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

FILED
May 06, 2024, 12:57 pm
OFFICE OF FAIR HEARINGS

[redacted],

PETITIONER, **AHCA Case No.: 23-FH3157**

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 8, 2024, at 9:37 a.m. EST.

APPEARANCES

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

For the Respondent: Chrissie Simmons
Medical Health Care Program Analyst
Agency for Health Care Administration

STATEMENT OF ISSUE

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

The second issue is whether Petitioner proved by a preponderance of the evidence that Respondent's denial of additional BA services was incorrect.

PRELIMINARY STATEMENT

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

Chrissie Simmons, Medical Health Care Program Analyst for the Agency for Health Care Administration ("Agency" or "AHCA"), appeared on behalf of Respondent. Dr. Alissa Conway ("Dr. Conway"), BCBA at the Doctoral Level ("BCBA-D") and second level reviewer for eQHealth Solutions, Inc. ("eQHealth"), attended as a witness for Respondent.

Petitioner did not introduce any exhibits at the Fair Hearing.

Prior to the hearing, Respondent sent to the Office of Fair Hearings and Petitioner a four hundred and ten (410)-page evidence packet. The packet appears in the Office of Fair Hearings' case management system as "[redacted]FH 02.08.2024 1-340.pdf" and "[redacted] FH 02.08.2024 341-410.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 fifty (50)-page evidence packet. The packet appears in the Office of Fair Hearings' case management system as "23-FH3157 AHCA EVIDENCE PKT Revised.pdf." Absent an objection from the Petitioner, the undersigned admitted the evidence packet into evidence as Respondent's Composite Exhibit 2.

FINDINGS OF FACT

1. Petitioner receives Medicaid services on a fee-for-service basis from the Agency. eQHealth is a Quality Improvement Organization contracted by the Agency to review prior authorization requests for services. *See* Respondent's Composite Exhibit 2 at page 2.

2. Petitioner is [redacted] and diagnosed with [redacted] *See* Respondent's Composite Exhibit 1 at page 16. Petitioner also suffers from [redacted]. *Id*. at 341. Dr. Conway's testimony established that Petitioner has participated in BA services with the current provider, [redacted]., since [redacted]. The Behavioral Assessment - Re-assessment, updated October 18, 2023 ("Treatment "Plan"), identified the following maladaptive behaviors: [redacted], [redacted], [redacted], [redacted], [redacted], [redacted], [redacted], [redacted], [redacted], [redacted], and [redacted]. *Id*. at 338.

3. Petitioner requested the following BA services: 2,600 units of code 97153, 208 units of code 97156, and 312 units of code 97155 for the certification period of September 15, 2023, through March 10, 2024. *Id*. at 21-22. As Dr. Conway testified, this request is for an increase in BA services over the last authorization period. Administrative approval of BA services was granted pending the outcome of the Fari Hearing. *Id*. at 21.

4. The Treatment Plan data graphs for maladaptive behaviors show the following: incidents of [redacted] continue to occur at a rate of [redacted] times per week; incidents of [redacted] decrease from [redacted] per week; incidents of [redacted] decreased from [redacted] incidents per week; incidents of [redacted] decreased from [redacted] per week; incidents of [redacted] decrease from [redacted] incidents per week; incidents of [redacted] decreased from [redacted] per week; incidents of [redacted] decrease from [redacted] per week; incidents of [redacted] decrease from [redacted] per week; incidents of [redacted] decrease from [redacted] per week; and incidents for [redacted] decrease from [redacted] per week. *Id*. at 361-366.

5. The Treatment Plan data graphs for replacement behaviors show the following: [redacted] increased from [redacted] increased from [redacted] per week; [redacted] increased from [redacted] increased from [redacted] increased from [redacted] increased from [redacted] increased from [redacted]; [redacted] increased from [redacted] increased from [redacted] increased from [redacted] increased from [redacted] increased from [redacted] increased from [redacted] was mastered at [redacted] increased from [redacted] increased from [redacted] and [redacted] increased from [redacted] *Id*. at 373 – 384.

6. On September 20, 2023, Respondent issued a Notice of Outcome ("NOO"), terminating Petitioner's BA services. *Id.* at 24-26. The NOO explained the basis for the termination as follows:

> [T]he requested services are not medically necessary under the following standard(s):
>
> Individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness under treatment, and not in excess of the patient's needs.

The NOO further provided:

> Requested services are denied because documentation is neither showing [i]mprovement nor support for maintenance.

> PR Clinical Rationale – Denial: According to the Florida Medicaid State Plan (Appendix 9.3.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. The recommendations for procedural modifications include additions/changes to treatment plan to impact behaviors targeted for reduction. Procedural modifications should include one or more of the following: antecedent manipulation modifications, modifications of prompting procedures used in acquisition, modifications in consequence-based strategies – ones that either reduce maladaptive behavior or reinforce replacement behavior (e.g., manipulation of reinforcement schedules, switch to a difference decelerative procedure), or if lack or progress was due to therapist error (e.g., poor data collection or poor training on intervention methods), how you will address human error. The provider has not addressed the lack of progress during the last observation period and did not amend the treatment plan in relation to the lack of progress or the proposed changes have little chance at improving behavior. The information submitted does not meet standards of care within the field of behavior analysis. This request is denied.

Id. at 24-25.

7. Petitioner requested reconsideration of the Respondent's decision. On January 5, 2023, Respondent issued a Notice of Reconsideration Determination ("NRD") upholding its decision. *Id.* at 36-37. The NRD states, in pertinent part as follows:

> Specifically the services must be:
>
> Individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness under treatment, and not in excess of the patient's needs.
>
> At reconsideration all documents were carefully reviewed. According to the Florida Medicaid State Plan (page 8, 6.2.3), 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. The recommendations for procedural modifications include: additions/changes to treatment plan to impact behaviors targeted for reduction. Procedural modifications should include one or more of the following: antecedent manipulation modifications, modifications of prompting procedures used in acquisition, modifications in consequence-based strategies – ones that either reduce maladaptive behavior or reinforce replacement behavior (e.g., manipulation or reinforcement schedules, switch to a different decelerative procedure), or if lack or progress was due to therapist error (e.g., poor data collection or poor training on intervention methods), how the provider will

> address human error. The provider has not addressed the lack of progress during the last observation period and did not amend the treatment plan in relation to the lack of progress or the proposed changes have little chance at improving behavior. The information submitted does not meet standards of care within the filed of behavior analysis. The denial is upheld.

Id.

8. Dr. Conway established that eQHealth reviews behavior analysis cases to ensure that providers are giving quality care consistent with the standards enumerated in the BA Policy as well as professional medical standards of applied behavior analysis ("ABA"). Three qualified BCBA's with eQHealth independently reviewed the Treatment Plan submitted in this case to determine whether all five (5) conditions of medical necessity are met. Dr. Conway asserted that Petitioner's services were terminated because the reviewers determined that the Treatment Plan is not "individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness under treatment, and not in excess of the patient's needs" and is not "consistent with generally accepted professional medical standards as determined by the Medicaid program." Dr. Conway agreed with the previous eQHealth reviewers that the Petitioner is in need of behavior analysis services, an may qualify with a different BA provider; however, the Treatment Plan at issue does not meet medical necessity criteria and termination is appropriate.

9. Dr. Conway established that an effective treatment plan is built around maladaptive behaviors (which decrease in frequency) and replacement skills (which increase in frequency) over the course of treatment. The effectiveness of a treatment plan is determined by reference to data, which is visually depicted in graphs showing a recipient's progress through treatment. Further, standards of care in ABA require an intervention or modification of the treatment plan

if there is minimal to no progress made. An intervention is shown by a vertical line on the data graph marking its start point so that progress can be evaluated.

10. Referring to Respondent's Composite Exhibit 1, beginning at page 361, Dr. Conway questioned the credibility of the data for maladaptive behaviors because each graph generally followed the same downward trend rather than showing variability in behavior. Further, [redacted] asserted that the Treatment Plan does not show that the frequency of Petitioner's maladaptive behaviors has significantly decreased over the course of treatment and the graphs do not show that modifications or interventions were made to address Petitioner's lack of progress. Dr. Conway asserted that the data graphs show that there has been no significant improvement for over a year on maladaptive behaviors or replacement behaviors and no interventions to address the lack of progress. Dr. Conway established that the BA provider was authorized for 312 units – or 3 hours per week – of protocol modification to make changes to the Treatment Plan to ensure progress. Modifications have not occurred and are not shown on the graphs. Therefore, Dr. Conway concluded that the Treatment Plan does not meet standards of care in ABA and is not effective because it has not been individualized and specific to Petitioner's needs.

11. Dr. Conway testified that the data graphs for maladaptive and replacement behaviors do not meet standards of care in the field of BA because the values on the "y" axis for each graph differ and this distorts the visual analysis of the data. Moreover, each of the data graphs contains base line data ("BL") without a date so it is unclear how long each behavior has been in treatment. Overall, the graphs show that Petitioner's maladaptive behaviors are still occurring at high levels with minimal progress over the course of treatment. The provider proposed some modifications

to the Treatment Plan, *Id*. at 397, but these were not reflected on the data graphs nor were these new modifications. *Id*. at 288-290.

12. With regard to replacement behaviors, Dr. Conway testified that the data graphs lack credibility because they all show the same general trend and levels of increase. Further, the "y" axis on the data graphs is not uniform and distorts the visual interpretation of data by making it appear as though there is more progress being made. Dr. Conway testified that, especially in light of Petitioner's [redacted], the data should show more variability. Dr. Conway asserted that [redacted] at a rate of [redacted] of opportunities does not reflect true "mastery" of the replacement behavior.

13. Finally, Dr. Conway testified that Petitioner may qualify for BA services from another BA provider under a Treatment Plan that meets standards of care in the field of BA and is individualized and specific to [redacted] needs. [redacted] encouraged Petitioner to seek another BA provider since this one has not complied with professional medical standards.

14. [redacted] testified that Petitioner's [redacted] is absent from [redacted] life and that, if observed in person, the medical necessity of the services would be obvious to Dr. Conway. [redacted] testified that although Petitioner is [redacted]. Due to Petitioner's [redacted], [redacted] can learn something today and not remember it tomorrow. Petitioner has [redacted]. [redacted] believes that the BA provider is a good fit for Petitioner and that they are trying to give [redacted] the help [redacted] needs.

CONCLUSIONS OF LAW

15. 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).

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

17. Because Respondent terminated a previously approved service, Fla. Admin. Code R. 59-1.100(17)(g) assigns the burden of proof to the Respondent. The standard of proof in an administrative hearing is a preponderance of the evidence. The preponderance of the evidence standard requires proof by "the greater weight of the evidence" (Black's Law Dictionary at 1201, 7th Ed.).

18. 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).

19. 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.

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

21. 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.

22. 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.

23. The Florida Medicaid Behavior Analysis Services Coverage Policy (September 2023) ("BA Policy"), incorporated by reference in Fla. Admin. Code. R. 59G-4.125, governs BA services available under Florida Medicaid. The BA Policy provides as follows:

> **1.0 Introduction**
> Behavior analysis (BA) services are highly structured interventions, strategies, and approaches provided to decrease maladaptive behaviors and increase or reinforce appropriate behaviors.

. . .

1.4.6 Medically Necessary/Medical Necessity

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

. . .

2.0 Eligible Recipient

. . .

2.2 Who Can Receive

Florida Medicaid recipients under the age of 21 years requiring BA services that are medically necessary to address behavior that impairs a recipient's ability to perform a major life activity. Such functional impairment is expressed through the following behaviors:

- Safety – aggression, self-injury, property destruction, elopement
- Communication – problems with expressive/receptive language, poor understanding or use of non-verbal communications, stereotyped, repetitive language
- Self-stimulating – abnormal, inflexible, or intense preoccupations
- Self-care – difficulty recognizing risks or danger, grooming, eating, or toileting
- Other behaviors not identified above but not limited to complexity of treatment, programming, or environmental variables

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

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

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

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

. . .

4.0 Coverage Information

4.1 General Criteria

Florida Medicaid covers services that meet all of the following:

- Are determined medically necessary
- Do 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 BA Policy.

24. In this case, Respondent terminated Petitioner's BA services. The NOO and NRD explained that Petitioner's request for continuation of services did not meet medical necessity as the

Treatment Plan was not "individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment." *See* supra ¶ 6-7.

25. As provided in the BA policy and the EPSDT requirements, the recipient must meet the meet the medical necessity criteria as outlined in Fla. Admin. Code R. 59G-1.010. Two components of medical necessity are that services must be "consistent with generally accepted professional medical standards" and "consistent with generally accepted professional medical standards as determined by the Medicaid program." As outlined above, Dr. Conway provided credible and persuasive testimony identifying several instances where the revised Treatment Plan did not follow generally accepted standards of BA. For example, the Treatment Plan does not show evidence that the frequency of Petitioner's maladaptive behaviors has decreased and does not show that there was a modification or intervention to address Petitioner's lack of progress. *See* supra ¶ 4-5, 8-12. The data graphs for maladaptive behaviors and replacement behaviors lack credibility because the "y" axis visually distorts the data, there are no dates given for baseline data making it difficult to know how long a behavior has been in treatment, and the graphs all follow the same general trends. *See* supra ¶ 4-5, 8-12. The credibility of the data is also questionable given the learning challenges presented by Petitioner's [redacted]. *See* supra ¶ 4-5, 8-12. Petitioner's provider was authorized to provide 3 hours per week of protocol modification to ensure Petitioner's continued to make progress but the data graphs do not reflect that modification or interventions were actually implemented. *See* supra ¶ 4-5, 8-12. Thus, Respondent demonstrated that, based on the information in the record, the requested BA services are not "consistent with generally accepted professional medical standards" and are not "individualized and specific to [Petitioner's] needs." Because the services are not consistent with

generally accepted professional medical standards, the critical element of medical necessity is not met and the recipient will not gain any additional benefit by continuing services under the Treatment Plan at issue.

26. In this case, Petitioner's provider recommended the continuation of BA services. However, the fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services does not, in itself, make such care, goods or services medically necessary or a medical necessity or a covered service. *See* supra ¶ 22.

27. Accordingly, Respondent met their burden of proof to show that the requested BA services under the Treatment Plan at issue are no longer medically necessary. Looking at all the evidence relevant to the particular needs of Petitioner, the BA services at issue are not necessary to correct or ameliorate a defect or a physical and mental illness or condition.

28. Upon consideration of the testimony provided, Respondent's Composite Exhibit 1, Respondent's Composite Exhibit 2, and the applicable law and policies, the undersigned finds that Respondent proved by a preponderance of the evidence that Respondent's termination of BA services was correct.

29. With regard to the second issue of whether the Petitioner proved by a preponderance of the evidence that Respondent's denial of additional BA services was incorrect, Petitioner did not submit any documents or direct evidence to support the request for additional BA services under the Treatment Plan at issue. Respondent, on the other hand, demonstrated that the services at issue no longer meet medical necessity criteria. Therefore, the record does not demonstrate that the requested additional BA services meet medical necessity criteria. Upon consideration of the testimony provided, Respondent's Composite Exhibit 1, Respondent's Composite Exhibit 2, and

the applicable law and policies, the undersigned finds that Petitioner did not prove by a preponderance of the evidence that Respondent's denial of additional BA services was incorrect.

DECISION

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

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 6th day of May 2024, in Tallahassee, Leon County, Florida.

Laura Gallagher
23-FH3157
2024.05.06 08:00:42
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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]

AHCA Medicaid Hearing Unit
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