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

FILED
May 10, 2024, 1:08 pm
OFFICE OF FAIR HEARINGS

[redacted],

PETITIONER, **AHCA Case No.: 24-FH0127**

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 March 5, 2024, at 1:00 p.m. EST.

APPEARANCES

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

For the Respondent: Diana Hearod
Medical Health Care Program 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 for an increase in applied behavior analysis ("BA") services was incorrect.

PRELIMINARY STATEMENT

All parties and witnesses appeared telephonically. Petitioner's Authorized Representative [redacted], ("[redacted]"), Board Certified Behavior Analyst ("BCBA") for the Petitioner appeared on behalf of the Petitioner. [redacted], ("[redacted]") Petitioner's [redacted] appeared as a witness for Petitioner. [redacted] and [redacted] with [redacted] appeared as observers and did not testify.

Diana Hearod, 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. Kathy Hurley, ("Dr. Hurley") Board Certified Behavior Analyst at the doctoral level ("BCBA-D"), Florida Licensed Mental Health Counselor and Scond Level Reviewer for eQHealth Solutions, Inc. ("eQHealth"), attended as a witness for Respondent.

Aurora #221459 and Misael #411483 appeared and provided Spanish translator services.

Prior to the hearing, Petitioner sent to the Office of Fair Hearings and Respondent a two hundred and thirty-eight (238)-page evidence packet. The packet appears in the Office of Fair Hearings' case management system as "24-FH0127 Email correspondence.pdf." Absent an objection from the Respondent, the undersigned admitted the evidence packet into evidence as Petitioner's Composite Exhibit 1.

Prior to the hearing, Respondent sent to the Office of Fair Hearings and Petitioner a two hundred and thirty-nine (239)-page evidence packet. The packet appears in the Office of Fair Hearings' case management system as "[redacted] FH 03.05.2024 1-79.pdf," "[redacted] FH 03.05.2024 80-113.pdf," "[redacted] FH 03.05.2024 114-147.pdf," "[redacted] FH 03.05.2024 148-182.pdf," "[redacted] FH 03.05.2024 183-216.pdf," and "[redacted] FH 03.05.2024 217-239.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-FH0127 BAnalysis AHCA EVIDENCE 49 PG (recipients name).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 was [redacted] at the date of the hearing. *See* Respondent's Composite Exhibit 1 at page 22. The Petitioner has been diagnosed with [redacted]. The provider has received previous authorizations for services and a previous partial denial. The provider is currently requesting 40 hours per week. *Id.* at 23.

3. Petitioner requested the following BA services: 3,640 units of code 97153, 416 units of code 97155, and 208 units of code 97156 for the certification period of September 30, 2023, through March 27, 2024. *Id*. at 29.

4. On November 22, 2023, Respondent issued a Notice of Outcome ("NOO"), partially denying Petitioner's BA services. *Id.* at 29-30. The NOO explained the basis for the partial denial 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 Behavior Analysis Services Coverage Policy, (page 3, 2.2) the recipient of ABA therapy services must engage in maladaptive behavior that interferes with the recipient's daily functioning. Although the recipient is engaging in topographies of maladaptive behaviors, the frequency and intensity of the maladaptive do not support the request for services. This request for behavior analysis services is in excess of medical necessity. Behavior analysis services are approved, but at a lower level than what the provider requested.

Id. at 29-30.

5. Petitioner requested reconsideration of the Respondent's decision. On November 22, 2023, Respondent issued a Notice of Reconsideration Determination ("NRD") upholding its decision, however, an additional 520 units was authorized for code 97153. *Id.* at 41-42. The NRD states, in pertinent part as follows:

> Specifically, the services must be:
>
> Individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness under treatment, and not in excess of the patient's needs.
>
> . . .
>
> PR Recon Determination: At reconsideration all documents were carefully reviewed. Based upon the information submitted for review at reconsideration, additional units of services are approved. However, although the recipient is engaging in topographies of maladaptive behaviors, the frequency and intensity of the maladaptive do not support the request for services. The current requested is in excess of medically necessary for BA services.

Id. at 41-42.

6. The Petitioner requested a Fair Hearing on January 11, 2024. The undersigned scheduled a telephonic hearing for March 5, 2024, at 1:00 p.m. and provided written notice of the hearing on February 8, 2024.

7. Dr. Hurley 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. Hurley asserted that Petitioner's services were denied because the treatment plan is not consistent with services being individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness under treatment, and not in excess of the patient's needs and therefore does not meet the conditions of being medically necessary. Dr. Hurley testified that the requested services were in excess of the recipient's needs.

8. Dr. Hurley reviewed the historical background of this provider and this recipient. The provider has been providing services to the recipient since [redacted]. [redacted] has been the recipient's BCBA since [redacted]. Dr. Hurley explained the review process that is followed by eQhealth. In this review, Dr. Hurley testified that the 1st level reviewer found that the recipient had been diagnosed with [redacted] and that other appropriate services may include Therapeutic Behavioral On-site Services (TBOS) or Parent Child Interactive Therapy (PCIT) for enhanced parent training. *Id.* at 23. The request was sent to a second level review. The second level reviewer is a Board-Certified Behavioral Analyst at the doctoral level (BCBA-D). Dr. Hurley testified that the second reviewer wrote that the data indicated that the recipient was engaging in topographies of maladaptive behaviors, however the frequency and

intensity of the maladaptive behaviors do not support the requested services. The requested services are in excess of medical necessity. *Id.* at 25. A request was made for reconsideration and a third reviewer reconsidered the previous partial denial. The third reviewer is a Board-Certified Behavior Analyst at the doctoral level (BCBA-D). The third reviewer agreed that the overall requested services were in excess of the recipients needs but did authorize additional code 97153 services. The prior partial denial was upheld with the exception of the additional 520 units of code 97153 being authorized. *Id.* at 25.

9. Dr. Hurley 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. Hurley testified that this provider submitted data graphs for maladaptive behaviors and skill acquisition (the Treatment Plan) that demonstrated that progress was being made by the recipient.

10. Dr. Hurley reviewed the data graphs submitted by the provider. The first graph is for [redacted] This graph starts with a base line of occurrences with as many as [redacted]. Beginning with [redacted], the graph shows a data point drop below [redacted] per day. Dr. Hurley testified that this graph shows the child making very good progress. *Id.* at 80. The next graph reviewed was for [redacted]. This graph indicates a base line with most occurrences above [redacted] per day and as high as [redacted] per day. In [redacted], the occurrences drop to below [redacted] per day and more often are documented at [redacted] times per day. *Id.* at 82. Dr. Hurley reviewed the graph for [redacted]. The Petitioner had mastered [redacted] goals and was making further progress after beginning speech therapy in [redacted]. *Id.* at 83. Dr. Hurley also testified that the Petitioner was making

progress in [redacted] and [redacted] according to the data graphs. *Id.* at 85. The next graph reviewed was for [redacted]. Dr. Hurley testified that the Petitioner had mastered [redacted] goals during the authorization period. This is evidence of good progress being made. *Id.* at 91. Dr. Hurley reviewed the graph for adaptive functioning goals and noted that the Petitioner had met [redacted] goals. Again, this result demonstrates that good progress is being made with this Petitioner. *Id.* at 96.

11. Dr. Hurley testified that the Petitioner had made good progress under the current authorized units. For a provider to require/request an increase in service units, there must be new data presented to justify additional units being authorized. The evidence presented and reviewed in this matter does not warrant an increase in service units.

12. [redacted] testified on behalf of the Petitioner. [redacted] started as the Petitioner's BCBA in [redacted]. [redacted] testified extensively from various articles and organizations such as an original article from Translational Psychiatry (2017) and a guideline publication from The Council of Autism Service Providers. *See* Petitioner's Composite Exhibit 1, Pages 1-56. In referring to the articles and publications, [redacted] argued that younger children with [redacted] should have forty (40) hours of ABA services. The essence of the articles, publications and [redacted] testimony is that more services at a young age will produce a better result. [redacted]'s testimony also reviewed Medicaid provisions for the Early and Periodic Screening, Diagnostic and Treatment services. (EPSDT). *Id.* at 92- 132. The substance of [redacted]'s testimony was to provide support for an increase in the service units available to the Petitioner. [redacted] did not address Dr. Hurley's testimony concerning the progress being made by the recipient. As shown by Dr. Hurley's testimony from the data graphs, the recipient began making

progress in reducing the maladaptive behaviors and much of the improvement began in [redacted] when [redacted] assumed control of the case as the lead BCBA. [redacted] testified that there are behaviors that the Petitioner needs additional services for such as [redacted]. [redacted] testified that the Petitioner has attempted [redacted] as often as [redacted] a day. The behavior of [redacted] presents a safety concern for the Petitioner. In the evidence presented, the behavior of [redacted] is addressed on page 176 through 178 of REC 1. The treatment plan identified an area of "Resurgence of Challenging Behaviors." *Id.* at 176. The only resurgent behavior listed was [redacted]. *Id.* at 177. The data graph shows significant days with no [redacted] events. *Id.* Also, [redacted] writes that the recipient had "previously mastered behavior reduction goal of [redacted]." *Id.* The resurgence of this behavior appears to be related to a change in the consistent team of RBTs in [redacted] and during an afternoon incident with a "novel RBT" and the recipient [redacted]. *Id.* [redacted] testified that the Petitioner attends [redacted] Monday through Friday for 35 hours per week and the new authorization request was to increase the service hours to 40 hours per week.

13. [redacted] testified that the recipient was diagnosed with [redacted]. [redacted] has seen the benefits of ABA treatment. [redacted] has learned to adapt to different circumstances. [redacted] has been dealing better with [redacted] emotions. [redacted] [redacted] does not believe that [redacted] is ready for a regular school environment. [redacted] believes that [redacted] will continue to improve with more time. [redacted] believes the Petitioner needs to continue to receive professional help.

CONCLUSIONS OF LAW

14. 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).

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

16. Because Petitioner is requesting an increase in services, 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.).

17. 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).

18. 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.

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

20. 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.

21. 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

22. 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.

23. 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.

24. In this case, Petitioner sought to increase the number of ABA service units. The NOO and NRD explained that Petitioner's request for services did not meet medical necessity as the treatment plan was 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.

25. As provided in the BA policy and the EPSDT requirements, the recipient must meet the meet the medical necessity criteria as outlined in Fla. Admin. Code R. 59G-1.010. A component of medical necessity is that services must be "individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness under treatment, and not in excess of the patient's needs." As outlined above, Dr. Hurley provided testimony identifying several instances where the revised Treatment Plan request for services was in excess of the patient's needs. For example, the documentation provided for review showed that the Petitioner was reducing maladaptive behaviors and increasing skill replacement behaviors. *See* supra ¶ 9, & 10. Thus, Respondent demonstrated that, based on the information in the record, the total amount of requested BA services was in excess of the patient's needs and a lower number of service units was approved. Because the services are in excess of the patient's needs, a critical element of

medical necessity is not met as to the service units in excess of the patient's needs. *See* supra ¶ 7.

26. In this case, Petitioner's provider recommended the 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 ¶ 21.

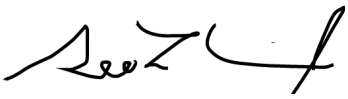
27. Accordingly, Petitioner has failed to establish by a preponderance of the evidence that the requested increase in BA services are medically necessary. The evidence presented indicates that the recipient is making progress in reducing maladaptive behaviors while increasing skill behavior replacement. An increase in ABA service hours/units would be in excess of the recipients' needs and therefore 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.

28. Upon consideration of the testimony provided, Petitioner's Composite Exhibit 1, Respondent's Composite Exhibit 1, Respondent's Composite Exhibit 2, and the applicable law and policies, the undersigned finds that Petitioner did not prove by a preponderance of the evidence that Respondent's partial denial of BA services was incorrect.

DECISION

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

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



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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