



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

FILED

Nov 30, 2023, 10:41 am
OFFICE OF FAIR HEARINGS

[REDACTED]

PETITIONER,

AHCA Case No.: 23-FH2057

vs.

AGENCY FOR HEALTH CARE
ADMINISTRATION,

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic Fair Hearing on the instant case on October 3, 2023, at 10:04 a.m. Eastern Standard Time (“EST”).

APPEARANCES

For the Petitioner: [REDACTED]
Petitioner’s Authorized Representative

For the Respondent: Doris Rivera
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 Petitioner’s behavior analysis (“BA” or “ABA”) services was incorrect.

PRELIMINARY STATEMENT

All parties and witnesses appeared telephonically. [REDACTED] (“[REDACTED]”), Petitioner’s Authorized Representative and [REDACTED], appeared for the Fair Hearing to provide testimony on behalf of Petitioner, and did not call any witnesses.

Doris Rivera, Medical/Health Care Program Analyst for the Agency for Health Care Administration (“Agency” or “AHCA”), appeared for the Fair Hearing as representative for Respondent. Dr. Alyssa Conway (“Dr. Conway”), BCBA and Second Level Reviewer for eQHealth Solutions Florida (“eQHealth”), appeared for the Fair Hearing as a witness for Respondent.

Petitioner did not introduce any exhibits at Fair Hearing.

Prior to the hearing, the Office of Fair Hearings received a two hundred and six (206)-page evidence packet and a forty-nine (49)-page evidence packet from Respondent. The two hundred and six (206)-page packet appears in the Office of Fair Hearings document management system as the file titles “[REDACTED] FH 10.03.2023 1-169.pdf” and “[REDACTED] FH 10.03.2023 170-206.pdf”. The forty-nine (49)-page evidence packet appears in the Office of Fair Hearings document management system as the file title “23-FH2057 - AHCA evidence BA 49 pgs.pdf.pdf.” Absent an objection from the Petitioner, the undersigned admitted two hundred and six (206)-page evidence packet into evidence as Respondent’s Composite Exhibit 1 (“RCE 1”) and the forty-nine (49)-page evidence packet into evidence as Respondent’s Composite Exhibit 2 (“RCE 2”).

FINDINGS OF FACT

1. Petitioner receives Medicaid services on a fee-for-service basis from the Agency. eQHealth is a Quality Improvement Organization (“QIO”) contracted by the Agency to review authorization requests for services. *See* RCE 2 at page 2.
2. Petitioner is [REDACTED]. *See* RCE 1 at page 21. Petitioner is diagnosed with [REDACTED] [REDACTED] (“[REDACTED]”). *Id.*
3. As provided in the Behavior Analysis Initial Assessment (“Treatment Plan”) submitted by [REDACTED], Petitioner is engaging in the following maladaptive

behaviors: [REDACTED], [REDACTED], [REDACTED], [REDACTED], [REDACTED], [REDACTED], [REDACTED], [REDACTED], [REDACTED], [REDACTED], [REDACTED], and [REDACTED]. *Id.* at 58. The Treatment Plan indicates that for the direct observation conducted on [REDACTED], and [REDACTED], and [REDACTED], Petitioner engages in [REDACTED] maladaptive behaviors at the following rates: between [REDACTED] incidents each day for [REDACTED]; around [REDACTED] of incidents each day for [REDACTED]; between [REDACTED] incidents each day for [REDACTED]; between [REDACTED] incidents each day for [REDACTED]; between [REDACTED] incidents each day for [REDACTED]; between [REDACTED] incidents each day for [REDACTED]; between [REDACTED] incidents each day for [REDACTED]; between [REDACTED] incidents each day for [REDACTED]; between [REDACTED] incidents each day for [REDACTED]; between [REDACTED] incidents each day for [REDACTED]; and, between [REDACTED] incidents each day for [REDACTED]. *Id.* at 60-68.

4. Petitioner requested ABA services for the certification period of August 21, 2023, to February 16, 2024; specifically, 3,120 units of code 97153; 520 units of code 97155; and 104 units of code 97156. *Id.* at 28-30. On August 1, 2023, Respondent issued a request for information (“PEND”) to Petitioner’s provider, [REDACTED], stating as follows:

Provider, please carefully edit your treatment plan to reflect the intended recipient of services (goals listed under the intervention chart do not match this recipient).

Provider, please submit a current treatment plan with this request that complies with Florida Medicaid Behavior Analysis Service Coverage Policy. Your treatment plan must include graphed baseline data for all behaviors for the current authorization period directly observed by the analyst during the assessment observations (not including parent report or extrapolated/hypothesized weekly/daily averages) including recipient maladaptive, recipient replacement/skill acquisition, and caregiver behaviors. Please submit graphs for all behaviors.

Provider, please review and revise your treatment plan. The definitions of behaviors under treatment must be written according to generally accepted practice within the field of ABA and according to AHCA standards of care (the Florida Behavior Analysis Services Coverage Policy, page 6, 9.2.i). The behavioral definitions must be clear, complete, objective and free of unobservable intentional states. The behaviors should be inclusive and not open ended, have definite on-set and off-set and should not overlap with other target behaviors definitions ([REDACTED] / [REDACTED]). The behavior definitions in this treatment plan do not conform to generally accepted standards of care within the field of applied behavior analysis. Please review your plan carefully to ensure the accuracy of the information submitted for review.

Provider, there are behaviors listed for decrease and goals for increase that do not meet medical necessity criteria (consuming healthy foods, fine motor skills). All goals must significantly interfere with normal functioning by threatening access to typical environments and negatively affecting activities of daily living. Please clarify and remove behaviors/goals that do not meet medical necessity criteria.

Id. at 23, 53-54.

In response to the PEND, the provider issued the following statement:

Hello,

In response to your additional information request, I have reviewed and revised the Assessment for [Petitioner]. Please let me know if there is anything else we need to move forward.

...

Id. at 23.

5. In a Notice of Outcome (“NOO”), dated August 9, 2023, Respondent denied Petitioner’s requested ABA services. *Id.* at 28-30. 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.

The NOO further provided:

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

PR Clinical Rationale - Denial: The provider has proposed goals in this treatment plan that do not meet medical necessity criteria (consuming healthy foods). According to the Behavior Analysis Services Coverage Policy (5.1, page 3), these goals are not necessary to protect life, to prevent significant illness, significant disability, or to alleviate severe pain. That are not consistent with the symptoms of any diagnosis for which ABA is medically necessary. These are skills that do not require a behavior analyst to teach. They can be learned in a less costly and equally effective manner by someone not specifically trained in ABA. They are furnished in a manner primarily intended for the convenience of recipient, the recipient's caretaker, or the provider.

The supporting documentation does not meet generally accepted practices within the field of applied behavior analysis and standards set forth in the Florida Behavior Analysis Services Coverage Policy (Pages 6-7). The provider was approved to complete an assessment. The provider has not submitted all graphed data for skill acquisition goals and maladaptive behaviors that were to be completed during the assessment. The provider was requested to produce those graphed data to initiate behavior analysis services. The provider has submitted graphed data that do not reflect information in their treatment plan. The data appear fabricated. The request for services is denied.

Id. at 28-29.

6. Petitioner requested reconsideration of the Respondent's decision. In a Notice of Reconsideration Determination ("NRD"), dated August 18, 2023, Respondent upheld its decision.

Id. at 40-41. The NRD explained the basis for the decision as follows:

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 (Appendix 9.2.c), assessment results must be present in the plan. The provider has included baseline data and graphs for skill acquisition goals and maladaptive behaviors that were based on parent report, 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.

7. On August 22, 2023, Petitioner requested a Fair Hearing to challenge the denial of ABA services. On September 8, 2023, the undersigned issued an Order Scheduling Fair Hearing and Prehearing Instructions, setting the hearing for October 3, 2023, at 10:00 a.m. EST.

8. [REDACTED] is Petitioner's [REDACTED]. [REDACTED] testified to the following at Fair Hearing:

- a. [REDACTED] believes Petitioner needs help with [REDACTED] behavior because [REDACTED] is [REDACTED]. [REDACTED] asserts that Petitioner's maladaptive behaviors occur so frequently daily that [REDACTED] cannot sleep.
- b. The provider's lead analyst came to Petitioner's home on [REDACTED], [REDACTED], and [REDACTED], for approximately 2 hours each instance and completed the initial assessment with Petitioner and [REDACTED] present.

9. Dr. Conway is a BCBA and Second Level Reviewer for eQHealth. Dr. Conway established the following at Fair Hearing:

- a. EQHealth reviews requests for services based on medical necessity. *See* RCE 2 at 7. eQHealth reviews behavior analysis cases to ensure ABA services are consistent with the standards enumerated in the Behavior Analysis Coverage Policy as well as professional medical standards of behavior analysis. The Behavior Analysis Coverage Policy criteria 2b requires baseline data for initial assessments. *See* ¶ 13. Dr. Conway contends that the Treatment Plan submitted did not meet criteria 3.
- b. Petitioner is new to ABA services and this case is an initial stay request. *See* RCE 1 at 21.

- c. In the field of ABA, the BCBA obtains baseline data through a Functional Behavioral Assessment before treatment commences. The Treatment Plan indicates the analyst completed a direct observation, as confirmed by [REDACTED]; however, Dr. Conway argued that the antecedent behavior consequence (“ABC”) data does not reflect the data and levels reported as directly observed.
- d. Dr. Conway emphasized that the Treatment Plan is not individualized to Petitioner. For example, Dr. Conway pointed out that the original Treatment Plan contains the name of another recipient and has Petitioner’s age incorrect. *Id.* at 56, 104. Dr. Conway additionally argues that the antecedent behavior consequence (ABC) data, i.e., direct observations, described behaviors that are low severity such as [REDACTED], [REDACTED], [REDACTED], and [REDACTED]. *Id.* at 57. Dr. Conway pointed out that Petitioner’s skills are contradicted from the background information. For example, under “[REDACTED]” the provider indicates Petitioner “[REDACTED]” and “[REDACTED]” but [REDACTED] background information indicates Petitioner “[REDACTED]” and “[REDACTED]”. *Id.* at 56, 58. The provider incorrectly indicated that the Preference Assessment was completed in [REDACTED]. *Id.* at 59.
- e. Dr. Conway argues that a consistent pattern of high frequency levels is reported across all of Petitioner’s maladaptive behaviors that do not match the data reported in the Treatment Plan. For example, the graph for [REDACTED] indicates that over the 2-day observation, Petitioner engaged in this behavior at

about [REDACTED] each day, while the baseline indicates the average is about [REDACTED] per week. *Id.* at 60. Dr. Conway explains that this would mean Petitioner engaged in this behavior at about [REDACTED] per hour. The graph for [REDACTED] indicates about a [REDACTED] frequency which Dr. Conway argued would represent engagement in this behavior for almost the entire observation period. *Id.* at 61.

- f. Dr. Conway pointed out the inconsistency of the baseline for [REDACTED] at an average of [REDACTED] per week but the graph shows about [REDACTED] incidents each day of the observation. *Id.* at 62. Dr. Conway emphasized that this inconsistency is also prevalent for all other behaviors. *Id.* at 63-67.
- g. The updated Treatment Plan submitted at reconsideration removed the incorrect name, but still included the incorrect age and incorrect assessment date. *Id.* at 158, 161. The provider also changed the dates on the graphs to dates [REDACTED], with some changes to the behavior frequencies. *Id.* at 162-169. Dr. Conway argued that the inconsistencies between the treatment plans submitted make it unclear whether the data reported reflect only direct observations of each behavior.

CONCLUSIONS OF LAW

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

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

12. Because Petitioner requested new ABA services, Fla. Admin. Code R. 59G-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.)

13. The Florida Medicaid Behavior Analysis Services Coverage Policy (October 2017) (“BA Policy”), incorporated by reference in Fla. Admin. Code. R. 59G-4.125, governs ABA 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.

...

1.4.5 Medically Necessary/Medical Necessity

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

...

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

One per fiscal year, per recipient, when completed within 30 days of the start of the assessment.

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 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 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 General Policies on authorization requirements.

See RCE 2 at 38-44.

14. Appendix 9.0 of the BA Policy provides Review Criteria for Behavior Analysis Services.

These Review Criteria state as follows:

Review Criteria for Behavior Analysis Services

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 BA 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 Rule 59G-1.010, F.A.C.
- c. The recipient currently engages in maladaptive behaviors
- d. These maladaptive behaviors interfere with the recipient's daily functioning

1. Criteria for Initial Behavior Analysis Assessment - BOTH of the following MUST be satisfied:

- a. **ALL** critical elements are met

- b. Provide submits a valid written physician's order as stipulated in the Behavior Analysis Services Coverage Policy, Rule 59G-4.125, F.A.C.

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)
 - ...
- 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.

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 treatments 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

See RCE 2 at 45-47.

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). 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.

16. Petitioner is under age 21, and therefore EPSDT applies to [REDACTED] request for services. However, a state may place medical necessity limitations on EPSDT services. See 42 C.F.R. §§ 440.230(a), (b), (d). Fla. Stat. § 409.905(2) limits EPSDT services with a medical necessity standard:

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

17. The Florida Medicaid Definitions Policy (August 2017) (“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.

18. The Florida Medicaid Authorization Requirements Policy (June 2016) ("Authorization Policy"), incorporated by reference in Fla. Admin. Code R. 59G-1.053, provides general requirements for providers to obtain authorization to render Florida Medicaid services. See RCE 2 at 30-36. The Authorization Policy states as follows:

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 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.

Id. at 34.

19. In the instant case, Petitioner is under 21 years of age and is diagnosed with [REDACTED]. See ¶

2. Petitioner requested ABA services. See ¶ 4. In a NOO, dated August 9, 2023, Respondent denied the services. See ¶ 4. Respondent cited to the medical necessity criteria as the basis for their decision, specifically that the requested hours of ABA services be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational. See ¶ 4. Petitioner has burden of proof to show by a preponderance of evidence that the Respondent's determination was incorrect. See ¶ 12.

20. As provided by the EPSDT requirements, the recipient must meet the medical necessity criteria as outlined in Fla. Admin. Code R. 59G-1.010. See ¶ 15-16. In the Definitions Policy, a prong of medical necessity is that services must be "consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational." See ¶ 17.

21. Section 9.0 of the BA Policy maintains that the "behavior plan is the cornerstone of the delivery of behavior analysis services." See ¶ 14. The BA Policy criteria for continuation of treatment at the present level and/or using current methods requires that providers must ensure

that all criteria are met. See ¶ 14. The criteria require that a behavior plan must be detailed enough to warrant the requested services and include mechanisms to monitor its effectiveness. See ¶ 14. The criteria for assessing the intensity of behavior analysis services, *supra* ¶ 14, requires that proper justification for the requested hours of services is adequately documented in the behavior plan.

22. As shown by the record, the provider's Treatment Plan did not conform to standards of care within the field of behavior analysis. See ¶ 5-6, 9. The information submitted by the provider in the Treatment Plan as a part of the request for services did not include information to satisfy the medical necessity criteria for ABA services. See ¶ 5-6, 9. Petitioner is new to ABA services and this case is an initial stay request. See ¶ 9. Dr. Conway provided testimony at Fair Hearing that Petitioner's provider included multiple inconsistencies as it relates to the Petitioner and the data reported in the Treatment Plan. See ¶ 9. Dr. Conway pointed out that in the original Treatment Plan contains the name of another recipient and has Petitioner's age incorrect. See ¶ 9. Dr. Conway also pointed out that Petitioner's skills are contradicted from the background information. See ¶ 9. For example, under "[REDACTED]" the provider indicates Petitioner "[REDACTED]" and "[REDACTED]" but [REDACTED] background information indicates Petitioner [REDACTED]" and [REDACTED] [REDACTED]". See ¶ 9. The record shows the provider incorrectly indicated that the Preference Assessment was completed in [REDACTED]. See ¶ 9. In the provider's most updated Treatment Plan submitted at reconsideration, the incorrect name was removed but still included the incorrect age and incorrect assessment date. See ¶ 9.

23. Further, as testified by Dr. Conway, in the field of ABA, the BCBA obtains baseline data through a Functional Behavioral Assessment before treatment commences. See ¶ 9. The Behavior Analysis Coverage Policy criteria 2b requires baseline data for initial assessments. See ¶ 13. The Treatment Plan indicates the analyst completed a direct observation, as confirmed by [REDACTED]; however, Dr. Conway argued that the ABC data does not reflect the data and levels reported as directly observed. See ¶ 8, 9. Dr. Conway additionally argued that the ABC data, i.e., direct observations, described behaviors that are low severity such as [REDACTED], [REDACTED], [REDACTED], and [REDACTED]. See ¶ 9. Dr. Conway argued that a consistent pattern of high frequency levels is reported across all of Petitioner’s maladaptive behaviors that do not match the data reported in the Treatment Plan. See ¶ 9. For example, the graph for [REDACTED] indicates that over the 2-day observation, Petitioner engaged in this behavior at about [REDACTED] each day, which would mean Petitioner engaged in this behavior at about [REDACTED] per hour during the assessment. See ¶ 3, 9. Dr. Conway pointed out the inconsistency of the baseline for [REDACTED] at an average of [REDACTED] per week, but the graph shows about [REDACTED] incidents each day of the observation. See ¶ 3, 9. Dr. Conway emphasized that this inconsistency is also prevalent for all other behaviors. See ¶ 9. In the most updated Treatment Plan, the provider also changed the dates on the graphs to dates [REDACTED], with some changes to the behavior frequencies. See ¶ 9. [REDACTED] did not provide testimony of an assessment conducted [REDACTED] or confirmed these later dates. See ¶ 8. [REDACTED] asserts that Petitioner’s maladaptive behaviors occur so frequently that [REDACTED] cannot sleep. See ¶ 8. Dr. Conway argued that the inconsistencies between the treatment plans submitted make it unclear whether the data reported reflect only direct observations of each behavior. See ¶ 9. The undersigned

finds Dr. Conway's testimony persuasive and consistent with the evidence to demonstrate that the Treatment Plan was not consistent with generally accepted professional medical standards within the field of behavior analysis, and therefore not medically necessary.

24. Upon consideration of the testimony provided, evidence submitted, and applicable policies, the undersigned concludes that Petitioner did not prove by a preponderance of the evidence that the ABA services at issue meet medical necessity criteria. Looking at all the evidence relevant to the particular needs of Petitioner, Petitioner has not demonstrated that the requested services, based on the Treatment Plan at issue in this case, are necessary to correct or ameliorate a defect or a physical and mental illness or condition. Accordingly, Petitioner did not prove by a preponderance of the evidence that Respondent's denial of ABA services was incorrect.

IT IS HEREBY ORDERED AND ADJUDGED THAT:

Respondent's denial of ABA services is **AFFIRMED**. Petitioner's appeal based on Respondent's denial is **DENIED**.

DONE and ORDERED this 30th day of November, 2023 in Tallahassee, Leon County, Florida.

Laura Gallagher
for Kimberly Roche
23-FH2057
2023.11.30
10:19:37 -05'00'

KIMBERLY ROCHE, 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]

AHCA Medicaid Hearing Unit
MedicaidHearingUnit@ahca.myflorida.com

Notice of Nondiscrimination Policy

The Agency for Health Care Administration (“AHCA”) is committed to providing all people with an equal opportunity to participate in its programs, services, and activities. AHCA complies with applicable Federal civil rights laws and does not exclude people or treat them differently in admission to, access to, or employment in its programs, services, or activities on the basis of race, color, national origin, age, disability, or sex. Communication aids and services, such as: qualified sign language interpreters, qualified foreign language interpreters, and written information in alternative formats (i.e.: Braille, large print, foreign language, etc.) are provided free of charge, in accordance with federal law, when necessary to ensure equal opportunity and effective communication.

This Notice is provided as required by Title II of the Americans with Disabilities Act of 1990, Section 504 of the Rehabilitation Act, and Section 1557 of the Affordable Care Act and implementing regulations. This Notice is available, upon request, in alternative formats. Individuals who require free communication aids and services to effectively participate in AHCA’s programs, services, and activities are invited to make their requests to the Civil Rights Compliance Coordinator at the contact information listed below. If you believe that AHCA has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex you can file a grievance in person, by mail, or by telephone with:

Civil Rights Compliance Coordinator
2727 Mahan Drive, Mail Stop #3
Tallahassee, FL 32308
Voice: (850) 412-3661
TTY: (800) 955-8771



Spanish ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-(888) 419-3456 (TTY: 1-800-955-8771).

French Creole Atansyon: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-(888) 419-3456 (TTY: 1-800-955-8771).

Vietnamese CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-(888) 419-3456 (TTY: 1-800-955-8771).

Portuguese ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-(888) 419-3456 (TTY: 1-800-955-8771).

Chinese 注意 : 如果您使用繁體中文, 您可以免費獲得語言援助服務。請致電 1-(888) 419-3456 (TTY: 1-800-955-8771)

French ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-(888) 419-3456 (ATS: 1-800-955-8771).

Tagalog PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-(888) 419-3456 (TTY: 1-800-955-8771).

Russian ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-(888) 419-3456 (телетайп: 1-800-955-8771).

Arabic

ملحوظة: إذا كنت تتحدث العربية، فإن خدمات المساعدة اللغوية متاحة لك بالمجان. اتصل برقم 1-(888) 419-3456 (التحويلة: 1-800-955-8771)

Italian ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-(888) 419-3456 (TTY: 1-800-955-8771).

German ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-(888) 419-3456 (TTY: 1-800-955-8771).

Korean 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-(888) 419-3456 (TTY: 1-800-955-8771) 번으로 전화해 주십시오.

Polish UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-(888) 419-3456 (TTY: 1-800-955-8771).

Gujarati નોંધ: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-(888) 419-3456 (TTY: 1-800-955-8771).

Thai เรียบน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-(888) 419-3456 (TTY: 1-800-955-8771).