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

FILED
May 10, 2024, 1:00 pm
OFFICE OF FAIR HEARINGS

[redacted],

PETITIONER, **AHCA Case No.: 23-FH3220**

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 April 17, 2024, at 9:10 a.m. EST.

APPEARANCES

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

For the Respondent: Lee Ann Williams
Medical Health Care Provider Analyst
Fair Hearing Liaison
Agency for Health Care Administration

STATEMENT OF ISSUE

The issue is whether Petitioner proved by a preponderance of the evidence that Respondent's decision to deny Petitioner's request to increase behavior analysis ("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.

Lee Ann Williams, Medical Health Care Provider Analyst and Fair Hearing Liaison for the Agency for Health Care Administration ("Agency" or "AHCA") appeared on behalf of Respondent. Dr. Alissa Conway, ("Dr. Conway") Board Certified Behavior Analyst at the doctoral level (BCBA-D) and second level reviewer for eQHealth Solutions, Inc. ("eQHealth"), attended as a witness for Respondent.

Camilo #SCML appeared for translation services.

Alan #383828 appeared for translation services.

Petitioner did not introduce any documents as evidence for the Fair Hearing.

Prior to the hearing, Respondent sent to the Office of Fair Hearings and Petitioner a two hundred and forty-eight (248)-page evidence packet. The packet appears in the Office of Fair Hearings' case management system as "[redacted] FH 02.22.2024 1-75.pdf," "[redacted] FH 02.22.2024 76-109.pdf," "[redacted] FH 02.22.2024 110-169.pdf," "[redacted] FH 02.22.2024 170-199.pdf," "[redacted] FH 02.22.2024 200-233.pdf," and "[redacted] FH 02.22.2024 234-248.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-FH3220 Agency Evidence Legal Authorities 50 pages.pdf." Absent an objection

from the Petitioner, the undersigned admitted the evidence packet into evidence as Respondent's Composite Exhibit 2.

Prior to the commencement of the hearing, Respondent sent to the Office of Fair Hearings and Petitioner a five (5) page document entitled Notice of Reconsideration Determination. The document appears in the Office of Fair Hearing's case management system as "[redacted] AM INTAKE Approval Letter for [redacted].pdf." Absent an objection from Petitioner, the undersigned admitted the evidence packet into evidence as Respondent's Composite Exhibit 3.

FINDINGS OF FACT

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

2. Petitioner is [redacted]. *See* Respondent's Composite Exhibit 1 at page 22. The Petitioner has been diagnosed with [redacted]. The Petitioner has exhibited maladaptive behaviors including [redacted]. *Id.* at 54. The provider reports that during the authorization period the recipient has shown progress on all behaviors. *Id.* at 54.

3. The provider requested the following service units be authorized:

Code 97153, 3,120 units; Code 97155, 260 units, and Code 97156, 260 units. This requested authorization is an increase of Code 97153 from 2,496 units to 3,120 units. Further, the provider requested an increase in Code 97156 from 208 units to 260 units. The authorization period request was for December 8, 2023 through June 4, 2024.

4. On December 11, 2023, Respondent issued a Notice of Outcome ("NOO"), terminating Petitioner's BA services. *Id.* at 28-29. 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:

> Submitted information does not support the medical necessity for requested frequency and/or duration.
>
> > PR Clinical Rationale – Denial: 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 of reinforcement schedules, switch to a different decelerative procedure), or if lack of 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 28-29.

5. Petitioner requested reconsideration of the Respondent's decision. On December 28, 2023, Respondent issued a Notice of Reconsideration Determination ("NRD") upholding its decision. *Id.* at 40-42. The NRD states, in pertinent part as follows:

> Specifically, the services must be:
>
> Consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational.
> Individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness under treatment, and not in excess of the patient's needs.
>
> . . .
>
> PR Recon Determination: At reconsideration all documents were carefully reviewed. Calming/coping/relaxation strategies, social stories, and sensory alternatives are not empirically supported procedures within the conceptual system of behavior analysis for treating the functions of maladaptive behavior. According to Behavior Analysis Services Coverage Policy (page 2, 1.1), treatment that does not meet generally accepted standards of care within the field of applied behavior analysis are not covered under the behavior analysis service coverage policy. The provider has listed goals in this treatment plan that do not meet medical necessity criteria ([redacted]). According to the Behavior Analysis Services Coverage Policy (page 4, 4.1), these goals are not covered. The goals must be necessary to protect life, to prevent significant illness, significant disability, or to alleviate severe pain and be 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 the recipient, the recipient's caretaker, or the provider. According to the Florida Medicaid Behavior Analysis Services Coverage Policy (page 3, 2.2) the recipient of ABA therapy services must engage in maladaptive behaviors that interferes with the recipient's daily functioning for which ABA therapy is medically necessary. The behaviors identified in this treatment plan include: (e.g., [redacted]). Behavior analysis is not the most effective and least costly treatment available to treat the causes of these behaviors. These behaviors are outside the scope of treatment for behavior analysis. The request was denied for lack of progress. The provider submitted additional documents including data in graphs that are not consistent with data that are typically reported in behavior analytic treatment. Many of the graphs for maladaptive behavior and skill acquisition show the same general pattern, level,

> and trend in the data. These data do not appear to have been accurately reported or observed and measured according to standards of care within the field of behavior analysis. This denial is upheld.

Id. at 40-42.

6. On April 17, 2024, prior to the commencement of the Fair Hearing, the Respondent filed an additional Notice of Reconsideration Determination reversing the prior termination and granting /authorizing the requested service units as follows: Code 97153, denial modified, units approved 2,496; Code 97155, denial modified, units approved as requested at 260, and Code 97156, denial modified, units approved 208. Respondent's Composite Exhibit #3, page 1. Dr. Conway testified that the Reconsideration Determination filed on April 17, 2024 continued the exact same service units as previously authorized for this recipient.

7. The Petitioner requested a Medicaid Fair Hearing on December 27, 2023. The Fair Hearing was initially scheduled for February 22, 2024. However, due to the medical circumstances of [redacted], the Fair Hearing was postponed until April 17, 2024, at 9:00 a.m. EST.

8. [redacted] testified on behalf of [redacted]. [redacted] testified that [redacted] was receiving about 30 hours of service per week. [redacted] felt that [redacted] could use more services to help with the maladaptive behaviors. If [redacted] received additional services, [redacted] could improve more. [redacted] testified that [redacted] had recently had some medical issues of [redacted] own, but [redacted] still wanted [redacted] to receive ABA help.

9. 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"). eQHealth 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 denied because the treatment plan is not individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness un treatment, and not in excess of the patient's needs and not consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational and therefore does not meet the conditions of being medically necessary.

10. Dr. Conway explained the review process that is followed by eQhealth. In this review, Dr. Conway testified that the 1st level reviewer found that the recipient had been diagnosed with several medical conditions (*See* ¶ 2) and the provider was requesting 35 hours per week of services. *Id.* at 23. Further, considering the documentation submitted, the request for services was not 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. *Id.* The request was sent to a second level review. The second level reviewer is a Board-Certified Behavior Analyst at the doctoral level (BCBA-D). Dr. Conway testified that the second reviewer wrote that the data 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. *Id.* The second level reviewer denied the request for behavior analysis services based upon the documentation submitted. *Id.* A request was made for reconsideration and a third reviewer reconsidered the previous denial. The third reviewer is also a Board-Certified Behavior Analyst at the doctoral level (BCBA-D). In addition to confirming the previous denial the third reviewer also found that the treatment plan contained strategies that are not empirically support procedures for treating the

functions of maladaptive behaviors. Also, the provider included goals, such as [redacted] and [redacted], that do not meet medical necessity criteria. *Id.* at 23. The prior denial was upheld. *Id.* at 24. Dr. Conway testified that the provider had removed the behaviors and goals that did not meet the ABA standards.

11. Dr. Conway established that an effective treatment plan is built around maladaptive behaviors (which decrease in frequency) and skills to be acquired (which increase in frequency) over the course of treatment. As part of the additional reconsideration determination, Dr. Conway reviewed graphs involving maladaptive behavior. The first graph is for [redacted]. This graph shows the occurrences are [redacted] and this is considered a low severity behavior. *Id.* at 201. The next graph is for [redacted]. This graph shows this behavior occurring at low levels and is on a decreasing trend. *Id.* at 202. The next graph is for [redacted]. As with the previous graph, this behavior is occurring at lower levels and is on a decreasing trend. *Id.* at 202. The next graph for review is [redacted]. This graph depicts a slower decrease in the behavior than the previous graphs but is on a decreasing trend. *Id.* at 203. The next graph is for [redacted]. This is a serious behavior; however the graph shows a decreasing trend and the occurrences are slightly above [redacted]. *Id.* at 204. Dr. Conway testified that the remaining graphs for maladaptive behaviors were very similar showing a decreasing trend in the behaviors.

12. Dr. Conway also reviewed the Treatment Plan concerning replacement behaviors. The graphs for replacement behaviors begin on page 213 of RCE 1. Dr. Conway did not review each graph but testified that the skill replacement graphs overall showed an increasing trend and that most graphs are at or above 50%. Overall, the data shows progress.

13. Dr. Conway testified that based upon the documentation reviewed, the additional reconsideration determination modified the previous termination of services and authorized services to continue with the same units as were previously authorized, to wit: 2,496 units of Code 97153, 260 units of Code 97155 and 208 units of Code 97156. Dr. Conway testified that based upon the decreasing maladaptive behaviors and the increasing skill replacements, the evidence does not support the increase units requested by the provider. The increase in units would be in excess of the patient's needs and therefore not medically necessary.

14. [redacted] testified on rebuttal that [redacted] did not intend for [redacted] own medical circumstances to serve as a basis to increase services or suggest that it would be a convenience during [redacted] illness, only that [redacted] wants [redacted] to receive the services [redacted] needs to help improve [redacted] behaviors and [redacted] life.

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

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. The Florida Medicaid Authorization Requirements Policy ("Authorization Policy"), incorporated by reference in Fla. Admin. Code R. 59G-1.053, provides as follows:

3.2.1 Continued Authorization Request

The QIO shall not deny or reduce the amount, frequency, or duration of a service that is already being provided, unless:

- The reduction is to correct for factual error or omissions in prior certifications.
- There is a documented improvement in the recipient's medical condition.
- There is a documented change in the recipient's circumstances.
- The reviewing physician determines the recipient will not gain any additional benefit by continuing services at the current level.

. . .

Page 3 of Authorization Policy.

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

plan was not "[c]onsistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational" and not "Individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness under treatment, and not in excess of the patient's needs." *See* supra ¶ 4-5.

26. [redacted]'s testimony did not prove by a preponderance of the evidence that the behavior analysis services should be increased above the current authorization. No testimony or evidence was provided that would justify increasing the ABA service units.

27. As outlined above, Dr. Conway provided credible and persuasive testimony identifying several instances where the revised Treatment Plan did result in effective treatment of the recipient's maladaptive and replacement skills behaviors. For example, the documentation provided for review did show decreases in maladaptive behaviors and increases in replacement behaviors. *See* supra ¶ 11-12. Dr. Conway testified that the reduction in maladaptive behaviors was slow but did reflect a steady decline in the behaviors. *See* supra ¶ 11. Dr. Conway also testified that the skill replacement behaviors showed an increasing trend and that most graphs were at or slightly above 50%. *See* supra ¶ 12. Thus, Dr. Conway testified that based on the data in the record, the April 17, 2024 reconsideration determination supported the re-authorization of services at the existing level to wit: 2,496 units of Code 97153, 260 units of Code 97155 and 208 units of Code 97156. *See* supra ¶ 13. However, Dr. Conway testified that the data did not support an increase in the services units as requested by the provider. An increase in service units would be in excess of the patient's needs and therefore not medically necessary. *See* supra ¶ 13.

28. In this case, Petitioner's provider recommended the continuation and an increase 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.

29. Accordingly, Petitioner has failed to established by a preponderance of the evidence that the requested increase in BA services were medically necessary. Looking at all the evidence relevant to the particular needs of Petitioner, the increase in BA services at issue are not necessary to correct or ameliorate a defect or a physical and mental illness or condition.

30. Upon consideration of the testimony provided, Respondent's Composite Exhibit 1, Respondent's Composite Exhibit 2, Respondent's Composite Exhibit 3, and the applicable law and policies, the undersigned finds that Petitioner failed to prove by a preponderance of the evidence that Respondent's denial of the increase BA services was incorrect.

DECISION

Respondent's denial of the requested increase in Behavior Analysis services is **AFFIRMED**. Petitioner's appeal based on Respondent's denial of the requested increase in Behavior Analysis services is **DENIED**.

DONE and **ORDERED** this 10th day of May 2024, in Tallahassee, Leon County, Florida.

George L. Winslow, Jr.
23-FH3220
2024.05.10 10:16:06
-04'00'

_____

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

NOTICE OF A RIGHT TO JUDICIAL REVIEW

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

Copies Furnished To:

[redacted]

AHCA Medicaid Hearing Unit
MedicaidHearingUnit@ahca.myflorida.com