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

FILED
Mar 13, 2024, 1:58 pm
OFFICE OF FAIR HEARINGS

[redacted],

PETITIONER, **AHCA Case No.: 23-FH3025**

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 February 12, 2024, at 10:02 a.m. EST.

APPEARANCES

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

For the Respondent: Chrissie Simmons
Agency for Health Care Administration

STATEMENT OF ISSUE

The issue in this matter is whether the Petitioner has proved by a preponderance of the evidence that Respondent's decision to deny the use of two (2) Registered Behavior Technician ("RBTs") simultaneously for behavior analysis services related to the Petitioner's feeding disorder (Treatment Code 0373T) was incorrect.

PRELIMINARY STATEMENT

All parties and witnesses appeared telephonically. Petitioner's Authorized Representative and [redacted] ("[redacted]") appeared on behalf of the Petitioner. [redacted]

[redacted] ("[redacted]"), a Board Certified Behavior Analyst ("BCBA") at the Doctorate level appeared as a witness for the Petitioner. Chrissie Simmons, ("Ms. Simmons") Medical Healthcare Program Analyst and Fair Hearing Liaison for Health Care Administration ("Agency" or "AHCA"), appeared on behalf of Respondent. Dr. David Bicard ("Dr. Bicard"), a BCBA at the Doctorate level and second level reviewer, for eQHealth Solutions appeared as a witness for Respondent.

Prior to the Hearing, the Petitioner sent the Office of Fair Hearings and the Respondent an eighteen (18) page package of proposed evidence package that was admitted into evidence without objection, is identified as "Petitioner's Composite Exhibit 1" and is maintained in the Office of Fair Hearings document management system as "23-FH3025 Response to Order to Show Cause.pdf".

Prior to the Hearing, the Respondent sent the Office of Fair Hearings and Petitioner a two hundred and fifteen (215)-page proposed evidence package and a fifty (50)-page evidence package that were admitted into evidence without objection. The two hundred and fifteen (215)-page package is identified as "Respondent's Composite Exhibit 1" and is maintained in the Office of Fair Hearings' case management system as "[redacted] FH 1.22.2024 1-152.pdf", "[redacted] FH 1.22.2024 153-198.pdf", and "[redacted] FH 1.22.2024 199-215.pdf". The fifty (50)-page exhibit is identified herein as "Respondent's Composite Exhibit 2" and appears in the Office of Fair Hearings' case management system as "23-FH3025 ACHA Evidence (Pages 1-50 of 50).pdf".

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 Applied Behavioral Analysis ("ABA") services. *See* Respondent's Composite Exhibit 2, page 2.

2. The Petitioner is a [redacted]. *See* Respondent's Composite Exhibit 1, page 16 and *Testimony of* [redacted]. The Petitioner is currently a patient of [redacted] ("[redacted]"), a member of the behavior analysis leadership team and clinical supervisor at the [redacted] ("[redacted]"). *See* Respondent's Composite Exhibit 1, page 161. [redacted] submitted a letter on behalf of the Petitioner for this proceeding wherein he states in-part as follows:

[redacted]

See Petitioner's Composite Exhibit 1, page 14. (Emphasis added.)

3. On October 12, 2023, [redacted] as the provider and [redacted], Ph.D BCBA-D as the Program Coordinator both from the [redacted] at the [redacted]

[redacted], submitted an October 11, 2023, proposed Initial Assessment Report and Treatment Plan ("Treatment Plan") to provide initial BA services to the Petitioner. *See* Petitioner's Composite Exhibit 1, pages 134 and 161. The Petitioner requested the following ABA services in the initial Treatment Plan: 1,987 units of code 97153, 1,300 units of code 0373T, 414 units of Code 97155, and 206 units of code 97156 for the certification period of November 9, 2023, through May 6, 2024. *See* Respondent's Composite Exhibit 1, page 22.

4. On October 13, 2023, the Respondent sent the [redacted] a letter requesting additional information regarding the proposed initial Treatment Plan, seeking the following additional information;

a. Clarification of the correct number of unites for each billing code for the entire continued stay;
b. Baseline graphs of directly observed behavior gathered during the assessment, including the presence of absence of maladaptive behaviors and replacement skills directly assessed.

See Respondent's Composite Exhibit 1, page 45.

5. On or about October 16, 2023, the [redacted], submitted their response to the Respondent's October 13, 2023, request for additional information. *See* Respondent's Composite Exhibit 1, pages 171-172.

6. On October 24, 2024, the Respondent issued a Notice of Outcome ("NOO"), approving 1,987 units of code 97153, 414 units of Code 97155, and 206 units of code 97156 in the initial Treatment Plan but denied 1,300 units of code 0373T for the certification period of November 9, 2023, through May 6, 2024. *See* Respondent's Composite Exhibit 1, pages 22-26. The NOO explained the basis for the denial of 1,300 units of code 0373T as follows:

> The request for services is denied in whole or in part because they are not medically necessary as defined in Rule 59G-l.010, Florida Administrative Code.

> Specifically, the 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.
> 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.

Id. The NOO further provided:

> 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: This request for 2:1 service is denied. Services are approved only to render medically necessary behavior therapy. The protocols identified in this plan for the 2nd therapist can be rendered by someone without specific training in behavior analysis. This request does not meet medical necessity criteria. All other services meet medical necessity criteria and are approved at the level requested.
> . . .

See Respondent's Composite Exhibit 1, pages 22-25.

7. On November 3, 2023, the [redacted] submitted a response to the denial of 1,300 units of code 0373T and requested a reconsideration of the Respondent's denial. On November 9, 2023, the Respondent issue its' Notice of Reconsideration Determination ("NRD") upholding the denial of 1,300 units of code 0373T for the certification period of November 9, 2023, through May 6, 2024. *See* Respondent's Composite Exhibit , pages 34-37. The NRD explained the basis for the denial as follows:

> 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:
>
> Consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational.
> 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.
>
> The rationale for our decision is as follows:
>
> PR Recon Determination: At reconsideration all documents were carefully reviewed. This request for 2:1 service is denied. Services are approved only to render medically necessary behavior therapy. The protocols identified in this plan for the 2nd therapist can be rendered by someone without specific training in behavior analysis. This request does not meet medical necessity criteria. All other services meet medical necessity criteria and are approved at the level requested. This partial denial is upheld.
> . . .

Id.

8. The Petitioner's principal maladaptive behaviors in this matter are specifically related to [redacted]. In fact, the Petitioner's [redacted] and Authorized Representative testified the Petitioner's maladaptive behaviors are [redacted]. *Testimony of Petitioner.* In addition, the graphs in the Treatment Plan of the Petitioner's maladaptive behavior reflect a one hundred percent (100%) incidence whenever the Petitioner is [redacted]. Those maladaptive behaviors include several variations of [redacted]. *See* Respondent's Composite Exhibit 1, pages 140-143 and 209-210.

9. Dr. Bicard testified on behalf of the Respondent that it is not medically necessary for the Petitioner to have the simultaneous treatment by two (2) RBTs, and that the simultaneous use of

a single RBT and an assistant would suffice to treat the Petitioner and [redacted] More specifically, Dr. Bicard testified that therapy with two (2) RBTs is not consistent with generally accepted professional medical standards as determined by the Medicaid program and that the level of service that can be safely furnished in a less conservative and less costly method. Dr. Bicard testified that using two (2) simultaneous RBTs is a convenience for the provider, that the second RBTs is preforming administrative tasks, and just because the use of two (2) simultaneous RBTs was recommended, does not make it medically necessary. Finally, Dr. Bicard testified his concern that the Petitioner's ABA services relating to [redacted] have not already began using the single approved RBT.

10. [redacted], the Petitioner's [redacted] and Authorized Representative testified [redacted] has had [redacted].

11. [redacted] testified that the Petitioner's [redacted] were not addressed by any of the other Petitioner's other therapists, that the review of the Petitioner's medical records reflect less intensive therapy by a single RBT didn't work, and that the Petitioner is at risk of requiring a [redacted]. [redacted] further testified that a minimum amount of two (2) on one (1) therapy units being requested is customized/consistent with the Petitioner's diagnosis, that the two (2) on one (1) RBT sessions will only occur during [redacted], that the second RBT will collect simultaneous observational data on a specialized computer program that captures accurate "second by second" data, and that it is "absolutely impossible for a single RBT to [simultaneously] provide treatment and capture data". Next, [redacted] addressed the "grave concern" of Dr. Bicard that ABA services have not begun with a single RBT and stated that if the

feeding therapy did start with a single RBT, it would be detrimental to the Petitioner to receive the low intensity, less effective treatment, and that any delay in "[redacted]" treatment through the use of a single RBT would be detrimental to the Petitioner. Lastly, [redacted] testified that the two (2) on one (1) RBTs is "crucial", that the use of a second RBT during the Petitioner's feedings is "absolutely necessary", and that this level of treatment is "imperative" for the health of the Petitioner.

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. The burden of proof in this proceeding is governed by Florida Administrative Code, Rule. 59G-1.100(17)(g), which provides 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 termination 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.

15. Because the Respondent limited the authorization of a newly requested service, Fla. Admin. Code R. 59-1.100(17)(g) assigns the burden of proof to the Petitioner to establish by a preponderance of the evidence that the decision by the Respondent to deny the requested hours of BA therapy services for code 0373T (the use of two (2) simultaneous behavior analysts) in the

Treatment Plan was incorrect. The preponderance of the evidence standard requires proof by "the greater weight of the evidence" (Black's Law Dictionary at 1201, 7th Ed.).

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).

17. 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.

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

19. 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.

20. 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.

21. The Florida Medicaid Behavior Analysis Services Coverage Policy (September 2023) ("ABA 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.
. . .
1.4.6 Medically Necessary/Medical Necessity
As defined in Rule 59G-1.010, F.A.C.
. . .
2.0 Eligible Recipient
. . .
2.2 Who Can Receive
Florida Medicaid recipients under the age of 21 years requiring BA services that are medically necessary to address behavior that impairs a recipient's ability to perform a major life activity. Such functional impairment is expressed through the following behaviors:
- Safety – aggression, self-injury, property destruction, elopement
- Communication – problems with expressive/receptive language, poor understanding or use of non-verbal communications, stereotyped, repetitive language

- Self-stimulating – abnormal, inflexible, or intense preoccupations
- Self-care – difficulty recognizing risks or danger, grooming, eating, or toileting
- Other behaviors not identified above but not limited to complexity of treatment, programming, or environmental variables

The recipient must be referred by an independent physician or practitioner qualified to assess and diagnose disorders related to functional impairment, including:

- Primary care physician with family practice, internal medicine, or pediatric specialty
- Board certified or board eligible physician with specialty in developmental behavioral pediatrics, neurodevelopmental pediatrics, pediatric neurology, adult or child psychiatry
- Child psychologist

The referral must include a comprehensive diagnostic evaluation (CDE) performed according to national evidence-based practice standards. CDEs may be performed by a multidisciplinary team or individual practitioner. In either case, the CDE must be led by a licensed practitioner working within their scope of practice. The CDE must include assessment findings and treatment recommendations appropriate to the recipient. For example, the CDE may include data from behavioral reports by parents, guardians, and/or teachers; diagnostic testing related to recipients' development, behavior, hearing, and/or vision; genetic testing; and/or other neurological and/or medical testing.

Some services may be subject to additional coverage criteria as specified in section 4.0.

. . .

4.0 Coverage Information

4.1 General Criteria

Florida Medicaid covers services that meet all of the following:

- Are determined medically necessary
- Do no duplicate another service
- Meet the criteria as specified in this policy

4.2 Specific Criteria

Florida Medicaid covers the following BA services in accordance with the applicable Florida Medicaid fee schedule(s), or as specified in this policy:

4.2.1 Behavior Assessment and Behavior Plan

A behavior assessment must be conducted prior to the initiation of behavior analysis interventions. The assessment must identify behavioral deficits that interfere with a major life activity including the events and subsequent interactions that elicit and sustain targeted behavior.

The initial assessment must include the administration, scoring, and reporting of two core standardized behavior instruments, as follows:

- Vineland-3 Comprehensive Parent Interview Form Including Maladaptive Behavior Domain, for all recipients
- Behavior Assessment System for Children, Third Edition, Parenting Relationship Questionnaire (BASC-3 PRQ), for all recipients 2 years old and less than 19 years old

The complete scoring report, including outcome measure scores, must be submitted with service prior authorization requests. Additional assessment tools may be used at the Lead Analyst's discretion.

The behavior plan identifies intervention strategies that are likely to eliminate, mitigate or replace the behavior to produce change sufficient to reengage the recipient in the major life activity. The plan must include specific behavior goal(s), intervention strategies for each goal, anticipated timeframes that are of sufficient duration to address the targeted behavior, and how the ongoing progress of intervention strategies will be reported.

The behavior plan must reflect the requested authorization period (up to six months).

A reassessment and updated behavior plan to renew prior authorization for continued services must be completed at least every six months. The core instruments must be included with reassessments every 12 months.

More frequent assessments must be conducted when:

- New behavior emerges that interferes with a recipient's participation in a major life activity
- Additional BA services are medically necessary and are likely to address the emergent behavior

A full reassessment may be requested if there is a change in provider; however, a change of a practitioner status (e.g., an RBT becoming certified as a BCaBA) is not grounds for conducting a reassessment or updating a behavior plan.

4.2.2 Behavior Analysis Interventions

Florida Medicaid covers up to 40 hours per week of BA intervention services as indicated in the recipient's prior-authorized behavior plan. These services much be delivered to reduce maladaptive behaviors and assist the recipient reach the best possible function level for that individual. Services include:

- Adaptive behavior treatment by protocol - behavior analysis services provided according to the authorized treatment protocol
    - Services may be provided by Lead Analyst, BCaBA, or RBT

- Adaptive behavior treatment with protocol modification – behavior analysis services provided with modifications to the authorized treatment protocol to address behavior and/or response changes or progress
    - Services may be provided by Lead Analyst or BCaBA
- Group adaptive behavior treatment by protocol – behavior analysis services provided in a group setting according to the authorized treatment protocol
    - Maximum group size is six recipients
    - Services may be provided by Lead Analyst, BCaBA, or RBT
- Group adaptive behavior treatment with protocol modification – behavior analysis services provided in a group setting with modifications to the authorized treatment protocol to address behavior and/or response changes or progress
    - Maximum group size is six recipients
    - Services may be provided by Lead Analyst or BCaBA
- Family adaptive behavior treatment guidance – parent, guardian, and/or caregiver training on the implementation of the behavior plan and intervention strategies
    - The recipient may or may not be present depending upon clinical appropriateness.
    - Services may be provided by Lead Analyst or BCaBA
    - The Lead Analyst may provide up to two hours per week of training to parents or guardians via telemedicine in accordance with Rule 59G-1.057, Florida Administrative Code (F.A.C.)

. . .

4.2.4 Discharge

Recipients receiving Florida Medicaid BA services who meet one or more of the following will be considered for discharge from services:

- The recipient is no longer eligible for BA services as outlined in the Florida Medicaid Behavior Analysis Services Coverage Policy, incorporated by reference in Rule 59G-4.125, F.A.C.
- The recipient no longer meets medical necessity criteria as defined in Rule 59G-1.010, F.A.C.
- The recipient no longer engages in maladaptive behaviors.
- Data indicates the frequency and severity of maladaptive behavior(s) or level functional impairment no longer poses a barrier to the recipient's ability to function in his/her environment.
- The level of functional impairment as expressed through behaviors no longer justifies continued BA services.
- Parent or guardian withdraws consent for treatment
-

4.3 Early and Periodic Screening, Diagnosis, and Treatment

As required by federal law, Florida Medicaid provides services to eligible recipients under the age of 21 years, if such services are medically necessary to correct or

ameliorate a defect, a condition, or a physical or mental illness. Included are diagnostic services, treatment, equipment, supplies, and other measures described in sectioned 1905(a) of the Social Security Act, codified in Title 42 of the United States Code 1396d(a). As such, services for recipients under the age of 21 years exceeding the coverage described within this policy or the associated fee schedule may be approved, if medically necessary. For more information, please refer to Florida Medicaid's Authorization Requirements Policy.

. . .

5.0 Exclusion

5.1 General Non-Covered Criteria

Services related to this policy are not covered when any of the following apply:

- The service does not meet the medical necessity criteria listed in section 1.0
- The recipient does not meet the eligibility requirements listed in section 2.0
- The service unnecessarily duplicates another provider's service

5.2 Specific Non-Covered Criteria

Florida Medicaid does not cover the following as part of this service benefit:

- Any procedure or physical crisis management technique that involves the use of seclusion or manual, technical, or chemical restraint utilized to control behaviors
- Services for the delivery of recipient supervision, personal care assistance (e.g., acting as a 1:1 aid), companion, chaperone, or shadow regardless of activity or setting. This may include supports and services that are reimbursed through a different Florida Medicaid service benefit or are able to be provided by individuals without professional skills or training.
- Caregiver or childcare services
- Psychological testing, neuropsychology, psychotherapy, cognitive therapy, sex therapy, psychoanalysis, hypnotherapy, or long-term counseling
- Services funded under section 110 of the Rehabilitation Act of 1973
- Services not listed on the fee schedule
- Services on the same day as behavioral health overlay services*
- Services on the same day as therapeutic behavioral on-site services*
- Services on the same day as therapeutic group care services*
- Services provided simultaneously by more than one BA provider, unless determined to be medically necessary, prior authorized, and indicated in the approved behavior plan
- Travel Time

* These services include behavior analysis treatment.

Florida Medicaid may cover some services listed in this section through a different service benefit.

6.0 Documentation

6.2 Specific Criteria

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

6.2.1 Referral Information

Original referral documentation must be maintained in the recipient's medical record.

6.2.2 Behavior Assessment and Behavior Plan

The behavior assessment and behavior plan must be signed by the Lead Analyst and the recipient's parent or guardian. Each behavior assessment and behavior plan must include:

- Patient information
- Reason for referral
- Medical and developmental history, including medications prescribed to ameliorate behaviors
- Relevant family history
- Clinical interview
- Review of recent assessments/reports (file review)
- Assessment procedures and results
- Behavior plan
    - Treatment setting(s)
    - Proposed treatment targets, goals, and objectives related to medically necessary behavioral interventions
    - For each:
        - Definition in observable, measurable terms
        - Direct observation and measurement procedures
        - Current level (baseline)
        - Behavior reduction or acquisition procedures
        - Condition(s) under which behavior is to be demonstrated and mastery criteria
        - Date of introduction
        - Estimated date of mastery
        - Plan for generalization
        - Timely reporting of progress, including statements as to whether goal or objective is met; not met; or, modified (with explanation)
- Parent/guardian/caregiver training
    - Proposed targets, goals, and objectives (as above)
    - Training procedures
    - Date of introduction
    - Estimated date of mastery
- Number of units requested
    - Number of units for each billing code
    - Medical necessity for units requested
- Supervision plan, including name(s) of authorized supervisor(s)

- Care coordination with parents/caregivers, schools, state disability programs, and others as applicable
- Transition (fading) plan
- Crisis management plan
- Discharge plan

6.2.3 Assessment and Behavior Plan for Reauthorization and Continuation of Services

In addition to the documentation requirements indicated in 6.2.2, subsequent assessments and behavior plans for reauthorization and continuation of services must include:

- Data reflecting progress of all behaviors targeted for improvement. Each behavior under treatment must have its own data table and corresponding graph.
- A narrative discussion of progress and a statement of justification for continuation of care at the intensity level requested

If significant clinical progress is not made over the course of an authorized period, the provider must explain why clinically significant progress was not made and treatment changes to promote progress.

. . .

Pages 1 – 8 of ABA Policy.

22. 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, in pertinent part:

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.

Respondent's Composite Exhibit 2 at page 33.

23. In this case, Respondent denied any ABA services relating to code 0373T and the use of two (2) RBTs simultaneously. The NOO and NRD explained that Petitioner's request for the use of two (2) RBTs simultaneously did not meet medical necessity because the use of a single RBT would be less costly, and the use of two (2) RBTs simultaneously was not consistent with generally accepted professional medical standards as determined by the Medicaid program. *See* supra ¶ ¶ 6, 7, and 9.

24. As provided in the ABA policy and the EPSDT requirements, the recipient must meet the medical necessity criteria as outlined in Fla. Admin. Code R. 59G-1.010. Respondent denied the BA services at issue on the basis that only the following two of the five components of medical necessity are not met: "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, and "consistent with generally accepted professional medical standards as determined by the Medicaid program." *See* supra ¶ ¶ 18 and 19. As outlined above, [redacted] is a BCBA at the Doctorate level and appeared as a witness for the Petitioner. [redacted] is a member of the behavior analysis leadership team and clinical supervisor at the [redacted] at the [redacted]. [redacted] testified it is impossible and ineffective for a single RBT to [redacted] to the Petitioner while recording specific data used to modify and adjust treatments, and that such an intensive therapy program is within generally accepted medical standards of applied behavior analysis therapy. In addition, [redacted] testified that time is of the essence to render intensive treatment to quickly rectify the Petitioner's [redacted]. [redacted] provided credible and persuasive testimony that the Treatment

Plan did follow generally accepted medical standards of ABA, and is reflective of the level of service that can be safely furnished at a lower costs.

25. The Petitioner has provided credible testimony that the use of two (2) RBTs simultaneously is appropriate in this matter. *See* supra ¶ 11. Thus, Petitioner has demonstrated by a preponderance of the evidence that, based on the information in the record, the requested ABA services are "consistent with generally accepted professional medical standards as determined by the Medicaid program", and "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," for a child with [redacted]. *See* supra ¶ 9, 10, and 11.

26. Accordingly, the Petitioner has demonstrated by a preponderance of the evidence that the requested 1,300 units of code 0373T for the certification period of July 25, 2023, through January 20, 2024 in the initial Treatment Plan by the [redacted] for the use of two (2) RBTs simultaneously is consistent with generally accepted professional medical standards as determined by the Medicaid program for the treatment of [redacted].

27. Upon consideration of the testimony provided, evidence submitted, and applicable policies, the undersigned concludes that Petitioner has proved by a preponderance of the evidence that the denied 1,300 units of code 0373T for the certification period of July 25, 2023, through January 20, 2024, in the initial Treatment Plan by the [redacted] for the use of two (2) RBTs simultaneously is medically necessary. Looking at all the evidence relevant to the particular needs of Petitioner, Respondent has demonstrated that the 1,300 units of code 0373T

for the certification period of July 25, 2023, through January 20, 2024 in the initial Treatment Plan by the [redacted] for the use of two (2) RBTs simultaneously included in the initial Treatment Plan by the [redacted], are necessary to correct or ameliorate the Petitioner's defect or a physical and mental illness or condition, namely the [redacted]. Accordingly, Petitioner did prove by a preponderance of the evidence that Respondent's denial of ABA services for 1,300 units of code 0373T was incorrect.

DECISION

Respondent's denial of behavior analysis services is **REVERSED**. Petitioner's appeal based on Respondent's denial of 1,300 units of code 0373T is **APPROVED**.

DONE and **ORDERED** this 13th day of March 2023, in Tallahassee, Leon County, Florida.

Alan J. Leifer
23-FH3025
2024.03.13 10:55:42
-04'00'

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

NOTICE OF A RIGHT TO JUDICIAL REVIEW

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

Copies Furnished To:

[redacted]

AHCA Medicaid Hearing Unit
MedicaidHearingUnit@ahca.myflorida.com