listed in section 2.0
- The service unnecessarily duplicates another provider's service

#### **5.2 Specific Non-Covered Criteria**

Florida Medicaid does not cover the following as part of this service benefit:

- Any procedure or physical crisis management technique that involves the use of seclusion or manual, technical, or chemical restraint utilized to control behaviors
- Services for the delivery of recipient supervision, personal care assistance (e.g., acting as a 1:1 aid), companion, chaperone, or shadow regardless of activity or setting. This may include supports and services that are reimbursed through a different Florida Medicaid service benefit or are able to be provided by individuals without professional skills or training.
- Caregiver or childcare services
- Psychological testing, neuropsychology, psychotherapy, cognitive therapy, sex therapy, psychoanalysis, hypnotherapy, or long-term counseling
- Services funded under section 110 of the Rehabilitation Act of 1973

- Services not listed on the fee schedule
- Services on the same day as behavioral health overlay services\*
- Services on the same day as therapeutic behavioral on-site services\*
- Services on the same day as therapeutic group care services\*
- Services provided simultaneously by more than one BA provider, unless determined to be medically necessary, prior authorized, and indicated in the approved behavior plan
- Travel Time

\* These services include behavior analysis treatment.

Florida Medicaid may cover some services listed in this section through a different service benefit.

## **6.0 Documentation**

### **6.2 Specific Criteria**

Providers must maintain the following documentation in the recipient's file:

#### **6.2.1 Referral Information**

Original referral documentation must be maintained in the recipient's medical record.

#### **6.2.2 Behavior Assessment and Behavior Plan**

The behavior assessment and behavior plan must be signed by the Lead Analyst and the recipient's parent or guardian. Each behavior assessment and behavior plan must include:

- Patient information
- Reason for referral
- Medical and developmental history, including medications prescribed to ameliorate behaviors
- Relevant family history
- Clinical interview
- Review of recent assessments/reports (file review)
- Assessment procedures and results
- Behavior plan
  - Treatment setting(s)
  - Proposed treatment targets, goals, and objectives related to medically necessary behavioral interventions
  - For each:
    - Definition in observable, measurable terms
    - Direct observation and measurement procedures
    - Current level (baseline)
    - Behavior reduction or acquisition procedures
    - Condition(s) under which behavior is to be demonstrated and mastery criteria
    - Date of introduction
    - Estimated date of mastery

- Plan for generalization
  - Timely reporting of progress, including statements as to whether goal or objective is met; not met; or, modified (with explanation)
- Parent/guardian/caregiver training
  - Proposed targets, goals, and objectives (as above)
  - Training procedures
  - Date of introduction
  - Estimated date of mastery
- Number of units requested
  - Number of units for each billing code
  - Medical necessity for units requested
- Supervision plan, including name(s) of authorized supervisor(s)
- Care coordination with parents/caregivers, schools, state disability programs, and others as applicable
- Transition (fading) plan
- Crisis management plan
- Discharge plan

### **6.2.3 Assessment and Behavior Plan for Reauthorization and Continuation of Services**

In addition to the documentation requirements indicated in 6.2.2, subsequent assessments and behavior plans for reauthorization and continuation of services must include:

- Data reflecting progress of all behaviors targeted for improvement. Each behavior under treatment must have its own data table and corresponding graph.
- A narrative discussion of progress and a statement of justification for continuation of care at the intensity level requested

If significant clinical progress is not made over the course of an authorized period, the provider must explain why clinically significant progress was not made and treatment changes to promote progress.

Respondent's Composite Exhibit 2 at pages 43-48.

20. 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.

21. Petitioner is under age 21, and therefore eligible for EPSDT services. However, a state may place appropriate limits on a service based on such criteria as medical necessity. *See* 42 C.F.R. §§ 440.230(a), (b), (d). Section 409.905(2), Florida Statutes, limits EPSDT services with a medical necessity standard:

The [Agency] shall pay for early and periodic screening and diagnosis of a recipient under age 21 to ascertain physical and mental problems and conditions and all services determined by the agency to be medically necessary for the treatment, correction, or amelioration of these problems and conditions, including personal care, private duty nursing, durable medical equipment, physical therapy, occupational therapy, speech therapy, respiratory therapy, and immunizations.

22. The Florida Medicaid Definitions Policy (“Definitions Policy”) (August 2017), which is incorporated by reference in Rule 59G-1.010, F.A.C., defines Medical Necessity as:

**2.83 Medically Necessary or Medical Necessity**

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

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

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

Respondent’s Composite Exhibit 2 at page 23.

23. 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 32-34.

24. Petitioner is under the age of 21 years and diagnosed with [REDACTED]. See supra ¶

3. The parties agree that Petitioner currently engages in maladaptive behaviors that threaten access to typical environments and negatively affect [REDACTED] activities of daily living. See supra ¶ 3.

Respondent agreed that BA services are medically necessary for Petitioner, but Respondent determined that the BA provider submitted insufficient documentation to justify the level of BA services requested for the certification period of December 27, 2023, through June 23, 2024.

See supra ¶ 6-7.

25. Respondent reduced Petitioner's behavior analysis services on the basis of medical necessity; specifically, Respondent determined that the services at issue are not "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 ¶ 6-7, 9. The medical necessity criteria are expressly outlined in section 2.83 of the Definitions Policy and a critical element for BA services. See supra ¶ 18-19, 22. The BA Policy mandates that a treatment plan must be detailed enough to warrant the requested services and include mechanisms to monitor and evaluate its effectiveness. See supra ¶ 19. Moreover, the Authorization Requirements Policy

states that eQHealth may deny a portion of the requested units of service if it cannot substantiate medical necessity based upon the information submitted. *See supra* ¶ 23.

26. Dr. Darling, a BCBA at the doctoral level, testified that the requested BA services at issue are not individualized and specific to Petitioner's needs, are in excess of Petitioner's needs, and are inconsistent with generally accepted standards of Applied Behavior Analysis. *See supra* ¶ 9-12. The documentation from the BA provider was peer reviewed by three Board Certified Behavior Analysts at eQHealth who agreed that Petitioner's provider did not submit sufficient justification for the requested number of BA service units. *See supra* ¶ 9. Dr. Darling maintained that Treatment Plan at issue can be effectively delivered with the number and type of units that have been approved in this case. *See supra* ¶ 9.

27. Dr. Darling provided credible and persuasive testimony concerning a number of areas in which the Treatment Plan fails to provide sufficient detail to justify the units requested. *See supra* ¶ 9-12. Most notably, maladaptive behaviors should decrease, and functionally equivalent replacement behaviors should increase, over the course of effective BA treatment and the BA provider should propose timely modifications if progress is not made. *See supra* ¶ 10. Petitioner's BA provider had an opportunity to correct the Treatment Plan on reconsideration, but the documentation provided was insufficient to support the additional units requested. *See supra* ¶ 12.

28. In this case, the parties agree that Petitioner continues to need BA services. However, the record does not demonstrate that the submitted information supports the medical necessity for requested frequency and/or duration of BA services. Thus, the record does not demonstrate that the requested services are individualized, specific, and consistent with symptoms or confirmed


diagnosis of the illness under treatment, and not in excess of the patient's needs. Accordingly, Petitioner has not shown that the requested services at issue are medically necessary. Looking at all the evidence relevant to the particular needs of Petitioner, the requested level of BA services at issue is not necessary to correct or ameliorate a defect or a physical and mental illness or condition. Through Dr. Darling's testimony, it became apparent that the BA provider had originally requested an increase in BA services in this case. However, because Respondent met their burden of proof concerning the reduction in BA services, a decision on the requested increase in BA services is unnecessary.

29. Accordingly, upon consideration of Respondent's Composite Exhibit 1, Respondent's Composite Exhibit 2, the testimony, and the applicable laws and policies, the undersigned concludes that Respondent proved by a preponderance of the evidence that the reduction of BA 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 3rd day of June 2024, in Tallahassee, Leon County, Florida.

Laura Gallagher  
24-FH0409  
 2024.06.03 07:49:19  
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**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]  
[REDACTED]

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