



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

FILED

Jul 29, 2024, 1:41 pm
OFFICE OF FAIR HEARINGS

[REDACTED]

PETITIONER,

AHCA Case No.: 24-FH0459

vs.

AGENCY FOR HEALTH CARE
ADMINISTRATION,

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned Hearing Officer convened a telephonic Fair Hearing on the instant case on April 1, 2024, at 1:02 p.m. EST.

APPEARANCES

For the Petitioner:

[REDACTED]

Petitioner's Authorized Representative

For the Respondent:

Sandra Durden
Medical Health Care Program Analyst
Agency for Health Care Administration

STATEMENT OF ISSUE

The issue is whether Respondent proved by a preponderance of the evidence that Respondent's decision to reduce Petitioner's behavior analysis ("BA") services was correct.

PRELIMINARY STATEMENT

All parties and witnesses appeared telephonically. [REDACTED], Clinical Director of [REDACTED], [REDACTED], appeared on behalf of the Petitioner. [REDACTED], Board Certified Behavior Analyst (“BCBA”), and [REDACTED], Petitioner’s [REDACTED], appeared on behalf of Petitioner.

Sandra Durden, Medical Health Care Program Analyst for the Agency for Health Care Administration (“Agency” or “AHCA”), appeared on behalf of Respondent. Dr. Joseph Darling (“Dr. Darling”), BCBA at the Doctoral Level (“BCBA-D”) and second level reviewer for eQHealth Solutions, Inc. (“eQHealth”), attended as a witness for Respondent.

Petitioner sent to the Office of Fair Hearings a 73-page evidence packet. The packet appears in the Office of Fair Hearings’ case management system as “24-FH0459 Evidence.pdf.” Absent an objection from the Respondent, the undersigned admitted the evidence packet into evidence as Petitioner’s Composite Exhibit 1.

Prior to the hearing, Respondent sent to the Office of Fair Hearings and Petitioner a 344-page evidence packet. The packet appears in the Office of Fair Hearings’ case management system as “[REDACTED] FH 03.21.2024 1-80.pdf,” “[REDACTED] FH 03.21.2024 81-126.pdf,” “[REDACTED] FH 03.21.2024 127-172.pdf,” “[REDACTED] FH 03.21.2024 173-217.pdf,” “[REDACTED] FH 03.21.2024 218-316.pdf,” and “[REDACTED] FH 03.21.2024 317-344.pdf.” Absent an objection from the Petitioner, the undersigned admitted the evidence packet into evidence as Respondent’s Composite Exhibit 1.

Prior to the hearing, Respondent sent to the Office of Fair Hearings a 49-page evidence packet. The packet appears in the Office of Fair Hearings’ case management system as “24-

FH0459 AHCA Evidence (Pages 1-49 of 49).pdf.” Absent an objection from the Petitioner, the undersigned admitted the evidence packet into evidence as Respondent’s Composite Exhibit 2.

FINDINGS OF FACT

1. Petitioner receives Medicaid services on a fee-for-service basis from the Agency. See Respondent’s Composite Exhibit 1 at page 22. eQHealth is a Quality Improvement Organization contracted by the Agency to review prior authorization requests for services. See Respondent’s Composite Exhibit 2 at page 2.

2. Petitioner is [REDACTED]. See Respondent’s Composite Exhibit 1 at page 16. Dr. Darling’s testimony established that Petitioner has participated in BA services with the current provider for approximately [REDACTED]. The Behavior Analysis Reassessment and Treatment Plan, dated January 9, 2024 (“Treatment “Plan”), identified the following maladaptive behaviors: [REDACTED], [REDACTED], [REDACTED], [REDACTED], [REDACTED], [REDACTED], [REDACTED], [REDACTED], and [REDACTED], . *Id.* at 69 - 89.

3. Petitioner requested the following BA services: 2,600 units of code 97153, 52 units of code 97156, 52 units of code 97155 HN, 312 units of code 97155, and 312 units of 97155 HN for the certification period of December 3, 2023, through May 30, 2024. *Id.* at 24-26. Administrative approval of BA services was granted pending the outcome of the Fair Hearing. *Id.* at 24.

4. On December 8, 2023, Respondent issued a Notice of Outcome (“NOO”), reducing Petitioner’s BA services from approximately 25 to 20 hours per week. *Id.* at 28-30. The NOO explained the basis for the decisions as follows:

[t]he 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.

PR Principal reason – Denial:

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

PR Clinical Rationale – Denial: According to the 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 29.

7. Petitioner requested reconsideration of the Respondent's decision. On January 10, 2024, 2024, Respondent issued a Untimely Request for Reconsideration. *Id.* at 40.

8. Dr. Darling 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"). Two qualified BCBA's with eQHealth independently reviewed the Treatment Plan submitted in this case to determine whether all five (5) conditions of medical necessity are met. An occupational therapist and speech therapist also reviewed the plan. *Id.* at 22. Dr. Darling explained that Petitioner's BA services were reduced because the BA reviewers determined that the Treatment Plan is not "individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness under treatment, and [is] in excess of the patient's needs." Dr. Darling agreed with the previous eQHealth reviewers that the Treatment Plan is in excess of Petitioner's needs and that a reduction is appropriate.

9. Dr. Darling testified that Petitioner originally requested the continuation of a total of 32 hours per week of BA services. *Id.* at 21. A total of 25 hours per week were approved based on the progress achieved over the course of treatment and the Treatment Plan submitted. Respondent's determination included a reduction in intensive 1 on 1 treatment and a reduction in BCaBA therapy. An eQHealth reviewer contacted the BA provider on December 8, 2023, left a message, and received no return call. *Id.* at 26. The BA provider's request for reconsideration was not considered because it was untimely made. *Id.* at 40. Nevertheless, Dr. Darling reviewed the documentation provided on reconsideration in preparing for the Fair Hearing, and he concluded that the documentation does not change his opinion that the reduction is warranted in this case.

10. Dr. Darling testified that that eQHealth's decision was made based on generally accepted medical standards in the field of BA. Based on the standards, a reduction in the frequency of maladaptive behaviors over time indicates that progress is being made. Similarly, an increase in the frequency of replacement behaviors measured over time indicates effective treatment. In this case, there is progress and the Treatment Plan does not contain enough information to show how much time is being used by the BA therapist to generate this progress. Normally, a Treatment Plan would contain weekly or daily data showing how Petitioner is progressing through treatment. In this case, the data graphs contain data points every two months making it very difficult to determine how much time the therapist is spending to teach each skill. Not sure how much time is necessary to allot for next six months to implement.

11. With regard to replacement skills, the data graphs show slow improvement. [REDACTED] shows an increase from [REDACTED] after [REDACTED] and [REDACTED] shows an increase from [REDACTED] *Id.* at 63. The data graphs for these contain one data point

per month, which makes it difficult to tell how much time is actually being spent on teaching these skills and how much time is needed going forward. Some of the data graphs, such as [REDACTED], contain no data points. *Id.* at 65-66. If no data is provided, then it is assumed that no therapy time is spent on addressing these skills. The data graph for [REDACTED] has one data point and that data graph for [REDACTED] has two data points, which suggests that not much therapy is provided for these skills and that progress is not being made. *Id.* at 67.

12. With regard to maladaptive behaviors, the data graphs contain weekly data points showing slow progress or variability. *Id.* at 69 - 89. This part of the Treatment Plan contains procedures to reduce maladaptive behaviors, which provides support in showing how much time is needed to implement treatment. The ABLLS-R data graphs show slow progress over the previous year. *Id.* at 59 -61. As Dr. Darling testified, the fact that there was not a lot of added therapy over the past year of treatment, and not a lot of progress was shown, factor into the decision to reduce the level of services. Based on the Treatment Plan as a whole, target behaviors, and what progress has been made, the units approved are sufficient to effectively implement the Treatment Plan. Petitioner will not gain any additional benefit by continuing BA services at the previously-approved level.

13. [REDACTED] testified that an updated Treatment Plan was submitted for reconsideration. See Petitioner's Composite Exhibit 1. Based on the updated plan, Petitioner's maladaptive behaviors show improvement. Also, the intensity of maladaptive behavior is stronger in the home setting and parent training is ongoing. [REDACTED] asserted that the intensity of the behavior presents a safety risk and Petitioner cannot be left unsupervised.

CONCLUSIONS OF LAW

14. 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).

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

16. Because Respondent terminated a previously approved service, Fla. Admin. Code R. 59-1.100(17)(g) assigns the burden of proof to the Respondent with regard to the termination of services. With regard to the request for additional BA services, Fla. Admin. Code R. 59-1.100(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.).

17. States must provide Early and Periodic Screening, Diagnostic, and Treatment ("EPSDT") services to Medicaid-eligible children under age 21 when requested under the Medicaid state plan. *See* 42 U.S.C. § 1396a(a)(43); 42 U.S.C. § 1396d(a)(4).

18. 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. A state may place medical necessity limitations on EPSDT services. *See* 42 C.F.R. §§ 440.230(a), (b), (d).

20. 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.

21. The Florida Medicaid 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.

Respondent’s Composite Exhibit 2 at page 23.

22. The Florida Medicaid Behavior Analysis Services Coverage Policy (September 2023) (“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.

...

1.4.6 Medically Necessary/Medical Necessity

As defined in Rule 59G-1.010, F.A.C.

...

2.0 Eligible Recipient

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2.2 Who Can Receive

Florida Medicaid recipients under the age of 21 years requiring BA services that are medically necessary to address behavior that impairs a recipient's ability to perform a major life activity. Such functional impairment is expressed through the following behaviors:

- Safety – aggression, self-injury, property destruction, elopement
- Communication – problems with expressive/receptive language, poor understanding or use of non-verbal communications, stereotyped, repetitive language
- Self-stimulating – abnormal, inflexible, or intense preoccupations
- Self-care – difficulty recognizing risks or danger, grooming, eating, or toileting
- Other behaviors not identified above but not limited to complexity of treatment, programming, or environmental variables

The recipient must be referred by an independent physician or practitioner qualified to assess and diagnose disorders related to functional impairment, including:

- Primary care physician with family practice, internal medicine, or pediatric specialty
- Board certified or board eligible physician with specialty in developmental behavioral pediatrics, neurodevelopmental pediatrics, pediatric neurology, adult or child psychiatry
- Child psychologist

The referral must include a comprehensive diagnostic evaluation (CDE) performed according to national evidence-based practice standards. CDEs may be performed by a multidisciplinary team or individual practitioner. In either case, the CDE must be led by a licensed practitioner working within their scope of practice. The CDE must include assessment findings and treatment recommendations appropriate to the recipient. For example, the CDE may include data from behavioral reports by parents, guardians, and/or teachers; diagnostic testing related to recipients'

development, behavior, hearing, and/or vision; genetic testing; and/or other neurological and/or medical testing.

Some services may be subject to additional coverage criteria as specified in section 4.0.

...

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 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
 - 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
 - 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
 - Maximum group size is six recipients
 - 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
 - Maximum group size is six recipients
 - 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
 - The recipient may or may not be present depending upon clinical appropriateness.
 - Services may be provided by Lead Analyst or BCaBA

- 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.

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23. In this case, Respondent reduced Petitioner's BA services. The NOO explained that Petitioner's request for continuation of services did not meet medical necessity as the Treatment Plan was not "individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment." See supra ¶ 5.

24. As provided in the BA policy and the EPSDT requirements, the recipient must meet the medical necessity criteria as outlined in Fla. Admin. Code R. 59G-1.010. One component of medical necessity is that 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." As outlined above, Dr. Darling provided credible and persuasive testimony identifying several instances where the revised Treatment Plan did not meet this criterion. For example, Dr. Darling testified that a reduction in the frequency of maladaptive behaviors over time indicates that progress is being made. Similarly, an increase in the frequency of replacement behaviors measured over time indicates effective treatment. In this case, there is progress and the Treatment Plan does not contain enough information to show how much time is being used by the BA therapist to generate this progress. Normally, a Treatment Plan would contain weekly or daily data showing how Petitioner is progressing through treatment. In this case, the data graphs for replacement behaviors contain data points every two months making it very difficult to determine how much time the therapist is spending to teach each skill. See supra ¶ 9 – 12.

25. With regard to maladaptive behaviors, the data graphs contain weekly data points showing slow progress or variability. *Id.* at 69 - 89. This part of the Treatment Plan contains procedures to reduce maladaptive behaviors, which provides support in showing how much time is needed to implement treatment. Based on the Treatment Plan as a whole, targeted behaviors,

and what progress has been made, Dr. Darling provided credible and persuasive testimony that the units approved are sufficient to effectively implement the Treatment Plan that that Petitioner will not gain any additional benefit by continuing BA services at the previously-approved level. *See supra* ¶ 9 – 12. The provider had multiple opportunities to update the Treatment Plan and did not do so on a timely basis. *See supra* ¶ 9.

26. Thus, Respondent demonstrated that, based on the information in the record, the previously approved level of BA services are not “individualized and specific to Petitioner and are in excess of Petitioner’s needs.” Therefore, the critical element of medical necessity is not met and the recipient will not gain any additional benefit by continuing services under the Treatment Plan at issue.

27. In this case, Petitioner’s provider recommended the continuation of BA services and an increase in services. 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* ¶ 21.

28. Accordingly, Respondent met their burden of proof to show that the previously approved level of BA services under the Treatment Plan at issue are no longer medically necessary. Looking at all the evidence relevant to the particular needs of Petitioner, the BA services at issue are not necessary to correct or ameliorate a defect or a physical and mental illness or condition.

29. Upon consideration of the testimony provided, Petitioner’s Composite Exhibit 1, Respondent’s Composite Exhibits 1 - 2, and the applicable law and policies, the undersigned finds that Respondent proved by a preponderance of the evidence that Respondent’s reduction of BA services 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 29th day of July 2024, in Tallahassee, Leon County, Florida.



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Laura Gallagher
Reason: 24-FH0459
Date: 2024.07.29
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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:

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AHCA Medicaid Hearing Unit
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