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

**FILED**

Jul 24, 2024, 12:53 pm

OFFICE OF FAIR HEARINGS

[redacted],

**PETITIONER,** **AHCA Case No.: 24-FH0539**

**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 9, 2024, at 9:09 a.m. EST.

## APPEARANCES

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

For the Respondent: Linda Latson
Registered Nurse Specialist
Agency for Health Care Administration

## STATEMENT OF ISSUE

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

## PRELIMINARY STATEMENT

All parties and witnesses appeared telephonically. [redacted] ("[redacted]"), Petitioner's Authorized Representative and [redacted], appeared on behalf of Petitioner. [redacted] ("[redacted]"), Board Certified Behavior Analyst ("BCBA"), testified on behalf of the Petitioner.

Linda Latson, Registered Nurse Specialist for the Agency for Health Care Administration ("Agency" or "AHCA"), appeared on behalf of Respondent. Dr. David Bicard ("Dr. Bicard"), Medical Director for eQHealth Solutions, Inc. ("eQHealth"), attended as a witness for Respondent.

Interpreter Maribel (# MMSP) and Interpreter Lucy (# 3762186) with Language Line Solutions provided Spanish translation services for Petitioner.

Prior to the hearing, Petitioner sent to the Office of Fair Hearings a one hundred and twenty-two (122)-page evidence packet. The packet appears in the Office of Fair Hearings' case management system as "24-FH0539 Petitioner Evidence.pdf." Absent an objection from 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 two hundred and ninety (290)-page evidence packet. The packet appears in the Office of Fair Hearings' case management system as "[redacted] FH 04.09.2024 1 – 124.pdf," "[redacted] FH 04.09.2024 125-210.pdf," "[redacted] FH 04.09.2024 211-280.pdf," "[redacted] FH 04.09.2024 281-290.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 and Petitioner a forty nine (49)-page evidence packet. The packet appears in the Office of Fair Hearings' case management system as "24-FH0539 AHCA Evidence BA Services 49 Pages.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. 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] and diagnosed with [redacted]. *See* Respondent's Composite Exhibit 1 at page 22. The Behavior Reassessment and Treatment Package, dated February 9, 2024, ("Treatment "Plan"), states that Petitioner engages in the following maladaptive behaviors: [redacted], and [redacted]. *Id*. at 207.

3. Petitioner requested the continuation of the following BA services: 312 units of code 97155, 208 units of code 917156, and 2,600 units of code 97153 for the certification period of January 16, 2024, through July 13, 2024. *Id*. at 26. Administrative approval of BA services was granted pending the outcome of the Fair Hearing. *Id*. at 25.

4. On January 11, 2024, Respondent issued a Notice of Outcome ("NOO"), terminating Petitioner's BA services. *Id.* at 29-31. The services were terminated because the Treatment Plan

did not meet the following medical necessity criteria as defined in Rule 59G-1.010, Florida Administrative Code ("F.A.C."):

> 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.

The analysis in the PR Clinical Rationale - Denial contained in the NOO is hereby incorporated by reference. *Id.* at 31.

5. Petitioner requested reconsideration of the Respondent's decision. On February 19, 2024, Respondent issued a Notice of Reconsideration Determination ("NRD") upholding its decision. *Id.* at 41-42. The NRD reiterates that the Treatment Plan does not meet the above-stated medical necessity criteria of Rule 59G-1.010, F.A.C. The analysis in the PR Recon Determination section of the NRD is hereby incorporated by reference. *Id*. at 42.

6. Dr. Bicard 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"). Three qualified BCBA's at the masters and Doctoral Level with eQHealth independently reviewed the Treatment Plan submitted in this case to determine whether all five (5) conditions of medical necessity are met. Dr. Bicard asserted that Petitioner's services were terminated because the reviewers determined that the Treatment Plan is not "individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness under treatment, and not in excess of the patient's needs" and is not "consistent with generally accepted professional medical standards as determined by the Medicaid program." Dr. Bicard agreed with the previous eQHealth

reviewers that the Petitioner is in need of behavior analysis services, and may qualify with a different BA provider; however, the Treatment Plan at issue does not meet medical necessity criteria.

7. Dr. Bicard established that an effective treatment plan is built around maladaptive behaviors (which decrease in frequency) and replacement skills (which increase in frequency) over the course of treatment. The effectiveness of a treatment plan is determined by reference to data, which is visually depicted in graphs showing a recipient's progress through treatment. Further, standards of care in ABA require an intervention or modification of the treatment plan if there is minimal to no progress being made. Dr. Bicard testified that code 97155 was approved during the last authorization to allow the BA provider to make protocol modifications to ensure ongoing progress during treatment; however, no modifications were indicated on the data graphs and this is contrary to the BA Policy.

8. Referring to Respondent's Composite Exhibit 1, beginning at page 213 - 235, Dr. Bicard asserted that the data graphs show that there has been no improvement on maladaptive behaviors over the last authorization period as follows. With regard to [redacted], Petitioner has worked on the behavior since [redacted] and continues to engage in the behavior with little progress. With regard to [redacted], Petitioner has worked on the behavior since [redacted] and continues to engage in the behavior with little progress. With regard to [redacted], the treatment is not part of the research base of ABA. With regard to [redacted], Petitioner has worked on the behavior since [redacted] with no meaningful progress shown, and the Treatment Plan does not clarify how this behavior differs from [redacted]. With regard to [redacted], Petitioner has been

working on the behaviors since [redacted] with no improvement. With regard [redacted], this behavior is a skill deficit rather than a maladaptive behavior and should be targeted with social skills training. With regard to [redacted], this is considered an easily treated behavior that Petitioner has worked on since [redacted] with no progress. The treatment for [redacted] does not meet standards of care has little chance of success. Standards of care int eh field of BA dictate that the lead analyst should intervene in a timely manner when progress is not shown. This recipient has not shown progress in over a year and no modifications have been made to the Treatment Plan to address the lack of progress.

9. At the Fair Hearing, [redacted] testified that new documentation to improve performance was sent to eQHealth. *See* Petitioner's Composite Exhibit 1. Petitioner's RBT was changed and he has noticed improvement in Petitioner's performance.

**CONCLUSIONS OF LAW**

10. 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).

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

12. Because Respondent terminated a previously approved service, Fla. Admin. Code R. 59-1.100(17)(g) assigns the burden of proof to the Respondent. 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.).

13. 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).

14. 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.

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

16. 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.

17. 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.

18. 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**
**. . .**
**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 no 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 much 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.

Respondent's Composite Exhibit 2 at pages 42-48.

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

**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 32-35.

19. In this case, Respondent terminated Petitioner's BA services. The NOO and NRD explained that Petitioner's request for continuation of services did not meet medical necessity criteria as the Treatment Plan was not "individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment" and not "consistent with generally

accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational." *See* supra ¶ 4-5.

20. As provided in the BA policy and the EPSDT requirements, the recipient must meet all five medical necessity criteria outlined in Fla. Admin. Code R. 59G-1.010. Two criteria of medical necessity are that services must be "consistent with generally accepted professional medical standards" and "consistent with generally accepted professional medical standards as determined by the Medicaid program." As outlined above, Dr. Bicard provided credible and persuasive testimony identifying several instances where the revised Treatment Plan did not follow generally accepted standards of BA. For example, the data graphs show that there has been no improvement or minimal improvement on maladaptive behaviors over the last authorization period. *See* supra ¶ 8. As Dr. Bicard established, the BA provider was authorized for code 97155 during the last authorization to allow the BA provider to make protocol modifications to ensure ongoing progress during treatment; however, no modifications were indicated on the data graphs. *See* supra ¶ 8-9. Therefore, the undersigned concludes that Treatment Plan does not meet standards of care in the field of BA and is not effective because it has not been individualized and specific to Petitioner's needs. Although the provider proposed some modifications to the Treatment Plan, standards of care in the field of BA require timely modifications to ensure that progress is ongoing during treatment. *See* supra ¶ 8-9.

21. Thus, Respondent demonstrated that, based on the information in the record, the BA services at issue are not "consistent with generally accepted professional medical standards" and are not "individualized and specific to [Petitioner's] needs." Because the services are not consistent with generally accepted professional medical standards, 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.

22. In this case, Petitioner's provider recommended the continuation of BA 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 ¶ 17.

23. Accordingly, Respondent met their burden of proof to show that the requested 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.

24. Upon consideration of the testimony provided, Petitioner's Composite Exhibit 1, Respondent's Composite Exhibit 1, Respondent's Composite Exhibit 2, and the applicable law and policies, the undersigned finds that Respondent proved by a preponderance of the evidence that Respondent's termination of BA services was correct.

## DECISION

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

**DONE** and **ORDERED** this 24th day of July 2024, in Tallahassee, Leon County, Florida.

Laura Gallagher
24-FH0539
2024.07.24
07:51:08 -04'00'

**LAURA GALLAGHER, Hearing Officer**
**Agency for Health Care Administration**
**Office of Fair Hearings**

**2727 Mahan Drive, Mail Stop # 11**
**Tallahassee, FL 32308-5407**

## NOTICE OF A RIGHT TO JUDICIAL REVIEW

A PARTY WHO IS ADVERSELY AFFECTED BY THIS FINAL ORDER IS ENTITLED TO JUDICIAL REVIEW, WHICH SHALL BE INSTITUTED BY FILING THE ORIGINAL NOTICE OF APPEAL WITH THE AGENCY CLERK OF AHCA, AND A COPY, ALONG WITH THE FILING FEE PRESCRIBED BY LAW, WITH THE DISTRICT COURT OF APPEAL IN THE APPELLATE DISTRICT WHERE THE AGENCY MAINTAINS ITS HEADQUARTERS OR WHERE A PARTY RESIDES. REVIEW PROCEEDINGS SHALL BE CONDUCTED IN ACCORDANCE WITH THE FLORIDA APPELLATE RULES. THE NOTICE OF APPEAL MUST BE FILED WITHIN 30 DAYS OF THE RENDITION OF THE ORDER TO BE REVIEWED.

**Copies Furnished To:**

[redacted]

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