

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



FILED

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OFFICE OF FAIR HEARINGS

[REDACTED]

PETITIONER,

AHCA Case No.: 23-FH3224

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 21, 2024, at 9:00 a.m. EST.

APPEARANCES

For the Petitioner:

[REDACTED]

Petitioner's Authorized Representative

For the Respondent:

Marielisa Amador
Medical Health Care Program Analyst
Fair Hearing Liaison
Agency for Health Care Administration

STATEMENT OF ISSUE

The 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.

PRELIMINARY STATEMENT

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

Marielisa Amador, Medical Health Care Program Analyst and Fair Hearing Liaison for the Agency for Health Care Administration ("Agency" or "AHCA") appeared on behalf of Respondent. Dr. Karen Goldberg M.D. ("Dr. Goldberg"), Board Certified Child, Adolescent, and Adult Psychiatrist and medical director for eQHealth Solutions, Inc. ("eQHealth"), attended as a witness for Respondent.

Petitioner did not file any documents as evidence prior to the Fair Hearing.

Prior to the hearing, Respondent sent to the Office of Fair Hearings and Petitioner a one hundred and seventy-nine (179)-page evidence packet. The packet appears in the Office of Fair Hearings' case management system as "[REDACTED] FH 02.21.2024.pdf." Absent an objection from the Petitioner, the undersigned admitted the evidence packet into evidence as Respondent's Composite Exhibit 1.

Prior to the hearing, Respondent sent to the Office of Fair Hearings and Petitioner a forty-nine (49)-page evidence packet. The packet appears in the Office of Fair Hearings' case management system as "24-FH3224 AHCA Evidence (Pages 1-49 of 49).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]. *See Respondent’s Composite Exhibit 1 at page 16.* The Petitioner has been diagnosed with [REDACTED]. The Petitioner has exhibited maladaptive behaviors including [REDACTED], [REDACTED], [REDACTED], [REDACTED], [REDACTED], [REDACTED], [REDACTED], and [REDACTED]. *Id.* at 49-50.

3. Petitioner requested the following BA services: 3,120 units of code 97153, 624 units of code 97155, and 52 units of code 97156 for the certification period of October 26, 2023, through April 22, 2024. *Id.* at 28.

4. The provider submitted additional information in the form of a re-assessment dated October 2023. *Id.* at 47-179.

5. On October 18, 2023, Respondent issued a Notice of Outcome (“NOO”), denying Petitioner’s BA services. *Id.* at 23-25. The NOO explained the basis for the termination as follows:

[T]he requested services are not medically necessary under the following standard(s):

Consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational.

...

The NOO further provided:

Requested services are denied because documentation is neither showing improvement nor support for maintenance.

PR Clinical Rationale – Denial: The supporting documentation does not meet generally accepted practices within the field of applied behavior analysis and

standards set forth in the Florida Behavior Analysis Services Coverage Policy. Specifically, the provider has failed to write an intervention plan that upholds the standards of care of applied behavior analysis. The plan lists procedures that include punishment ([REDACTED]) and has not exhausted reinforcement-based strategies. There is no procedural safeguard or fading plan. Further, these reduction procedures do not appear effective per the data reported demonstrating variability with lack of progress across maladaptive behavior goals. 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 23-24.

6. Petitioner requested reconsideration of the Respondent’s decision. On December 30, 2023, Respondent issued a Notice of Reconsideration Determination (“NRD”) upholding its decision. *Id.* at 35-36. 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.

...

PR Recon Determination: Provider, the additional documentation submitted was not a complete treatment plan. Additionally, the provider has still included a time out procedure and the fading plan is unclear and nonspecific. Additionally, the recipient has shown lack of progress through multiple authorizations and no

modifications are included. At reconsideration all documents were carefully reviewed. The supporting documentation does not meet generally accepted practices within the field of applied behavior analysis and standards set forth in the Florida Behavior Analysis Services Coverage Policy. Specifically, the provider had failed to write an intervention plan that upholds the standards of care of applied behavior analysis. The plan lists procedures that include punishment and has not exhausted reinforcement-based strategies. There is no clear procedural safeguard or clear fading plan. 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. Additionally, the graphs depict inappropriate scales (maladaptive start above 0, skill acquisition end below 100%) and these distort the visual analysis of the graphs. 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 denial is upheld.

Id. at 35-36.

7. Dr. Goldberg 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. Goldberg asserted that Petitioner’s services were denied because the treatment plan is 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.

8. Dr. Goldberg reviewed the historical background of this provider and this recipient. The provider has been providing services to the recipient since the initial assessment in [REDACTED]. Dr. Goldberg explained the review process that is followed by eQhealth. In this review, Dr. Goldberg testified that the 1st level reviewer found a lack of progress by the recipient concerning the maladaptive behaviors. *Id.* at 18. The request was then sent to a second level review. Dr. Goldberg testified that the second reviewer wrote that the provider failed to write an intervention plan according to the ABA standard of care. Further, the plan included punishment [REDACTED] without exhausting reinforcement-based strategies. Dr. Goldberg testified that if punishment is included in the Treatment Plan, there must be a fading plan for the punishment. Dr. Goldberg testified that the use of timeout is punishment even though the provider is calling it [REDACTED]". The provider submitted a revised plan during the reconsideration review, however the reviewer found that the plan still included the timeout procedure, and the fading plan is unclear and nonspecific. Also, the recipient has shown a lack of progress through multiple authorizations and no modifications are included. *Id.* at 19.

9. Dr. Goldberg 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. Dr. Goldberg testified that this provider has failed to establish a Treatment Plan that will accomplish the purpose of ABA and address the lack of progress with this recipient.

10. Dr. Goldberg reviewed graphs involving maladaptive behavior. The first graph is for aggression towards adults. This graph shows variable data points throughout the authorization period. This graph does not depict a downward or reducing trend for the maladaptive behavior.

Also, there is a general rule in ABA that after three data points with no improvement there should be an intervention / modification of the Treatment Plan. On this graph, after three data points there should have been an intervention to address the maladaptive behavior. *Id.* at 68. The next graph is for [REDACTED]. This graph is very similar to the previous graph. There is significant variability in the reported data. Also, this graph contains no interventions after three data points with no progress. *Id.* at 71. The next graph is for [REDACTED]. This graph depicts very high variability for this maladaptive behavior. This graph, as well as the previous graphs, do not show any consistency of improvement in the maladaptive behaviors. Also, there are no indications on the graph of interventions to address the lack of progress. *Id.* at 74. The next graph for review is [REDACTED]. As with the previous graphs, this graph shows high variability, no consistent improvement in the maladaptive behavior and no intervention. *Id.* at 77. Dr. Goldberg also reviewed the graph for [REDACTED]. This graph shows an increasing trend and there is no intervention to help explain why this occurred. *Id.* at 80. The same concern exists for the graph of [REDACTED]. There is a slight upward trend with a significant spike in September of [REDACTED]. The provider has failed to make any modification or intervention to address this issue. *Id.* at 83. The graph for [REDACTED] shows a variability of the data with an upward trend beginning in August of [REDACTED] through September of [REDACTED]. This graph does not show any intervention by the provider. *Id.* at 98.

11. Dr. Goldberg also reviewed the Treatment Plan concerning how to react to maladaptive behaviors. A major concern is the immediate use of the “safe corner”, which Dr. Goldberg has identified as a punishment. As Dr. Goldberg testified, punishment should not be the first response until all other available reinforcement strategies have been exhausted. On page 127 of the

Respondent's Composite Exhibit 1, the plan states that if there is successful aggression toward an individual, "[REDACTED]." The exact same direction is given if there is behavior of [REDACTED] or [REDACTED]. *Id.* at 128. Dr. Goldberg testified that she could not emphasize enough that punishment as a first response is not a good behavior analysis practice. Dr. Goldberg noted that the provider did not consider the [REDACTED]" as punishment but more to protect the Petitioner and others around [REDACTED]. Dr. Goldberg pointed out that she, as well as the other reviewers involved in this case, considered the timeout procedure a form of punishment and no fading plan existed.

12. [REDACTED] testified that a peer-to-peer review was not requested as [REDACTED] office believed that type of meeting required months of advance scheduling. [REDACTED] testified that their response to the initial denial was an effort to clarify and defend the services provided to the recipient. The response was not intended as a refusal to work the eQHealth reviewers, but an effort to resolve any differences in the Treatment Plan for the recipient. [REDACTED] also believed that the quickest way to resolve the denial of services was to go through the Fair Hearing and therefore did not make any additional efforts to meet with eQHealth personnel.

13. [REDACTED] also testified on behalf of the Petitioner. The provider began services with this recipient in [REDACTED]. At that time the recipient was in a [REDACTED] but because [REDACTED] was older, getting taller and bigger, [REDACTED] was moved to the next classroom level. [REDACTED] [REDACTED] pointed out that the recipient had two different classrooms from [REDACTED] [REDACTED]. [REDACTED] testified that the strategies of reinforcement are used first before considering other possibilities. [REDACTED] is of the opinion that the [REDACTED]" is not used as a punishment for the recipient. [REDACTED] stated that the classroom corner was used

to allow the recipient to de-escalate from the maladaptive behavior and to provide safety for others in the area. [REDACTED] testified that if reinforcement strategies were used, the recipient would escalate and become aggressive. [REDACTED] stated that there was a general increase in the recipients' behaviors in August of [REDACTED] when [REDACTED] was moved into a classroom with more age-equal peers. Also, [REDACTED] reported that the school personnel advised that the recipient did not do as well when the ABA treatment team was not at school with the recipient. [REDACTED] also noted that in July of [REDACTED], in order to prepare the recipient for the classroom change that would take place in August of [REDACTED], the recipient was taken to the new classroom for short visits and that resulted in a slight increase in the maladaptive behaviors. [REDACTED] stated that using a three data point intervention would not work in this case as three data points would only span a day and a half for this recipient and that would be insufficient time to make a proper adjustment. [REDACTED] testified that the recipient had a break in services when the denial went through and shortly thereafter the recipient was withdrawn from the daycare school. The recipient now receives services at the provider's location and the classroom corner/safe corner is not used in that environment.

14. [REDACTED] also testified on behalf of [REDACTED]. Prior to the termination of ABA services, [REDACTED] noticed improvements in communication, behaviors, and positive reports from the school's teachers. [REDACTED] was able to better interact with [REDACTED] peers at school. This level of improvement also transitioned to [REDACTED]'s behavior at home and helping with various chores. [REDACTED] also interacted better with other people when outside the school and home environment. [REDACTED] progress has also resulted in a greater level of confidence in [REDACTED]. There has

also been improvement because of the services being offered at the provider's office where there is more attention on [REDACTED] behaviors.

15. Dr. Goldberg provided rebuttal testimony. As previously stated by Dr. Goldberg, no matter what name or title is used, when an individual is removed from a situation and placed in a classroom corner or safe corner, that is an active punishment procedure. This type of procedure requires a clear fading plan. Also, there are avenues available to a provider to continue services while a Fair Hearing is pending. If the provider did not take advantage of those options, it is not fair to put a recipient's break in services on the reviewers or on Medicaid. Each person must own their own decisions. The use of peer-to-peer review is available for the provider to learn from and work with the reviewers for the benefit of the recipient. The burden is on the provider to make those requests and not Medicaid.

CONCLUSIONS OF LAW

16. 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).

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

18. 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.).

19. 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).

20. 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.

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

22. 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.

23. 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

24. 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 not duplicate another service
- Meet the criteria as specified in this policy

4.2 Specific Criteria

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

4.2.1 Behavior Assessment 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 must 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
 - o 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
 - o Maximum group size is six recipients
 - o 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
 - o Maximum group size is six recipients
 - o 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
 - o The recipient may or may not be present depending upon clinical appropriateness.
 - o Services may be provided by Lead Analyst or BCaBA
 - o 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
 - o Treatment setting(s)
 - o Proposed treatment targets, goals, and objectives related to medically necessary behavioral interventions
 - o 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
 - o Proposed targets, goals, and objectives (as above)
 - o Training procedures
 - o Date of introduction
 - o Estimated date of mastery
- Number of units requested
 - o Number of units for each billing code
 - o 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.

25. 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.

26. In this case, Respondent denied 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* ¶ 5-6.

27. 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. A component of medical necessity is that services must be “consistent with generally accepted professional medical standards.” As outlined above, Dr. Goldberg provided credible and persuasive testimony identifying several instances where the revised Treatment Plan did not follow generally accepted standards of ABA. For example, the provider is using a strategy of classroom corner or safe corner, which is a form of punishment and has failed exhaust other strategies and failed to provide a fading plan for the punishment. *See supra* ¶ 8, 11. Thus, Respondent demonstrated that, based on the information in the record, the requested BA services are not “consistent with generally accepted professional medical standards.” Because the services are not consistent with generally accepted professional medical standards, the critical element of medical necessity is not met. *See supra* ¶ 7.

28. 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* ¶ 23.

29. Accordingly, Respondent has established by a preponderance of the evidence that the requested BA services are not 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.

30. 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 denial of BA services was correct.

DECISION

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

DONE and ORDERED this 25th day of March 2024, in Tallahassee, Leon County, Florida.

George L.
Winslow, Jr.
 23-FH3224
2024.03.25
09:58:48 -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]
[REDACTED]

AHCA Medicaid Hearing Unit
MedicaidHearingUnit@ahca.myflorida.com