

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



FILED

Oct 27, 2023, 12:15 pm
OFFICE OF FAIR HEARINGS

[REDACTED]

PETITIONER,

AHCA Case No.: 23-FH1435

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 13, 2023, at 9:00 a.m. EST.

APPEARANCES

For the Petitioner:

[REDACTED]

Petitioner's Authorized Representative

For the Respondent:

Lee Ann Williams
Medical Health Care Program Analyst
Agency for Health Care Administration

STATEMENT OF ISSUE

The issue is whether Petitioner proved by a preponderance of the evidence that Respondent's denial of additional behavior analysis ("BA") services (564 units of code 97153) was incorrect.

PRELIMINARY STATEMENT

All parties and witnesses appeared telephonically. Petitioner's Authorized Representative and [REDACTED], [REDACTED] ("[REDACTED]"), appeared on behalf of the Petitioner. Denisse Alvarez Mesa appeared as a witness for Petitioner.

Lee Ann Williams, Medical Health Care Program Analyst for the Agency for Health Care Administration ("Agency" or "AHCA"), appeared on behalf of Respondent. Dr. David Bicard ("Dr. Bicard"), BCBA at the Doctoral Level ("BCBA-D") and Director of Clinical Operations for eQHealth Solutions, Inc. ("eQHealth"), attended as a witness for Respondent.

Interpreter Alberto, ID No. 369310 with Language Line Solutions, provided Spanish translation services for Petitioner.

Prior to the hearing, Petitioner sent to the Office of Fair Hearings an seventy-six (76)-page evidence packet. The packet appears in the Office of Fair Hearings' case management system as "23-FH1435 Received Mail Supporting Documents 1.pdf" and "23-FH1435 Received Mail Supporting Documents 2.pdf." Absent an objection from the Respondent, the undersigned admitted the evidence packet into evidence as Petitioner's Composite Exhibit 1.

Prior to the hearing, Petitioner sent to the Office of Fair Hearings a fifty-two (52)-page evidence packet. The packet appears in the Office of Fair Hearings' case management system as "23-FH1435 DAR and Supporting Documents.pdf." Absent an objection from the Respondent, the undersigned admitted the evidence packet into evidence as Petitioner's Composite Exhibit 2.

Prior to the hearing, Respondent sent to the Office of Fair Hearings and Petitioner a one hundred and sixty-eight (168)-page evidence packet. The packet appears in the Office of Fair Hearings' case management system as "[REDACTED] FH 08.24.2023 1-124.pdf" and "[REDACTED] FH

08.24.2023 125-168.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 “AHCA EVIDENCE PKT.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 through the Agency. *See* Respondent’s Composite Exhibit 1 at page 21.

2. eQHealth is a Quality Improvement Organization (“QIO”) contracted by the Respondent to review prior authorization requests for services. *See* Respondent’s Composite Exhibit 2 at page

2. Respondent, through contractual agreement, authorizes eQHealth to make medical necessity determinations for services requiring prior authorization, including BA services. *Id.*

3. As of the date of the Fair Hearing, Petitioner is a [REDACTED] diagnosed with [REDACTED]. *See* Respondent’s Composite Exhibit 1 at page 21. Petitioner’s BA provider,

[REDACTED]. identified the following maladaptive behaviors in the Intervention Plan: Update, signed by [REDACTED] on April 26, 2023, (“Treatment Plan”):

[REDACTED], [REDACTED], [REDACTED] (“[REDACTED]”), [REDACTED], [REDACTED], [REDACTED], [REDACTED], and [REDACTED]. *Id.* at 100-101. The

parties agree that Petitioner engages in maladaptive behaviors that threaten access to typical environments and negatively affect [REDACTED] activities of daily living. *Id.* at 28. Petitioner submitted

letters from providers requesting forty (40) hours per week of BA services. *Id.* at 144, 145, 147, 152.

4. On June 8, 2023, Respondent issued a Notice of Outcome (“NOO”) denying a requested increase in BA services. *Id.* at 27.28. The NOO states as follows:

Code: 97153 Intervention without protocol modification, per 15 minutes, Lead Analyst, BCaBA, or RBT
From: 4/03/23
Thru: 10/26/23
Total Units Denied – 1,084
Total Units Approved – 2,600

Code: 97155 Intervention with protocol modification, per 15 minutes
From: 4/03/23
Thru: 10/26/23
Total Units Approved - 307

Code: 97156 Family Training, per 15 minutes
From: 4/03/23
Thru: 10/26/23
Total Units Approved - 205

The request for services is denied in whole or in part because they are not medically necessary as defined in Rule 59G-1.010, Florida Administrative Code. Specifically, the 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 rationale for our decision is as follows:
PR Principal Reason - Denial:

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

PR Clinical Rationale – Denial: According to Behavior Analysis Services Coverage Policy requests for services must be based on the medical necessity of the recipient’s maladaptive behaviors and skill deficits. **The recipient is engaging in problem behaviors that threaten access to typical environments and negatively**

affects activities of daily living. However, the frequency, intensity, or severity of the recipient’s maladaptive behaviors does not justify the requested units of services. The requested hours of ABA services are in excess of medical necessity.

Id. (emphasis added).

5. On May 26, 2023, Petitioner requested reconsideration. *Id.* at 38. On June 8, 2023, Respondent issued a Notice of Reconsideration Determination (“NRD”) approving an additional 520 units of code 97153 and leaving the balance of Petitioner’s request (564 units of code 97153) in dispute. *Id.* at 38-39. The NRD states as follows:

Code: 97153 Intervention without protocol modification, per 15 minutes, Lead Analyst, BCaBA, or RBT
From: 4/03/23
Thru: 10/26/23
Total Units Denied – 1,084
Total Units Approved – 2,600
Units Added at Recon - 520

Code: 97155 Intervention with protocol modification, per 15 minutes
From: 4/03/23
Thru: 10/26/23
Total Units Approved - 307

Code: 97156 Family Training, per 15 minutes
From: 4/03/23
Thru: 10/26/23
Total Units Approved – 205

The reason for the denial is that the services are not medically necessary as defined in 59G-1.010, Florida Administrative Code. 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.

The rationale for our decision is as follows:

PR Recon Determination: Provider, the document submitted for reconsideration is illegible (faded, blurred out). The document cannot be viewed by the reviewer at reconsideration. At reconsideration all documents were carefully reviewed. The

provider did not submit any new documentation that supports the medical necessity of this request. According to the Behavior Analysis Services Coverage Policy, (page 6, 9.0.c-d) 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.

6. On June 15, 2023, Petitioner requested a Fair Hearing based on Respondent's denial of additional BA services (564 units of code 97153). *Id.* at 8. After two continuances, the undersigned issued an order rescheduling the Fair Hearing for October 3, 2023, at 9:00 a.m.

7. At the Fair Hearing, [REDACTED] testified as a lay person to Petitioner's right to BA treatment and medication. [REDACTED] stressed that Petitioner should be authorized for the full amount of behavior analysis services [REDACTED] requested and needs.

8. Ms. Mesa, a BCBA, is lead analyst on Petitioner's case and the person who is responsible for writing the Treatment Plan at issue. She has been the lead analyst since [REDACTED]. Ms. Mesa conceded that she is not on-site to perform clinical supervision over Petitioner's case. *Id.* at 148. She performs supervision via telehealth and conducts a site visit "every month or so." She testified that Petitioner's BA provider does not have any Spanish-speaking behavior analysts in the [REDACTED] area. Ms. Mesa admitted that her physical absence has had a "huge impact" and has "hindered Petitioner's progress." Ms. Mesa testified that Petitioner's BA services have been provided inconsistently because the provider could not find a Spanish speaking Registered Behavior Technician ("RBT") in the area.

9. Dr. Bicard testified that Petitioner has received BA services since [REDACTED], and [REDACTED] has received BA services from the current provider since [REDACTED]. Dr. Bicard confirmed

that, during the last authorization period, Petitioner was approved for twenty-seven (27) hours per week of BA services. Further, the Petitioner's services were increased this authorization period to thirty (30) hours per week of BA services. Dr. Bicard testified that the increase in services is authorized despite the following: the provider admittedly provided services inconsistently during the last authorization period; the provider testified that her inability to be physically present with Petitioner has affected ■ progress; and the provider could not explain the basis for requesting the additional hours at issue in this case. Dr. Bicard testified that an increase in BA services was authorized because the Treatment Plan shows that the recipient is engaging in several forms of maladaptive behavior that are concerning. The reviewers also considered and accounted for the fact that a new RBT was starting on Petitioner's case. However, based on Ms. Mesa's testimony at the hearing, Dr. Bicard testified that the eQHealth reviewers were not aware that the lead analyst would not be able to perform case management tasks on site, which is a requirement for BA services. According to standards of care in the field of BA, an RBT cannot provide services without the clinical oversight of the Lead Analyst. Dr. Bicard opined that the authorized level of BA services is more than adequate based on the Treatment Plan, maladaptive behaviors, and identified replacement goals and that the additional services at issue are in excess of Petitioner's needs.

CONCLUSIONS OF LAW

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

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

12. Pursuant to Fla. Admin. Code R. 59G-1.100(17)(g), the burden of proof is as follows:

The burden of proof is on the party asserting the affirmative of an issue, except as otherwise required by statute. The burden of proof is on the Agency or plan, whichever is applicable, when the issue presented is the suspension, reduction, or reduction of a previously authorized service. The burden of proof is on the recipient or enrollee, when the issue presented is the denial or a limited authorization of a service. The party with the burden of proof shall establish its position to the satisfaction of the Hearing Officer by a preponderance of the evidence.

13. Because Petitioner requested additional services in this case, the burden of proof is on the Petitioner. *See* Fla. Admin. Code R. 59G-1.100(17)(g). The standard of proof in an administrative hearing is a preponderance of the evidence. *Id.* The preponderance of the evidence standard requires proof by “the greater weight of the evidence” (Black’s Law Dictionary at 1201, 7th Ed.).

14. The Behavior Analysis Services Coverage Policy (October 2017) (“BA Policy”), incorporated by reference in Fla. Admin. Code R. 59G-4.125, governs Behavior Analysis services available to Medicaid recipients in the State of Florida. *See* Respondent’s Composite Exhibit 2 at pages 40 - 44. The BA Policy states 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.

1.1 Florida Medicaid Policies

This policy is intended for use by providers that render BA services to eligible Florida Medicaid recipients. It must be used in conjunction with Florida Medicaid’s General Policies (as defined in section 1.3) and any applicable service-specific and claim reimbursement policies with which providers must comply.

Note: All Florida Medicaid policies are promulgated in Rule Division 59G, Florida Administrative Code (F.A.C.). Coverage policies are available on the Agency Web site at <http://ahca.myflorida.com/Medicaid/review/index.shtml>.

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1.4 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.

1.4.4 Lead Analyst

Practitioner responsible for the implementation of BA services including: the completion and review of behavior assessments, reassessments, behavior plans, and behavior plan reviews.

1.4.5 Medically Necessary/Medical Necessity

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

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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:

4.2.2 Behavior Analysis

Up to 40 hours per week, per recipient, consisting of services identified on the recipient's behavior plan in order to reduce maladaptive behaviors and to restore the recipient to his or her best possible functional level. Services include:

- Implementing behavior analysis interventions, and monitoring and assessing the recipient's progress towards goals in the behavior plan
- Behavior analysis interventions, for example, discrete trial teaching, task analysis training, differential reinforcement, non-contingent reinforcement, conducting task analyses of complex responses, and teaching using chaining, prompting, fading, shaping, response cost, and extinction
- Training the recipient's family, caregiver(s), and other involved persons on the implementation of the behavior plan and intervention strategies (the recipient must be present when clinically appropriate)

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 section 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 General Policies on authorization requirements.

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6.0 Documentation

6.1 General Criteria

For information on general documentation requirements, please refer to Florida Medicaid's General Policies on recordkeeping and documentation.

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6.2 Specific Criteria

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

- Behavior assessment, and assessment review that must be reviewed and signed by a lead analyst;
- Behavior plan, and behavior plan review that must be reviewed and signed by a lead analyst;
- Notations when the recipient's family or caregiver is not able to participate in BA services, and instances when it was clinically inappropriate for the recipient to be present during training services; and
- Written physician's order.

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7.0 Authorization

7.1 General Criteria

The authorization information described below is applicable to the fee-for-service delivery system. For more information on general authorization requirements, please refer to Florida Medicaid's General Policies on authorization requirements.

7.2 Specific Criteria

Providers must obtain authorization from the quality improvement organization (QIO) prior to the initiation of BA services and at least every 180 days thereafter.

Providers may request authorization more frequently upon a change in the recipient's condition requiring an increase or decrease in services.

The QIO uses the review criteria specified in section 9.0 for the first level review. For more information on how the QIO uses the criteria in the review process, please refer to Florida Medicaid's General Policies on authorization requirements.

Id.

15. The BA Policy's Appendix 9.0 states the following review criteria:

Behavior analysis (BA) services are considered as either the treatment of choice or as an adjunct treatment modality for a variety of conditions and disorders where maladaptive behaviors are part of the recipient's clinical presentation, including behavioral manifestations of diagnoses such as Autism Spectrum Disorder and other behavioral health conditions.

Critical Elements Necessary for ANY Type of Behavior Analysis Service:

The following critical elements **MUST** be satisfied to qualify for BA services:

- a. Eligibility – the recipient must meet all criteria for Behavior Analysis services as outlined in the Behavior Analysis Services Coverage Policy, Rule 59G-4.125, F.A.C.;
- b. Medical necessity – the recipient must meet medical necessity criteria as outlined in in Rule 59G-1.010, F.A.C.;
- c. The recipient currently engages in maladaptive behaviors; and
- d. These maladaptive behaviors interfere with the recipient's daily functioning.

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2. Criteria for Behavior Analysis Services and Reassessments - ALL of the following MUST be satisfied:

- a. **ALL** critical elements are met
- b. An assessment or, if applicable, a reassessment, authored by a lead analyst, is provided. An assessment of the maladaptive behavior(s) is a necessary element of the process of identifying the frequency and magnitude of the behaviors as well as the variables associated with the occurrence of the maladaptive behavior(s). This helps in defining what are the functional consequences of the problem behavior(s) so that an adequate behavior plan can be implemented. This (re)assessment **MUST** include, at a minimum, **ALL** of the following:
 - i. A clear operational description of the maladaptive behavior(s)
 - ii. Baseline and/or updated treatment data (if reassessment)
 - iii. Progress toward identified goals (if a reassessment)
 - iv. Identification of the events, times, and situations that appear to be associated to the occurrence of the maladaptive behavior(s)
 - v. Identification of the functional consequences of the maladaptive behavior(s)
 - vi. Development of hypotheses and summary statements that describe the maladaptive behavior(s) and its(their) functions
 - vii. Summary and recommendations
- c. A behavior plan authored or updated by a lead analyst. The behavior plan is the cornerstone of the delivery of behavior analysis services and it is based on the information obtained in the assessment. It proposes specific interventions

to reduce or eliminate the maladaptive behavior. These interventions take into consideration the variables, both present before the behavior, as well as after the behavior, that influence the occurrence of the maladaptive behavior(s). This plan also includes replacement appropriate behaviors for the recipient to engage in instead of the maladaptive behaviors in order to obtain the same function. The plan must be detailed enough to warrant the requested services and include mechanisms to monitor its effectiveness. This **MUST** include, at a minimum, **ALL** of the following:

- i. Observable and measurable descriptions of the maladaptive behavior(s)
- ii. Identified function of the maladaptive behavior(s) behavior as a result of the assessment or reassessment conducted
- iii. Goals and strategies for changing the maladaptive behavior(s)
- iv. Written detailed description of when, where, and how often these goals will be addressed and proposed strategies will be implemented
- v. System for monitoring and evaluating the effectiveness of the plan
- vi. Safety and crisis plan, if applicable
- vii. Summary and recommendations
- viii. Discharge criteria
- ix. Transition Plan (if applicable)

NOTE: Although the assessment and behavior plan were addressed separately in section 2, both of them can be submitted as a single document.

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3. Criteria for Continuation of Treatment at the Present Level and/or Using Current Methods: Providers must ensure that ALL of the following criteria are met to request continuation of treatment at the present level or using the current methods. If criteria for 3a is met, but criteria for 3b and/or 3c are not met, then a reduction of the treatment level and/or change of treatment methods may be warranted.

...

a. **ALL** criteria listed in 2a, 2b, and 2c regarding critical elements, assessment or reassessment, and behavior plan, are met.

b. The data provided must show evidence that the frequency of the maladaptive behavior(s) has decreased since the last review and, if not, that there is a modification of the behavior plan.

c. The level of functional impairment justifies continuation of BA services. The reviewer utilizes the information provided below as a guide as it relates to the level of functional impairment as expressed through the following behaviors:

- i. Safety – aggression, self-injury, property destruction, elopement
- ii. Communication – problems with expressive/receptive language, poor understanding or use of non-verbal communications, stereotyped, repetitive language

- iii. Self-stimulating, abnormal, inflexible, or intense preoccupations
- iv. Self-care – difficulty recognizing risks or danger, grooming, eating, or toileting
- v. Other – behaviors not identified above

4. Criteria to Assess the Intensity of Behavior Analysis Services: Providers may request up to 40 hours of BA services per week, per recipient, based upon the following:

As a rule, higher number of maladaptive behaviors, higher severity and frequency of behaviors, as well as the multiplicity of settings where the behaviors occur, would usually justify a higher number of services hours. The greater the number of goals targeted to reduce maladaptive behaviors, the more the likelihood that a higher number of services hours could also be warranted.

Providers **MUST** ensure that proper justification for the requested hours of services is adequately documented in the behavior plan. Based on the information provided in the assessment, behavior plan, and any other supporting documentation, the reviewer utilizes the information provided below as a guide as it relates to the level of functional impairment as expressed through the following behaviors:

- i. Safety - aggression, self-injury, property destruction, elopement
- ii. Communication - problems with expressive/receptive language, poor understanding or use of non-verbal communications, stereotyped, repetitive language
- iii. Self-stimulating, abnormal, inflexible, or intense preoccupations
- iv. Self-care - difficulty recognizing risks or danger, grooming, eating, or toileting
- v. Other- behaviors not identified above

Respondent’s Composite Exhibit 2 at pages 45-48.

16. States must provide Early and Periodic Screening, Diagnostic, and Treatment (“EPSDT”) services to Medicaid-eligible children under age 21 when requested under the Medicaid state plan. See 42 U.S.C. § 1396a(a)(43); 42 U.S.C. § 1396d(a)(4). According to 42 U.S.C. § 1396d(r)(5), EPSDT services mean, in relevant part, the following items and services:

Such other necessary health care, diagnostic services, treatment, and other measures described in subsection (a) of this section to correct or ameliorate defects and physical and mental illness and conditions discovered by the screen services, whether or not such services are covered under the state plan.

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

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

18. The Florida Medicaid Definitions Policy (“Definitions Policy”) (August 2017), which is incorporated by reference in Fla. Admin. Code R. 59G-1.010, defines Medical Necessity as:

2.83 Medically Necessary or Medical Necessity

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

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

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

Definitions Policy at page 7.

19. The Florida Medicaid Authorization Requirements Policy (“Authorization Requirements Policy”) (June 2016), incorporated by reference in Fla. Admin. Code R. 59G-1.053, provides

general requirements for providers to obtain authorization to render Florida Medicaid services.

The Authorization Requirements Policy states:

1.2 Definitions

The following definitions are applicable to this policy. For additional definitions that are applicable to all sections of Rule Division 59G, F.A.C., please refer to the Florida Medicaid definitions policy.

1.3.1 Authorization

The process of obtaining approval for reimbursement of a service based on medical necessity.

1.3.6 Provider

The term used to describe any entity, facility, person, or group that has been approved for enrollment or registered with Florida Medicaid.

1.3.7 Quality Improvement Organization

Entity designated to perform utilization review, quality assurance, and quality improvement activities for Florida Medicaid-covered services rendered by fee-for-service providers (also known as the QIO).

...

2.0 Authorization Requirements

2.4.2 Requests for Additional Information

The QIO may request additional information, as necessary, to determine medical necessity.

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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.

Florida Medicaid Authorization Requirements Policy at pages 1-3.

20. Petitioner is under the age of 21 years and diagnosed with [REDACTED]. See supra ¶ 3. The parties agree that Petitioner currently engages in maladaptive behaviors that interfere with [REDACTED] daily functioning. See supra ¶ 3. Respondent agreed that BA services are medically necessary for Petitioner, but Respondent determined that the BA provider submitted insufficient documentation to justify an increase in BA services. See supra ¶ 4, 5.

21. Respondent denied Petitioner's request for additional BA services (564 units of code 97153) because the submitted documentation did not establish the medical necessity of the requested level of services. See supra ¶ 4, 5. Based on the record, Respondent determined that the documentation did not meet the following medical necessity standards: individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs. See supra ¶ 4, 5, 9. This criteria of medical necessity is expressly outlined in section 2.83 of the Definitions Policy and a critical element for behavior analysis services reassessments. See supra ¶ 15. The BA Policy mandates that the treatment plan must be detailed enough to warrant the requested services and include mechanisms to monitor and evaluate its effectiveness. See supra ¶ 15. Finally, pursuant to Criteria 4 of Appendix 9.0, providers **must** ensure that proper justification for the requested hours of services is adequately documented in the behavior plan. See supra ¶ 15.

22. In this case the record does not reflect that the requested additional BA services are warranted. Dr. Bicard provided credible and persuasive testimony that the additional BA services at issue are in excess of Petitioner's need, and [REDACTED] also showed, based on Ms. Mesa's testimony, that the BA services are not being provided in a manner that is consistent with generally accepted professional standards of care in the field of BA. See supra ¶ 9. The record reflects that the Petitioner's BA services were increased on reconsideration from twenty-seven (27) to thirty (30) hours per week. The increase was authorized despite Ms. Mesa's testimony: that services were provided inconsistently during the last authorization period; that the lead analyst's physical absence affected Petitioner's progress; and that she did not provide an credible explanation for why the additional hours at issue are needed. Dr. Bicard explained that an increase in BA services was authorized because the Treatment Plan shows that the recipient is engaging in several forms of maladaptive behavior that are concerning and because a new RBT was starting on Petitioner's case, and that the increased was sufficient to implement the Treatment Plan. Dr. Bicard also established that the eQHealth reviewers were not aware that the lead analyst would not be able to perform case management tasks on site, which is a requirement for BA services and not consistent with standards of care. As Dr. Bicard testified, the authorized level of BA services is more than adequate based on the Treatment Plan, maladaptive behaviors, and identified replacement goals, and the additional services at issue are in excess of Petitioner's needs.

23. As previously stated, Petitioner's BA provider recommended additional BA services (564 units of code 97153). Petitioner also submitted additional letters from providers in support of a total of a total of forty (40) hours per week of BA services, supra ¶ 2; however, the letters lacked credibility because they were either not from providers experienced in the field of BA or they

were requesting more BA services than supported by the Treatment Plan at issue. Moreover, 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* ¶18.

24. Accordingly, although Petitioner continues to need BA services, Petitioner has not met their burden of proof to show that the requested additional behavior analysis services are medically necessary. Looking at all the evidence relevant to the particular needs of Petitioner, the requested additional BA services at issue are not necessary to correct or ameliorate a defect or a physical and mental illness or condition.

25. Accordingly, upon consideration of Petitioner's Composite Exhibits 1-2, Respondent's Composite Exhibit 1-2, the testimony, and the applicable laws and policies, the undersigned concludes that Petitioner did not prove by a preponderance of the evidence that Respondent's denial of additional BA services at issue was incorrect.

DECISION

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

DONE and ORDERED this 27th day of October 2023, in Tallahassee, Leon County, Florida.



Laura Gallagher
23-FH1435
2023.10.27 10:26:08 -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]
[REDACTED]
[REDACTED]
[REDACTED]

AHCA Medicaid Hearing Unit
MedicaidHearingUnit@ahca.myflorida.com