



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

**FILED**

Sep 25, 2024, 11:37 am

[REDACTED]

PETITIONER,

OFFICE OF FAIR HEARINGS  
AHCA Case No.: 24-FH2014

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 September 10, 2024, at 9:01 a.m. EST.

**APPEARANCES**

For the Petitioner:

[REDACTED]

Petitioner's Authorized Representative

For the Respondent:

Diana Hearod  
Medical Health Care Provider Analyst  
Fair Hearing Liaison  
Agency for Health Care Administration

**STATEMENT OF ISSUE**

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

**PRELIMINARY STATEMENT**

All parties and witnesses appeared telephonically. Petitioner’s Authorized Representative and [REDACTED], [REDACTED], (“[REDACTED]”), appeared and testified on behalf of [REDACTED].

Diana Hearod, 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.

Petitioner did not submit any documents for evidence for the Fair Hearing.

Prior to the hearing, Respondent sent to the Office of Fair Hearings and Petitioner a two hundred and eighteen (218)-page evidence packet. The packet appears in the Office of Fair Hearings’ case management system as “[REDACTED] FH 09.10.2024 1-78.pdf,” “[REDACTED] FH 09.10.2024 79-118.pdf,” “[REDACTED] FH 09.10.2024 119-163.pdf,” “[REDACTED] FH 09.10.2024 164-204.pdf,” and “[REDACTED] FH 09.10.2024 205-218.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-FH2414 B A AHCA EVIDENCE 49 PGS (Petitioner’s name).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 16. The Petitioner has been diagnosed with [REDACTED]. *Id.* at 16. The Petitioner has exhibited maladaptive behaviors including [REDACTED], [REDACTED], [REDACTED], [REDACTED], [REDACTED], [REDACTED], [REDACTED], [REDACTED], [REDACTED], [REDACTED], [REDACTED], and [REDACTED]. *Id.* at 82.

3. Petitioner requested the following BA services: 3,120 units of code 97153, 312 units of code 97155, 312 units of code 97155HN, 104 units of code 97156 and 104 units of code 97156HN for the certification period of June 3, 2024, through November 29, 2024. *Id.* at 24.

4. On June 5, 2024, Respondent issued a Notice of Outcome ("NOO"), denying Petitioner's BA services. *Id.* at 24-25. The NOO explained the basis for the denial as follows:

[T]he requested services are not medically necessary under the following standard(s):

Consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational.  
Individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness under treatment, and not in excess of the patient's needs.

...

The NOO further provided:

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

PR Clinical Rational – Denial: The information submitted does not meet standards of care within the field of behavior analysis. According to the Florida Medicaid State Plan (page 7, 6.2.2), assessment results must be present in the plan. The provider has included data and graphs for skill acquisition goals and maladaptive behaviors that were based on parent report, estimated or extrapolated average and sourced from indirect interview; and were not directly observed or measured as standards of care within the field of behavior analysis. This request is denied.

*Id.* at 24-25.

5. Petitioner requested reconsideration of the Respondent’s decision. On June 13, 2024, Respondent issued a Notice of Reconsideration Determination (“NRD”) upholding its decision. *Id.* at 36-37. 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.  
Consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational.

...

PR Recon Determination: At reconsideration all documents were carefully reviewed. The information submitted does not meet standards of care within the field of behavior analysis. According to the Florida Medicaid State Plan (page 7, 6.2.2), assessment results must be present in the plan. The provider has included data and graphs for skill acquisition goals and maladaptive behaviors that were based on parent report, estimated or extrapolated average and sourced from indirect interview; and were not directly observed or measured as standards of care within the field of behavior analysis. This denial is upheld.

*Id.* at 37.

6. [REDACTED] testified on behalf of [REDACTED]. [REDACTED] testified that [REDACTED] had received [REDACTED] is concerned about [REDACTED]’s behavioral issues. [REDACTED]

[REDACTED]

[REDACTED] said that [REDACTED] does not understand that the way to handle the situation is to obtain help from an adult. [REDACTED] stated that [REDACTED] had been in other schools and in a school which was established to deal with students that have behavior problems. Currently, [REDACTED] attends the school where [REDACTED] is employed in a security position. With this arrangement, [REDACTED] is able to protect and re-direct [REDACTED] and also protect others around [REDACTED]. [REDACTED] testified that there are adult individuals at the school that deal with behavioral issues, and [REDACTED] requested their assistance concerning [REDACTED]. [REDACTED] prepared the behavior analysis plan involving the recipient. This plan will be further reviewed by Dr. Bicard. [REDACTED] stated that [REDACTED] wants help for [REDACTED] as [REDACTED] feels like [REDACTED] is on edge everyday concerning [REDACTED] behaviors.

7. 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 because the treatment plan is not consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational and therefore does not meet the conditions of being medically necessary.

8. Dr. Bicard explained the review process that is followed by eQhealth. In this review, Dr. Bicard testified that the 1<sup>st</sup> level reviewer found that the recipient had been diagnosed with [REDACTED]. The provider requested [REDACTED] hours per week of services. *Id.* at 19.

Further, the first reviewer questioned the appropriateness of the hours requested based upon the documentation submitted and the request was sent to a second level review. *Id.* at 19. 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 submitted did meet the standard of care in the field of behavior analysis. Further, the second reviewer found that the data and graphs for maladaptive behaviors and skill acquisition appeared to be based upon parent reports, estimated or extrapolated averages or sourced from indirect interviews. *Id.* at 19. The second level reviewer denied the request for behavior analysis services based upon the documentation submitted. *Id.* at 19. A request was made for reconsideration and a third reviewer reconsidered the denial. The third reviewer is also a Board-Certified Behavior Analyst at the doctoral level (BCBA-D). In addition to confirming the previous denial the third reviewer also found that the treatment plan appeared to be based upon non-directly observed information *Id.* at 20. The prior denial was upheld. *Id.*

9. 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 this provider has failed to establish a Treatment Plan that will accomplish the purpose of ABA. Dr. Bicard did state that the recipient may need ABA services but that a proper treatment plan would need to be presented for consideration.

10. Dr. Bicard reviewed the treatment plan, and the information submitted concerning the maladaptive behaviors. Dr. Bicard first commented on the recipient's higher than normal [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED] Dr. Bicard stated that with this level of communication the recipient has a higher opportunity to respond to proper ABA treatment. Dr. Bicard reviewed the graph for [REDACTED] which recorded [REDACTED] occurrences on [REDACTED]. *Id.* at 85. Next, [REDACTED] reviewed the graph for [REDACTED] which showed [REDACTED] occurrences on [REDACTED]. *Id.* at 86. Next graph is for [REDACTED] with [REDACTED] occurrences on [REDACTED]. *Id.* at 87. The next graph is for [REDACTED] with [REDACTED] occurrences recorded on [REDACTED]. *Id.* at 88. At this point Dr. Bicard referred back to a question during cross examination of [REDACTED] concerning where and how often the behavior analyst observed the recipient. [REDACTED] had testified that the analyst was present approximately one hour during observation of [REDACTED] at home and the analyst could see [REDACTED] on some occasions at school during [REDACTED] other duties. Dr. Bicard pointed out that this evidence indicates that during the one-hour observation at the recipient's home, on just the four graphs listed above, the analyst observed [REDACTED] maladaptive behavior occurrences. Further, if you included all of the graphs submitted, there are over [REDACTED] maladaptive behavior occurrences in the one-hour period. Dr. Bicard testified that the data submitted is incorrect and unreliable as recorded by the provider. Dr. Bicard found the same lack of believability in the data recorded on the skill replacement graphs. Dr. Bicard opined that the treatment plan as written was not consistent with generally accepted professional medical standards as determined by the Medicaid program and not experimental and investigational and therefore did not meet the criteria to be found to be medically necessary.

11. Dr. Bicard also testified that eQHealth has available a peer-to-peer program where a provider can consult with eQHealth personnel concerning treatment plans, however this provider did not seek to use that opportunity.

### **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 Petitioner is seeking a new service, 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.).

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.

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### **1.4.6 Medically Necessary/Medical Necessity**

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

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## **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.

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#### **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.)

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#### **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.

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### **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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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.

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Page 3 of Authorization Policy.

22. In this case, Respondent denied 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 “[c]onsistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational.” See supra ¶¶ 4-5.

23. As provided in the BA policy and the EPSDT requirements, the recipient must meet the meet the medical necessity criteria as outlined in Fla. Admin. Code R. 59G-1.010. A component of medical necessity is that services must be “consistent with generally accepted professional medical standards.” As outlined above, Dr. Bicard provided credible and persuasive testimony identifying several instances where the Treatment Plan did not follow generally accepted standards of ABA. For example, the treatment plan provided for review appears to be based upon parent reports, estimated or extrapolated averages, or sourced from indirect interviews. Further, as Dr. Bicard testified, the number of maladaptive events recorded by the provider would result

in over [REDACTED] events during a one-hour observation of the recipient at home. Dr. Bicard found the recorded data to be unbelievable and unreliable. *See supra* ¶ 10. Thus, Respondent demonstrated that, based on the information in the record, the requested BA services are not “consistent with generally accepted professional medical standards.” Because the services are not consistent with generally accepted professional medical standards, the critical element of medical necessity is not met. *See supra* ¶ 7.

24. In this case, Petitioner’s provider recommended the 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, Petitioner has not established by a preponderance of the evidence that the requested BA services are not medically necessary. Looking at all the evidence relevant to the particular needs of Petitioner, the Petitioner has not shown that BA services at issue are 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 Petitioner has failed to prove by a preponderance of the evidence that Respondent’s denial of BA services was incorrect.

### **DECISION**

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

**DONE** and **ORDERED** this 25<sup>th</sup> day of September 2024, in Tallahassee, Leon County, Florida.

  
George L.  
Winslow, Jr.  
24-FH2014  
2024.09.25  
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**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**