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



[redacted],

**PETITIONER,** **AHCA Case No.: 24-FH0016**

**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 15, 2024, at 1:13 p.m. EST.

## APPEARANCES

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

For the Respondent: Linda Latson
Registered Nurse Specialist, 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], BCBA with [redacted]., appeared on behalf of the Petitioner.

Linda Latson, Registered Nurse Specialist, 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 of eQHealth Solutions, Inc. ("eQHealth"), attended as a witness for Respondent.

Rosario #200765 and Karina #356181 appeared to offer translation services.

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 three hundred and twenty-seven (327)-page evidence packet. The packet appears in the Office of Fair Hearings' case management system as "[redacted] FH 02.15.2024 1-94.pdf," "[redacted] FH 02.15.2024 95-149.pdf," "[redacted] FH 02.15.2024 150-219.pdf," "[redacted] FH 02.15.2024 220-302.pdf," and "[redacted] FH 02.15.2024 303-327.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 "24-FH0016 AHCA Evidence BA Svcx 50 Pages.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 22. Dr. Conway testified that this recipient has been receiving ABA services since [redacted]. The Petitioner has been with the current provider since [redacted]. The Petitioner's diagnosis is [redacted]. *Id.* at 22.

3. Petitioner requested continuation of the following BA services: 2,600 units of code 97153, 208 units of code 97155, 312 units of code 97155HN, 104 units of code 97156, and 104 units of code 97156HN for the certification period of November 28, 2023, through May 25, 2024. *Id*. at 30. On December 11, 2023, a written request was sent to the provider for additional information. *Id.* at 56. Specifically, the request stated that the Treatment Plan contained goals that do not meet medical necessity criteria, definitions of behaviors must be written according to generally accepted practice in the field of ABA, behaviors should have clear boundaries and definite on-sets and off-sets and should not overlap with other behaviors, and skills that do not require a trained ABA individual should be removed and presented in a less costly manner. *Id.* at 56. The provider did submit a behavior analysis re-assessment dated November 22, 2023, for reconsideration. *Id.* at 60-95.

4. On December 21, 2023, Respondent issued a Notice of Outcome ("NOO"), terminating Petitioner's BA services. *Id.* at 30-32. 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.
> Individualized, specific, and consistent with symptoms of confirmed diagnosis of the illness under treatment, and not in excess of the patient's needs.
> . . .

The NOO further provided:

> PR Principal Reason – Denial:
>
> Submitted information does not support the medical necessity for requested frequency and/or duration.
>
> PR Clinical Rationale – Denial: According to Florida Behavior Analysis Services Coverage Policy (Pages 7, 5.2) [redacted] are not a covered service. Further, [redacted] strategies are not an 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 submitted 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 request is denied.

*Id.* at 30-31.

5. Petitioner requested reconsideration of the Respondent's decision. On December 29, 2023, Respondent issued a Notice of Reconsideration Determination ("NRD") upholding its decision. *Id.* at 42-43. 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.
> . . .

> At reconsideration all documents were reviewed carefully. 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. Additionally, there are strategies listed that are not function based. The strategies include physical prompts for verbal maladaptive behaviors and strategies that do not meet the standard of care in the field of ABA (pp5-7). According to the Behavior Analysis Services Coverage Policy (page 5, 4.2.2), treatment for behaviors must be tied to the function of maladaptive behaviors. The treatment must be individualized, specific, and meet generally accepted standards of care within the field of behavior analysis. The provider's treatment plan includes a general listing of procedures for treatment plan that is not tied to behavioral function. The interventions cannot be implemented simultaneously. The treatment plan is not individualized for the recipient and does not meet generally accepted standards of care within the field of behavior analysis. This denial is upheld.

*Id*. at 43.

6. 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 terminated 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 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.

7. Dr. Conway began her review of the treatment plan with the modifications of prompt levels used by the provider. The provider is using the "most to least" prompt schedules which is the most restrictive form of prompting. This method does not allow the recipient to make any

errors. The provider also uses physical prompts which involve touching or adjusting the body of the recipient. These prompts do not match the topography of the behavior. Full or partial physical prompts are listed for each of the behaviors on page 279 of Respondent's Composite Exhibit 1. The provider has also included strategies that cannot be implemented simultaneously. For example, with the behavior of [redacted], the provider includes the strategy of [redacted]. *Id.* at 282. The provider also includes "[redacted]", and "[redacted]" which are not supported by ABA and could be provided at a lower less costly level. *Id.* at 288-289. Also, [redacted] provider indicates a need to conduct a functional behavior assessment. Dr. Conway testified that the functional assessment should be completed before trying to establish a Treatment Plan. *Id.* at 288-289. While a function may be updated with data collection, the initial function determination should be completed before intervention.

8. The first maladaptive behavior is identified as [redacted]. *Id.* at 298. The data depicted in this graph would not appear to meet the standards under ABA. *Id.* at 298. The data does not appear to have been accurately observed and recorded. *Id.* The graph indicates that the behavior occurred [redacted] of the time from September 24, 2023, through November 15, 2023. *Id.*

9. The next maladaptive behavior for review is [redacted]. *Id.* at 299. As stated with the previous graph, this graph also shows that the behavior is occurring [redacted] of the time with the exception of one day. *Id.* at 299. This graph also shows that the data appears to have been inaccurately recorded and/or observed as the behavior is occurring [redacted] of the time from September 25, 2023, until October 31, 2023. *Id.*

10. The graph for [redacted] is found at page 300 of RCE #1. This graph shows the behavior occurring at [redacted] of the time with the exception of four days. *Id.*

11. The next graph shows [redacted]. *Id.* at 301. This graph measures the behavior in duration (minutes). This graph indicates that the recipient is only [redacted] or this data is inaccurate.

12. The next maladaptive behavior graph is for [redacted]. *Id.* at 302. This graph shows the behavior occurring [redacted] of the time during the most recent authorization period. *Id.* The graph for [redacted] shows the same behavior pattern. *Id.* at 303.

13. Thus, Dr. Conway summarized her opinion that the graphs of the maladaptive behaviors reflect inaccurate data recording. Each graph records the data at [redacted] for a majority of the reporting period and each graph has the same trends and levels reported. The inaccurate collection of data continued for several months without intervention by the lead analyst.

14. For further review of the treatment plan, Dr. Conway reviewed the skill acquisition graphs for this recipient. The first graph is for [redacted]. *Id.* at 307. The graph shows highly variable data points throughout the last authorization period. Performance fell below the established base line throughout the evaluation. *Id.* at 307. The next skill graph is for [redacted] *Id.* at 308. While this graph shows some slight improvement, the last data point would be considered an outlier. *Id.* at 308. The third skills graph is for [redacted]. *Id.* at 309. This graph shows highly variable performance with minimal improvement throughout the authorization period. The next graph that Dr. Conway reviewed was for [redacted]. *Id.* at 310. This graph shows improved performance during the last few months of the authorization

period; however, the improvement is minimal compared to the baseline. *Id.* at 310. The next skills [redacted] was doing activities for increasing lengths of time. *Id.* at 313. As the graph does not measure the skill in lengths of time, it is unclear what the goal may have been. This skill shows a high variability ranging from [redacted] during a one-month period. *Id.* at 313. As testified to by Dr. Conway, overall, the skills graphs show a high variability through the authorization without showing any significant progress.

15. The provider has indicated that there will be additional training and proper data collection instruction for the RBT. *Id.* at 290. While this recipient has only been with this provider for a short period of time, there has been very little progress, and the Treatment Plan does not meet the standards for ABA.

16. In summary, Dr. Conway found that the treatment plan submitted by the provider shows a lack of progress during the authorization period and no effective modifications have been included with the plan. While the recipient may meet the medical necessity criteria, the current treatment plan does not meet medical necessity based upon the standards of ABA, in particular, the treatment plan is not consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational.

17. [redacted], [redacted] and authorized representative for the Recipient testified that the Petitioner is [redacted]. [redacted] has seen some improvement in my child's behavior since [redacted] started ABA services. [redacted] believes all individuals have the right to therapy. Services were stopped because of a change from one city to another. The family moved from [redacted] [redacted] asserted that the data information may not show a medical necessity but

that Petitioner has a medical necessity for ABA services, and some of the data written down does not clearly show that need.

18. [redacted], the BCBA for the Petitioner also testified. [redacted] stated [redacted] has been the BCBA for approximately [redacted] after the family moved from [redacted]. In the last reassessment, [redacted] made the modifications requested by eQHealth. [redacted] removed parts of the treatment plan that dealt with mental health issues and not ABA matters. [redacted] removed some of the replacement behaviors and reviewed the skill replacements with [redacted]. During the [redacted] working with the Petitioner, [redacted] discontinued some of the maladaptive behaviors. During this short time, the Petitioner has improved at a higher level than when [redacted] started in [redacted]. Goals have been established for the RBT and said goals will be charted. [redacted] also pointed out that a new BCBA and RBT took over services as a result of the move from [redacted] area. [redacted] disagreed with Dr. Conway's testimony that there was a lack of improvement with the replacement goals considering there had only been [redacted] to work with the Petitioner following the move from [redacted]. [redacted] notes that during the [redacted] period [redacted] has worked with the Petitioner there has been improvement. [redacted] does agree that the treatment plan that the Petitioner had when [redacted] was in [redacted] needs to be overhauled and concentrate on the ABA issues and not the mental health issues of the prior plan.

19. Dr. Conway provided brief rebuttal testimony. Dr. Conway stated that there are still parts of the treatment plan that are not empirically supported procedures. Also, in response to the mother's testimony, the medical necessity of the child's behaviors is not in question. The issue lies with the treatment plan and whether the plan meets the generally accepted medical

standards. The current plan and interventions do not meet professional medical standards and therefore does not meet medical necessity. The Petitioner may qualify for ABA services with a different provider.

## CONCLUSIONS OF LAW

20. 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).

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

22. 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.).

23. 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).

24. 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.

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

26. 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.

27. 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

28. 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.

29. The Florida Medicaid Authorization Requirements Policy ("Authorization Requirements Policy") (June 2016), incorporated by reference in Fla. Admin. Code R. 59G-1.053, provides general requirements for providers to obtain authorization to render Florida Medicaid services. The Authorization Requirements Policy states, in pertinent part:

> **3.0 Determination Process**
> **3.1 Review Criteria**
> The QIO may use a national standardized set of criteria, or other set of criteria, approved by AHCA, as a guide for authorizations performed at the first review level. If services cannot be approved at the first level review, the QIO's physician peer reviewer will determine medical necessity using his or her clinical judgment, acceptable standards of care, state and federal laws, and AHCA's medical necessity definition.
>
> **3.2 Review Process**
> The QIO will review each authorization request and will approve, deny, or request additional information. The QIO may deny a portion of the requested units of service if it cannot substantiate medical necessity based upon the information submitted.
>
> **3.2.1 Continued Authorization Requests**
> The QIO shall not deny or reduce the amount, frequency, or duration of a service that is already being provided, unless:
> - The reduction is to correct for factual errors 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.

Respondent's Composite Exhibit 2 at pages 32-34.

30. 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 "[c]onsistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational." *See* supra ¶ 4-5.

31. 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. 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 fails to show that the frequency of Petitioner's maladaptive behaviors has decreased during the authorization period nor have the skill acquisition or replacement behaviors increased during the same period. Further, the Treatment Plan contains no modifications to address the lack of progress during the authorization period. *See* supra ¶ 15-16. 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 ¶ 6.

32. 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 ¶ 27.

33. Accordingly, Respondent met their burden of proof to show that the requested BA services 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.

34. 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.

## DECISION

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

**DONE** and **ORDERED** this 27th day of March 2024, in Tallahassee, Leon County, Florida.

George L. Winslow, Jr.
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**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**