



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

FILED

May 28, 2024, 4:19 pm

OFFICE OF FAIR HEARINGS

[REDACTED]

PETITIONER,

AHCA Case No.: 24-FH0279

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 10:00 a.m. EST.

APPEARANCES

For the Petitioner:

[REDACTED]

Petitioner's Authorized Representative

For the Respondent:

Chrissie Simmons
Medical Health Care Program Analyst
Agency for Health Care Administration

STATEMENT OF ISSUE

The issue is whether Respondent proved by a preponderance of the evidence that Respondent's decision to reduce Petitioner's behavior analysis ("BA") services from thirty-seven (37) to twenty-eight (28) hours per week 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]"), Board Certified Behavior Analyst ("BCBA") with [REDACTED], appeared as a witness for Petitioner. [REDACTED], BCBA with [REDACTED], appeared as a witness for Petitioner.

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

Prior to the hearing, Petitioner sent to the Office of Fair Hearings a ten (10)-page evidence packet. The packet appears in the Office of Fair Hearings' case management system as "24-FH0279 Evidence.pdf." Absent an objection from Respondent, the undersigned admitted the evidence packet into evidence as Petitioner's Composite Exhibit 1.

Prior to the hearing, Petitioner sent to the Office of Fair Hearings a two (2)-page evidence packet. The packet appears in the Office of Fair Hearings' case management system as "24-FH0279 Evidence(2).pdf." Absent an objection from Respondent, the undersigned admitted the evidence packet into evidence as Petitioner's Composite Exhibit 2.

Prior to the hearing, Respondent sent to the Office of Fair Hearings and Petitioner a two hundred and thirty-three (233)-page evidence packet. The packet appears in the Office of Fair Hearings' case management system as "[REDACTED] FH 03.05.2024 1-149.pdf," "[REDACTED] FH 03.05.2024 150-196.pdf," and "[REDACTED] FH 03.05.2024 197-233.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-FH0279_Behavior Analysis_AHCA EVIDENCE.pdf." Absent an objection from the Petitioner, the undersigned admitted the evidence packet into evidence as Respondent's Composite Exhibit 2.

FINDINGS OF FACT

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

2. Petitioner is [REDACTED] and diagnosed with [REDACTED]. See Respondent's Composite Exhibit 1 at page 16. The Behavior Assessment, dated December 6, 2023, ("Treatment Plan"), states that Petitioner engages in the following maladaptive behaviors: [REDACTED], [REDACTED], [REDACTED], [REDACTED], [REDACTED], and [REDACTED]. *Id.* at 221-222.

3. Petitioner requested the continuation of approximately forty-seven (47) hours per week of BA services as follows: 104 units of code 97156; 624 units of code 97155; and 3,848 units of code 97153 for the certification period of December 6, 2023, through June 2, 2024. *Id.* at 19-20, 22.

4. On December 7, 2023, Respondent issued a Notice of Outcome ("NOO"), reducing Petitioner's BA services from approximately forty-seven (47) hours per week to approximately

thirty-four (34) hours per week of BA services. *Id.* at 22-23. The services were reduced because the Treatment Plan did not meet the following medical necessity criteria as defined in Rule 59G-1.010, Florida Administrative Code (“F.A.C.”): [i]ndividualized, specific, and consistent with symptoms or confirmed diagnosis of the illness under treatment, and not in excess of the patient’s needs. The analysis in the PR Clinical Rationale - Denial contained in the NOO is hereby incorporated by reference. *Id.* at 23.

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 33-34. The NRD reiterates that the Treatment Plan does not meet the above-stated medical necessity criteria of Rule 59G-1.010, F.A.C. The analysis in the PR Recon Determination contained in the NRD is hereby incorporated by reference. *Id.* at 34. The analysis states, among other things, that the Treatment Plan also does not meet generally accepted standards of care within the field of applied behavior analysis. *Id.*

6. Dr. Darling, a BCBA at the doctoral level, established that eQHealth reviews behavior analysis cases to ensure that providers are giving quality care consistent with the standards enumerated in the BA Policy as well as professional medical standards of applied behavior analysis (“ABA”). Three qualified BCBA’s with eQHealth independently reviewed the Treatment Plan submitted in this case to determine whether all five (5) conditions of medical necessity are met. Dr. Darling asserted that Petitioner’s one-on-one therapy services (code 97153) were reduced from thirty-seven (37) to twenty-eight (28) hours per week because the Treatment Plan could be effectively implemented with the reduced level of services. The reviewers determined that the Treatment Plan is not “individualized, specific, and consistent with symptoms or

confirmed diagnosis of the illness under treatment, and not in excess of the patient's needs." Dr. Darling agreed with the previous eQHealth reviewers that the Petitioner is in need of behavior analysis services; however, the Treatment Plan at issue is in excess of Petitioner's need, does not meet standards of care in the field of BA, and the data presented and components in the Treatment Plan does not support the level of therapy requested; therefore, the services were appropriately reduced.

7. Dr. Darling provided credible and persuasive testimony establishing that the frequency and intensity of Petitioner's maladaptive behaviors, as reported in the Treatment Plan and updated data, do not support the level of services requested. Dr. Darling established that the Treatment Plan data graphs show the following: the data for [REDACTED] is variable rather than a downward trend; the data for [REDACTED] shows an increase in the behavior with no modifications to address the lack of progress; the data for [REDACTED] shows the frequency of the behavior but no information is given concerning the duration of the behavior so it is unclear how long it takes to treat the behavior; and the data for [REDACTED] shows an increase in the behavior with no modifications to address the lack of progress. *Id.* at 222 - 223. Petitioner's Composite Exhibit 1 at page 3-5 provided updated data graphs. The updated graphs show downward trends in Petitioner's maladaptive behaviors of [REDACTED], [REDACTED], [REDACTED], [REDACTED], and [REDACTED] for the dates of September 11, 2023, through January 23, 2024. The updated graphs also show an increased in maladaptive behaviors beginning on January 23, 2024. The data graphs attribute the increase to a reduction in BA services. Dr. Darling asserted that the updated graphs lack credibility due to

their uniformity across all topographies and because Petitioner's BA services were reduced in early December, 2023, rather than January 23, 2024.

8. Dr. Darling testified that the Treatment Plan shows that the following replacement behaviors were mastered in the last authorization period including: [REDACTED], [REDACTED], [REDACTED], [REDACTED], and [REDACTED]. *Id.* at 215 - 219. Dr. Darling established that the Treatment Plan lacks information on how much time it took to teach the replacement skills and procedures for how the skills are being taught. Therefore, the Treatment Plan lacks sufficient detail to determine how much time is needed to effectively implement the plan.

9. Finally, Dr. Darling testified that there are interventions and goals in the Treatment Plan that involve procedures that are not empirically supported procedures within the conceptual system of behavior analysis. These interventions and goals include: [REDACTED], [REDACTED], [REDACTED], and [REDACTED]. *Id.* at 215 - 217. Dr. Darling testified that these are not covered under the BA Policy as they are skills that do not require BA to teach and can be learned in a less costly and equally effective manner by someone not specifically trained in BA. Further, [REDACTED] are not consistent with the symptoms of any diagnosis for which ABA is medically necessary. Dr. Darling established that Petitioner will not gain any additional benefit with the increased level of BA services requested.

10. At the Fair Hearing, [REDACTED], a BCBA, asserted that all of the Treatment Plan interventions are accepted interventions in the field of BA, are research-based, and are used by

behavior analysts to work on core deficits related to Petitioner's diagnoses. [REDACTED] asserted that [REDACTED] in the Treatment Plan are necessary and needed for Petitioner's safety.

CONCLUSIONS OF LAW

11. 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).

12. This hearing was held as a *de novo* proceeding pursuant to Rule 59G-1.100(17)(b), F.A.C.

13. Because Respondent reduced a previously approved service, Rule 59-1.100(17)(g), F.A.C., 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.).

14. 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).

15. 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.

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

17. 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.

18. The Florida Medicaid Definitions Policy, incorporated by reference in Rule 59G-1.010, F.A.C., 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.

19. The Florida Medicaid Behavior Analysis Services Coverage Policy (September 2023) (“BA Policy”), incorporated by reference in Rule 59G-4.125, F.A.C., 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
 - 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.)

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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.

Respondent's Composite Exhibit 2 at pages 41-48.

22. The Florida Medicaid Authorization Requirements Policy (June 2016) ("Authorization Requirements Policy"), incorporated by reference in Rule 59G-1.053, F.A.C., provides general

requirements for providers to obtain authorization to render Florida Medicaid services. It states the following:

1.2 Definitions

The following definitions are applicable to this policy. For additional definitions that are applicable to all sections of Rule Division 59G, F.A.C., please refer to the Florida Medicaid definitions policy.

...

1.3.1 Authorization

The process of obtaining approval for reimbursement of a service based on medical necessity.

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1.3.6 Provider

The term used to describe any entity, facility, person, or group that has been approved for enrollment or registered with Florida Medicaid.

1.3.7 Quality Improvement Organization

Entity designated to perform utilization review, quality assurance, and quality improvement activities for Florida Medicaid-covered services rendered by fee-for-service providers (also known as the QIO).

...

2.0 Authorization Requirements

2.4.2 Requests for Additional Information

The QIO may request additional information, as necessary, to determine medical necessity.

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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 32-35.

20. In this case, Respondent reduced Petitioner's BA services. The NOO and NRD explained that Petitioner's request for continuation of services did not meet medical necessity criteria as the Treatment Plan was not "individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs." See supra ¶ 4-5.

21. As provided in the BA policy and the EPSDT requirements, the services must meet the medical necessity criteria outlined in Rule 59G-1.010, F.A.C. Two criteria of medical necessity is that services must 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"; and "consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational." See supra ¶ 18.

22. As outlined above, Dr. Darling provided credible and persuasive testimony identifying several instances where the revised Treatment Plan was not individualized and specific to Petitioner and in excess of need. For example, the data graphs show that there has been no improvement or minimal improvement on maladaptive behaviors over the last authorization period and updated data graphs lack credibility. See supra ¶ 7. Further, the Treatment Plan data graphs for replacement behaviors either show progress because several behaviors were mastered during the last authorization period or should be omitted from the Treatment Plan because they are not recognized interventions in the field of BA and can be implemented in a

less costly manner. *See supra* ¶ 8 - 9. As Dr. Darling testified, Petitioner will not gain any additional benefit from the additional BA services at issue.

23. Accordingly, the undersigned concludes that Treatment Plan does not meet standards of care in the field of BA and is not effective because it has not been individualized and specific to Petitioner's needs. Therefore, the critical element of medical necessity is not met and the recipient will not gain any additional benefit by continuing services at the current level.

24. In this case, Petitioner's provider recommended the continuation of the previously approved level 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* ¶ 20.

25. Accordingly, Respondent met their burden of proof to show that the requested level of BA services under the Treatment Plan at issue is 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.

26. Upon consideration of the testimony provided, Petitioner's Composite Exhibit 1, Petitioner's Composite Exhibit 2, 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 reduction of Petitioner's BA services was correct.


DECISION

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

DONE and **ORDERED** this 28th day of May 2024, in Tallahassee, Leon County, Florida.

Laura Gallagher

24-FH0279

 2024.05.28

07:44:15 -04'00'

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

NOTICE OF A RIGHT TO JUDICIAL REVIEW

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

Copies Furnished To:




AHCA Medicaid Hearing Unit
MedicaidHearingUnit@ahca.myflorida.com