



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

FILED

Jun 04, 2024, 9:42 am

OFFICE OF FAIR HEARINGS

[Redacted]

PETITIONER,

AHCA Case No.: 24-FH0418

vs.

AGENCY FOR HEALTH CARE
ADMINISTRATION,

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic Fair Hearing on the instant case on March 14, 2024, at 1:02 p.m. Eastern Standard Time ("EST").

APPEARANCES

For the Petitioner:

[Redacted]
Petitioner's Authorized Representative

For the Respondent:

Linda Latson
Registered Nurse Specialist
Agency for Health Care Administration

STATEMENT OF ISSUE

The first issue is whether Petitioner proved by a preponderance of the evidence that Respondent's decision to deny Petitioner's request for additional Behavior Analysis ("BA" or "ABA") services was incorrect.

The second issue is whether Respondent proved by a preponderance of the evidence that Respondent's decision to terminate Petitioner's ABA services was correct.

PRELIMINARY STATEMENT

All parties and witnesses appeared telephonically. [REDACTED] (“[REDACTED]”), Petitioner’s Authorized Representative and Board Certified Behavior Analyst (“BCBA”) at [REDACTED], appeared for Fair Hearing to provide testimony on behalf of Petitioner. [REDACTED] (“[REDACTED]”), Petitioner’s [REDACTED], appeared for Fair Hearing to provide testimony on behalf of Petitioner.

Linda Latson, Registered Nurse Specialist and Fair Hearing Liaison for the Agency for Health Care Administration (“Agency” or “AHCA”), appeared for Fair Hearing as representative for Respondent. Dr. Alyssa Conway (“Dr. Conway”), BCBA and Second Level Reviewer for eQHealth Solutions Inc. (“eQHealth”) appeared for Fair Hearing as a witness for Respondent.

Prior to the hearing, Petitioner sent to the Office of Fair Hearings a fifty-one (51)-page evidence packet. The fifty-one (51)-page evidence packet appears in the Office of Fair Hearings’ document management system as the file title “24-FH0418 Supporting Documents.pdf.” Absent an objection from the Respondent, the undersigned admitted the fifty-one (51)-page evidence packet into evidence as Petitioner’s Composite Exhibit 1 (“PCE 1”).

Prior to the hearing, Respondent sent to the Office of Fair Hearings and Petitioner a one hundred and fifty-two (152)-page evidence packet and a forty-nine (49)-page evidence packet. The one hundred and fifty-two (152)-page evidence packet appears in the Office of Fair Hearings’ document management system as the file titles “[REDACTED] FH 03.14.2024 1-96.pdf” and “[REDACTED] FH 03.14.2024 97-152.pdf.” The forty-nine (49)-page evidence packet appears in the Office of Fair Hearings document management system as the file title “24-FH0418 AHCA Evidence

BA Svcs 49 Pages.pdf.” Absent an objection from the Petitioner, the undersigned admitted the one hundred and fifty-two (152)-page evidence packet into evidence as Respondent’s Composite Exhibit 1 (“RCE 1”) and the forty-nine (49)-page evidence packet into evidence as Respondent’s Composite Exhibit 2 (“RCE 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 page 2 of RCE 2.

2. Petitioner is [REDACTED]. See page 16 of RCE 1. Petitioner is diagnosed with [REDACTED]. *Id.*

3. As provided in the Behavior Intervention Plan (“Treatment Plan”) submitted by [REDACTED], [REDACTED], Petitioner is engaging in the following maladaptive behaviors: [REDACTED], [REDACTED], [REDACTED], and [REDACTED]. *Id.* at 108-112. As provided in the Treatment Plan, Petitioner’s incidents of maladaptive behaviors, for the period of July 2023 to [REDACTED], are as follows: for [REDACTED], Petitioner’s incidents increased from about [REDACTED] [REDACTED] per week; for [REDACTED], Petitioner’s incidents decreased from about [REDACTED] [REDACTED] per week; for [REDACTED], Petitioner’s incidents decreased from about [REDACTED] [REDACTED] per week; and, for [REDACTED], Petitioner’s incidents decreased from about [REDACTED] [REDACTED] per week. *Id.* at 111-112.

4. Petitioner successfully engages in replacement behaviors, for the period of July 2023 to January 2024, at the following rates: for [REDACTED], Petitioner increased from about [REDACTED] for [REDACTED], Petitioner increased from about [REDACTED] for [REDACTED]

[REDACTED], Petitioner increased from about [REDACTED] for [REDACTED], Petitioner increased from about [REDACTED] for [REDACTED], Petitioner increased from about [REDACTED] for [REDACTED], Petitioner increased from about [REDACTED] for [REDACTED], Petitioner increased from about [REDACTED] for [REDACTED], Petitioner increased from about [REDACTED] for [REDACTED]; and, for [REDACTED], Petitioner increased from about [REDACTED]. *Id.* at 130-139. In the final Treatment Plan, for the period of January 15, 2024, to January 26, 2024, the provider included additional replacement behaviors: [REDACTED]

[REDACTED], [REDACTED], and [REDACTED]. *Id.* at 129, 140-142.

5. Petitioner requested additional ABA services and recertification of ABA services for the certification period of February 11, 2024, to August 7, 2024; specifically, 2,496 units of code 97153; 208 units of code 97155; and 208 units of code 97156. This is an increase from the previous authorization period of approximately two (2) hours per week of services. *Id.* at 18, 104. In a Notice of Outcome (“NOO”), dated January 26, 2024, Respondent terminated Petitioner’s ABA services and denied the requested additional ABA services. 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 or confirmed diagnosis of the illness or injury 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.

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

PR Clinical Rationale - Denial: According to the Florida Medicaid State Plan (page 8, 6.2.3), the data provided must show evidence that the frequency of the maladaptive behavior(s) has decreased since the last review and, if not, that there is a modification of the behavior plan. The recommendations for procedural modifications include: additions/changes to treatment plan to impact behaviors targeted for reduction. Procedural modifications should include one or more of the following: antecedent manipulation modifications, modifications of prompting procedures used in acquisition, modifications in consequence-based strategies-- ones that either reduce maladaptive behavior or reinforce replacement behavior (e.g., manipulation of reinforcement schedules, switch to a different decelerative procedure), or if lack of progress was due to therapist error (e.g., poor data collection or poor training on intervention methods), how you will address human error. The provider has not addressed the lack of progress during the last observation period and did not amend the treatment plan in relation to the lack of progress or the proposed changes have little chance at improving behavior. The information submitted does not meet standards of care within the field of behavior analysis. This request is denied.

Id. at 23-24.

6. Petitioner requested reconsideration of the Respondent's decision. In a Notice of Reconsideration Determination ("NRD"), dated February 7, 2024, Respondent upheld its decision. *Id.* at 35-36. The NRD explained the basis for the decision as follows:

PR Recon Determination: At reconsideration all documents were carefully reviewed. According to the Florida Medicaid State Plan (page 8, 6.2.3), the data provided must show evidence that the frequency of the maladaptive behavior(s) has decreased since the last review and, if not, that there is a modification of the behavior plan. The recommendations for procedural modifications include: additions/changes to treatment plan to impact behaviors targeted for reduction. Procedural modifications should include one or more of the following: antecedent manipulation modifications, modifications of prompting procedures used in acquisition, modifications in consequence-based strategies-- ones that either reduce maladaptive behavior or reinforce replacement behavior (e.g., manipulation of reinforcement schedules, switch to a different decelerative procedure), or if lack of progress was due to therapist error (e.g., poor data collection or poor training on intervention methods), how you will address human error. The provider has not addressed the lack of progress during the last observation period and did not amend the treatment plan in relation to the lack

of progress or the proposed changes have little chance at improving behavior. The information submitted does not meet standards of care within the field of behavior analysis. This denial is upheld.

Id. at 38.

7. On February 6, 2024, Petitioner requested a Fair Hearing to challenge the termination and denial of ABA services. *Id.* at 8-12. On February 21, 2024, the undersigned issued an Order Scheduling Fair Hearing and Prehearing Instructions, scheduling the hearing for March 14, 2024, at 1:00 p.m. EST. *Id.*

8. Dr. Conway is a BCBA and Second Level Reviewer for eQHealth. Dr. Conway testified to the following at the Fair Hearing:

- a. Baseline data in the Treatment Plan was taken from [REDACTED].
- b. Dr. Conway contended that the initial Treatment Plan showed no sufficient progress with the high frequency of Petitioner's behaviors and lacked modifications to address this lack of progress.
- c. The behavior graphs show a similar pattern of high variability and increasing trends prior to the change of the BCBA in [REDACTED].
- d. Dr. Conway argued that modifications were not made until [REDACTED] although these should have been implemented immediately. *Id.* at 55. For example, Dr. Conway explained that [REDACTED] is a severe behavior which was previously mastered but there were no modifications when Petitioner's incidents reverted until towards the end of the authorization period. *Id.*
- e. Dr. Conway opined that the [REDACTED] and [REDACTED] are low severity behaviors, however, each showed slow continued increases even after the change of BCBA, which may point to a lack of structural control by the provider.

- f. Petitioner's provider submitted additional data at reconsideration which shows a significant difference from the initial Treatment Plan. *Id.* at 111.
 - g. Dr. Conway contended that the revised Treatment Plan has unclear modifications and the significant decrease in frequencies of the behaviors is unclear.
 - h. Moreover, Dr. Conway contended that although the replacement skill graphs show increases in performance, performance is around or below 50% with no variability throughout the last authorization period even with prompts. *See* ¶ 4.
 - i. Dr. Conway argued that [REDACTED] is a basic skill, but performance is shown between [REDACTED] [REDACTED] by the end of authorization. *Id.* at 77-78.
 - j. Dr. Conway opined that research in the field of ABA indicates verbal prompts are the hardest to fade and recipients would become reliant on prompts over time.
 - k. Dr. Conway contended that the provider was authorized for protocol modifications under code 97155 throughout the authorization period, but the provider made changes only after the initial denial. *Id.* at 90, 97-99.
9. [REDACTED] is a BCBA at [REDACTED]. [REDACTED] testified to the following at the Fair Hearing:
- a. [REDACTED] argued that compared to the levels in [REDACTED], Petitioner has been making progress and modifications were implemented to address the lack of progress in the last four (4) weeks as seen in the revised Treatment Plan. *See* PCE 1 at 8-12, 30-41.

- b. [REDACTED] asserted that due to the modifications implemented, the frequency of [REDACTED] reduced to [REDACTED] per week, [REDACTED] reduced to [REDACTED] per week, [REDACTED] reduced to [REDACTED] per week, and [REDACTED] reduced to [REDACTED] per week. *Id.* at 8-12.
- c. [REDACTED] contended that most graphs show decreasing trends, and those without decreasing trends show stable trends.

10. [REDACTED] is Petitioner's [REDACTED]. [REDACTED] testified to the following at the Fair Hearing:

- a. [REDACTED] believes that due to [REDACTED] ABA therapy, Petitioner has shown progress in [REDACTED] behaviors especially while being homeschooled.
- b. [REDACTED] asserted that due to Petitioner's [REDACTED]
[REDACTED]
[REDACTED]
- c. [REDACTED] argued that Petitioner likes to interact with [REDACTED] therapist and should continue receiving ABA services.

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 (2022). 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), Florida Administrative Code ("Fla. Admin. Code R.").

13. Because Petitioner requested additional ABA services, Fla. Admin. Code R. 59G-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.)

14. Because Respondent terminated a previously approved service, Fla. Admin. Code R. 59G-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.)

15. The Florida Medicaid Behavior Analysis Services Coverage Policy (September 2023) (“BA Policy”), incorporated by reference in Fla. Admin. Code. R. 59G-4.125, governs ABA 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.

...

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 assessment 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 functional level for that individual. The recipient's parent or guardian should participate in treatment when possible and clinically appropriate. The provider must make every effort to accommodate parental participation and must document those efforts in treatment plan updates. If parent or guardian participation is not possible, the treatment plan and session notes must document the reasons for nonparticipation. Documentation should also explain potential impacts of nonparticipation and how potential impacts are being mitigated.

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.)

4.2.3 Supervision

Florida Medicaid requires supervision of BCaBAs and RBTs in accordance with certification board requirements and specified in the supervision plan of the approved behavior plan.

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 of 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 section 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.

...

5.2 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, mechanical, 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

...

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 authorization period, the provider must explain why clinically significant progress was not made and treatment changes to promote progress.

See RCE 2 at 41, 43-47.

16. 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). 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.

17. Petitioner is under age 21, and therefore EPSDT applies to request for services.

However, a state may place medical necessity limitations on EPSDT services. See 42 C.F.R. §§

440.230(a), (b), (d). Fla. Stat. § 409.905(2) 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 (August 2017) (“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.

See RCE 2 at 23.

19. The Florida Medicaid Authorization Requirements Policy (June 2016) (“Authorization Policy”), incorporated by reference in Fla. Admin. Code R. 59G-1.053, provides general

requirements for providers to obtain authorization to render Florida Medicaid services. See RCE 2 at 30-36. The Authorization Policy states as follows:

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 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.

Id. at 34.

20. In the instant case, Petitioner is under 21 years of age and is diagnosed with [REDACTED]. See

¶ 2. Petitioner requested an increase of ABA services and recertification of ABA services. See ¶ 5.

In a NOO, dated January 26, 2024, Respondent denied the additional services and terminated Petitioner's ABA services. See ¶ 5. Respondent cited the lack of medical necessity as the basis for their decision, specifically that the requested ABA services must be "consistent with generally accepted professional medical standards as determined by the Medicaid program, and not

experimental or investigational.” See ¶ 5, 18. In addition, Respondent determined that the requested services were 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 ¶ 5-6. As provided by the EPSDT requirements, the recipient must meet the medical necessity criteria as outlined in Fla. Admin. Code R. 59G-1.010. See ¶ 16-17. The Definitions Policy defines a component of medical necessity as “consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational.” See ¶ 18. Petitioner has burden of proof to show by a preponderance of evidence that the Respondent’s denial of additional services was incorrect. See ¶ 13. Respondent has burden of proof to show by a preponderance of evidence that the Respondent’s termination of services was correct. See ¶ 14.

21. The BA Policy maintains that the “[behavior] 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.” See ¶ 15.

22. At Fair Hearing, Dr. Conway described Petitioner’s Treatment Plan as lacking intervention to address Petitioner’s lack of progress with maladaptive behaviors since the previous authorization period. See ¶ 8. The Treatment Plan demonstrated Petitioner’s maladaptive behaviors overall show a similar pattern of high variability and increasing trends prior to the change of the BCBA in [REDACTED]. See ¶ 3, 8. Dr. Conway opined that although the [REDACTED] and [REDACTED] are low severity behaviors, each showed slow continued increases even after the change of BCBA, which may point to a lack of structural control by the provider. See ¶

8. Moreover, Dr. Conway explained that [REDACTED] is a severe behavior which was previously mastered but there were no modifications when Petitioner's incidents reverted until towards the end of the authorization period. See ¶ 8. As pointed out by Dr. Conway, modifications to address the lack of progress were not made until [REDACTED]. See ¶ 5-6, 8. [REDACTED] argued that modifications were implemented to address the lack of progress in the last four (4) weeks as seen in the revised Treatment Plan. See ¶ 9. [REDACTED] argued that compared to the levels in [REDACTED], Petitioner has been making progress and continues to show decreasing trends with maladaptive behaviors. See ¶ 9.

23. [REDACTED] also asserted that due to Petitioner's [REDACTED]
[REDACTED]
[REDACTED] See ¶ 10. [REDACTED] argued that Petitioner likes to interact with [REDACTED] therapist who has helped [REDACTED] progress with [REDACTED] behaviors and believes ABA services should continue. See ¶ 10. Generally accepted professional medical standards require modification of the treatment plan where there are no significant clinical changes in behaviors. See ¶ 8, 15. The record shows that additional data was provided at reconsideration which shows a significant difference from the initial Treatment Plan. See ¶ 6, 8, 9. Where modifications were included at the end of the prior authorization period, Dr. Conway explained that the behaviors still occurred at high levels. See ¶ 8. Dr. Conway contended that the revised Treatment Plan had unclear modifications and the significant decrease in frequencies of the behaviors is unclear. See ¶ 8. Moreover, Dr. Conway contended that although the replacement skill graphs show increases in performance, performance is around or below 50% with no variability throughout the last authorization period even with prompts. See ¶ 8. Dr. Conway argued that [REDACTED] is a basic skill,

but performance was shown between [REDACTED] by the end of authorization. See ¶ 8. Based on these discrepancies, the undersigned finds that the Treatment Plan does not appear to justify the requested increase in ABA services. See ¶ 5, 8, 15. All in all, the undersigned finds that the request for the additional hours of ABA services are in excess of Petitioner's needs. See ¶ 5, 8, 15, 18.

24. Upon consideration of the testimony provided, evidence submitted, and applicable policies, the undersigned concludes that Petitioner did not prove by a preponderance of the evidence that the denial of additional ABA services was incorrect. Looking at all the evidence relevant to the particular needs of Petitioner, Petitioner has not demonstrated that the requested services, based on the Treatment Plan at issue in this case, are necessary to correct or ameliorate a defect or a physical and mental illness or condition. Accordingly, Petitioner did not prove by a preponderance of the evidence that Respondent's denial of additional ABA services was incorrect.

25. Lastly, as QIO for the Agency, eQHealth is authorized to terminate services when "the reviewing physician determines the recipient will not gain any additional benefit by continuing services at the current level." See ¶ 19. Baseline data in the Treatment Plan was taken from [REDACTED]. See ¶ 8. As discussed, Petitioner had not made progress in reducing [REDACTED] maladaptive behaviors or improving [REDACTED] replacement behaviors until towards the end of the prior authorization period. See ¶ 8, 9. Dr. Conway contended that the provider was authorized for protocol modifications under code 97155 throughout the authorization period, but the provider made changes only after the initial denial. See ¶ 8. This is further evidenced in the testimony by [REDACTED] who pointed to decreasing trends in Petitioner's behaviors in the last four

(4) weeks prior to Fair Hearing. See ¶ 9. Accordingly, Respondent provided sufficient evidence to demonstrate that by the documentation in the submitted Treatment Plan Petitioner will not gain any additional benefit by recertification of ABA services and is not “consistent with generally accepted professional medical standards.” See ¶ 19, 21-23.


26. Upon consideration of the testimony provided, evidence submitted, and applicable policies, the undersigned concludes that Respondent proved by a preponderance of the evidence that continuing ABA services was not medically necessary for Petitioner. Looking at all the evidence relevant to the particular needs of Petitioner, Respondent has demonstrated that the ABA services are not medically necessary to correct or ameliorate a defect or a physical and mental illness or condition. Accordingly, Respondent proved by a preponderance of the evidence that Respondent’s termination of ABA services was correct.

IT IS HEREBY ORDERED AND ADJUDGED THAT:

Respondent’s denial of additional ABA services is **AFFIRMED**. Petitioner’s appeal based on Respondent’s denial of additional ABA services is **DENIED**.

Respondent’s termination of ABA services is **AFFIRMED**. Petitioner’s appeal based on Respondent’s termination is **DENIED**.

DONE AND ORDERED this 4th day of June, 2024 in Tallahassee, Leon County, Florida.

 Kimberly Roche
24-FH0418
2024.06.04 08:21:36
-04'00'

KIMBERLY ROCHE, Hearing Officer
Agency for Health Care Administration
Office of Fair Hearings
2727 Mahan Drive, Mail Stop # 11

NOTICE OF A RIGHT TO JUDICIAL REVIEW

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

COPIES FURNISHED TO:

[REDACTED]
[REDACTED]

AHCA Medicaid Hearing Unit
MedicaidHearingUnit@ahca.myflorida.com