



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

FILED

Sep 06, 2024, 10:52 am

[REDACTED]

PETITIONER,

OFFICE OF FAIR HEARINGS
AHCA Case No.: 24-FH1851

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 August 29, 2024, at 10:02 a.m. EST.

APPEARANCES

For the Petitioner:

[REDACTED]

Petitioner's Authorized Representative

For the Respondent:

Chrissie Simmons
Medical Health Care Provider Analyst
Fair Hearing Liaison
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. Petitioner’s Authorized Representative and [REDACTED], [REDACTED], (“[REDACTED]”), appeared and testified on behalf of [REDACTED].

Chrissie Simmons, Medical Health Care Provider Analyst and Fair Hearing Liaison for the Agency for Health Care Administration (“Agency” or “AHCA”) appeared on behalf of Respondent. Dr. David Bicard, (“Dr. Bicard”) Board Certified Behavior Analyst at the doctoral level (BCBA-D) and Director of Clinical Operations for eQHealth Solutions, Inc. (“eQHealth”), attended as a witness for Respondent.

Andrea, #389306 appeared and was sworn in as a Spanish translator.

The Petitioner did not submit any document for evidence prior to the hearing.

Prior to the hearing, Respondent sent to the Office of Fair Hearings and Petitioner a one hundred and ninety-one (191)-page evidence packet. The packet appears in the Office of Fair Hearings’ case management system as “[REDACTED] FH 08.29.2024 1-172.pdf” and “[REDACTED] FH 08.29.2024 173-191.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-FH1851 Behavior Analysis_AHCA Evidence.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]. See Respondent’s Composite Exhibit 1 at page 21. The Petitioner has been diagnosed with [REDACTED]. *Id.* at 21. The Petitioner has exhibited maladaptive behaviors including [REDACTED], [REDACTED], [REDACTED], [REDACTED], [REDACTED], [REDACTED] and [REDACTED]. *Id.* at 55-57.

3. Petitioner requested the following BA services: 3,120 units of code 97153, 104 units of code 97155, 208 units of code 97155HN, and 208 units of code 97156 for the certification period of January 30, 2024, through July 27, 2024. *Id.* at 28.

4. On February 7, 2024, Respondent issued a Notice of Outcome (“NOO”), denying Petitioner’s BA services. *Id.* at 28-29. The NOO explained the basis for the termination 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.

...

The NOO further provided:

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

PR Clinical Rational – 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 28-29.

5. Petitioner requested reconsideration of the Respondent's decision. On March 15, 2024, Respondent issued a Notice of Reconsideration Determination ("NRD") upholding its decision. *Id.* at 40-42. The NRD states, in pertinent part as follows:

Specifically, the services must be:

Individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness under treatment, and not in excess of the patient's needs.

...

PR Recon Determination: At reconsideration all documents were carefully reviewed. The provider did not submit and new documentation that supports the medical necessity of this request. The provider submitted new graphs that do not include data collected directly by the analyst during the authorized assessment. The baseline data was removed. 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 reconsideration request has been reviewed, reconsidered and the partial denial is upheld.

Id. at 40-42.

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"). eQHealth 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 denied/reduced because 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 therefore does not meet the conditions of being medically necessary.

7. Dr. Bicard explained the review process that is followed by eQhealth. However, before going through the review process, Dr. Bicard stated that the denial/reduction of services was based upon progress (improvement) in reducing maladaptive behaviors by the recipient. Dr. Bicard further testified that the treatment plan generally demonstrated improvement in treatment. The authorization period under consideration in this Fair Hearing began January 30, 2024, and expired on July 27, 2024. In fact, the recipient has already received a new authorization for services after the July 27, 2024, expiration date. However, the testimony of Dr. Bicard is directed to the point that under the previous authorization period (January to July), the recipient was approved for 17 hours of code 97153 (one on one therapy). Under this authorization, the recipient was making progress. This result by itself shows that the number of hours approved was sufficient to provide effective ABA treatment. Thus, the argument by the provider or the caregiver that more hours are needed simply confirms that such request is in excess of the patient's needs. To further support the fact that a request for additional hours would be in excess of the patient's needs, Dr. Bicard testified that the 1st level reviewer found that the recipient had been primarily diagnosed with [REDACTED]. The provider requested 33 hours per week of services. *Id.* at 23. Further, considering the documentation submitted, the first reviewer questioned the number of hours requested as being in excess of the patient's needs. The request

was sent to a second level review. The second level reviewer is a Board-Certified Behavior Analyst at the doctoral level (BCBA-D). Dr. Bicard testified that the second reviewer wrote that the documentation showed that while the recipient was still engaging in maladaptive behaviors, the frequency and intensity did not justify the number of hours requested by the provider. *Id.* at 23. Further, the second level reviewer stated that the services should be approved but at a lower level than requested by the provider. *Id.* The second level reviewer recommended denying/reducing the request for behavior analysis services based upon the documentation submitted. *Id.* at 23. A request was made for reconsideration and the provider, at that time, revised the requested services downward but still in an amount higher than what was suggested by the eQHealth review. *Id.* at 23. A third reviewer reconsidered the previous denial. The third reviewer is also a Board-Certified Behavior Analyst at the doctoral level (BCBA-D). The provider submitted a reduced request for services, but the third level reviewer found no documentation to support the providers requested hours of services. *Id.* at 23-24. In considering the previous denial/reduction, the third reviewer found that the supplemental documentation from the provider, did not medically support additional/increased units of treatment. The prior denial/reduction was upheld. *Id.* at 23 & 24.

8. Dr. Bicard established that an effective treatment plan is built around maladaptive behaviors (which decrease in frequency) and skills to be acquired (which increase in frequency) over the course of treatment. Dr. Bicard testified that when a provider request ABA service hours/units, the Treatment Plan must support the requested hours with data and goals that meet the requirements of medical necessity. If not, those hours cannot be authorized.

9. Dr. Bicard reviewed the initial review of the providers request in the Notice of Outcome. *Id.* at 28-29. The reason for the denial/reduction of the services request was stated that the request was in excess of the patient's needs. *Id.* Dr. Bicard also reviewed the Notice of Reconsideration. *Id.* 40-42. The reason the denial/reduction was upheld was that the requested services were in excess of the patient's needs. *Id.* Dr. Bicard also testified that in his review of this matter the provider's requested service hours exceeded the needs of the patient. Dr. Bicard pointed out that the first reviewer is a BCBA at the master's level and the second and third reviewers and himself are all BCBA's at the doctoral level and all four individuals came to the same conclusion. Dr. Bicard opined that the service hours/units requested by the provider for this recipient were in excess of the patient's needs and therefore the providers request did not meet medical necessity at the requested level.

10. [REDACTED] testified on behalf of [REDACTED]. [REDACTED] sees improvement in [REDACTED] with ABA services. [REDACTED] believes that [REDACTED] needs ABA services and would like him to receive the treatment hours requested by this provider. [REDACTED] testified that [REDACTED] is [REDACTED] is going back to school, and [REDACTED] has issues at school. [REDACTED] testified that [REDACTED] was only approved for seventeen (17) hours, and [REDACTED] needs at least twenty-five (25) hours of services. [REDACTED] is worried that if [REDACTED] therapy hours are reduced, [REDACTED] may regress in [REDACTED] behaviors. [REDACTED] stated that [REDACTED]

11. No rebuttal testimony was presented by Dr. Bicard, however [REDACTED] did suggest to [REDACTED] that if [REDACTED] or the provider observed any negative changes for [REDACTED] that the provider can request a modification of the authorized hours even in the middle of the authorization period. Dr. Bicard opined that based upon the treatment plan, the documentation submitted for review, and the results of the past therapy, the hours requested by the provider were in excess of the recipients needs at this time.

CONCLUSIONS OF LAW

12. 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).

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

14. Because Respondent reduced 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.).

15. 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).

16. 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.

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

18. 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.

19. 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

20. 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 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
 - 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
 - o Treatment setting(s)
 - o Proposed treatment targets, goals, and objectives related to medically necessary behavioral interventions
 - o 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
 - o Proposed targets, goals, and objectives (as above)
 - o Training procedures
 - o Date of introduction
 - o Estimated date of mastery
- Number of units requested
 - o Number of units for each billing code
 - o 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.

...

Pages 1 – 8 of BA Policy.

21. The Florida Medicaid Authorization Requirements Policy (“Authorization Policy”), incorporated by reference in Fla. Admin. Code R. 59G-1.053, provides as follows:

3.2.1 Continued Authorization Request

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 error 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.

...

Page 3 of Authorization Policy.

22. In this case, Respondent reduced Petitioner’s BA services. The NOO and NRD explained that Petitioner’s request for services did not meet medical necessity as the treatment plan was not “Individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness under treatment, and not in excess of the patient’s needs.” See supra ¶ 4-5.

23. 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. A component of medical necessity is that services are “not in excess of the patient’s needs.” As outlined above, Dr. Bicard provided credible and persuasive testimony identifying several instances where the recipient has made improvements in both the maladaptive behaviors and the replacement skills. See supra ¶ 7 & 9. For example, the documentation provided for review shows that while the recipient is still

engaging in maladaptive behaviors, the frequency and intensity did not justify the number of hours/units of services requested by the provider. *See supra* ¶ 7 & 9. Dr. Bicard testified that there is no specific standard for reducing therapy hours. It is determined on a case-by-case review. As ABA services are effective, the recipient learns to rely upon replacement skills and maladaptive behaviors are minimized. Because this recipient is making positive progress as shown by the evidence submitted, the requested hours exceed the recipients need for services. *See supra* ¶ 6-9.

24. 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* ¶ 19.

25. Accordingly, Respondent has established by a preponderance of the evidence that the requested BA services hours are not 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.

26. Upon consideration of the testimony provided, 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 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 6th day of September 2024, in Tallahassee, Leon County, Florida.

George L. Winslow,

Jr.



24-FH1851

2024.09.06 09:12:01

-04'00'

GEORGE WINSLOW, Hearing Officer
Agency for Health Care Administration
Office of Fair Hearings
2727 Mahan Drive, Mail Stop # 11
Tallahassee, FL 32308-5407

NOTICE OF A RIGHT TO JUDICIAL REVIEW

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

Copies Furnished To:



AHCA Medicaid Hearing Unit
MedicaidHearingUnit@ahca.myflorida.com