



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

FILED

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OFFICE OF FAIR HEARINGS

[REDACTED]

PETITIONER,

AHCA Case No.: 24-FH0501

vs.

AGENCY FOR HEALTH CARE
ADMINISTRATION,

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned Hearing Officer convened a telephonic Fair Hearing in the above-styled case on March 27, 2024, at 9:05 a.m. Eastern Standard Time (EST).

APPEARANCES

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

For the Respondent: Diana Hearod
Medical Health Care Program Analyst
Agency for Health Care Administration

STATEMENT OF ISSUE

At the start of the hearing, the parties agreed that the issue is whether Respondent proved by a preponderance of the evidence that Respondent's reduction of Petitioner's Behavior Analysis services was correct.¹

PRELIMINARY STATEMENT

¹ Based on the testimony, Petitioner also requested an overall increase in BA services that was denied. The denial is addressed in the Conclusions of Law section below.

All parties appeared for the Fair Hearing telephonically. [REDACTED] (“[REDACTED]”), Petitioner’s Authorized Representative and [REDACTED] appeared for the Fair Hearing on behalf of Petitioner.

Diana Hearod, Medical Health Care Program Analyst for the Agency for Health Care Administration (“Agency” or “AHCA”), appeared for the Fair Hearing as a representative for Respondent. Dr. Melissa Switzer (“Dr. Switzer”), Board-Certified Behavior Analyst at the doctoral level for eQHealth Solutions (“eQHealth”), appeared for the Fair Hearing as a witness for Respondent.

Interpreter Christina, translator number 222888 with Language Line Solutions, appeared for the hearing to provide language translation services for the Petitioner.

Petitioner did not introduce any exhibits at the Fair Hearing. Respondent introduced a 276-page evidence packet. The evidence packet appears in the Office of Fair Hearings’ case management system as “[REDACTED] FH 03.27.2024 1-76.pdf,” “[REDACTED] FH 03.27.2024 77-115.pdf,” “[REDACTED] FH 03.27.2024 116-180.pdf,” “[REDACTED] FH 03.27.2024 181-214.pdf,” “[REDACTED] FH 03.27.2024 215-248.pdf,” and “[REDACTED] FH 03.27.2024 249-276.pdf.” Absent an objection from Petitioner, the undersigned admitted the evidence packet into evidence as Respondent’s Composite Exhibit 1.

Respondent also introduced a forty-nine (49)-page evidence packet. The evidence packet appears in the Office of Fair Hearings’ case management system as “24-FH0501 Evidence BA Services 49 Pages.pdf.” Absent an objection from 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 through the Agency. See Respondent's Composite Exhibit 1 at page 22.

2. eQHealth is a Quality Improvement Organization ("QIO") contracted by the Respondent to review prior authorization requests for services. See Respondent's Composite Exhibit 2 at page

2. Respondent, through contractual agreement, authorizes eQHealth to make medical necessity determinations for services requiring prior authorization, including the Behavior Analysis ("BA") services at issue. *Id.*

3. Petitioner is [REDACTED] See Respondent's Composite Exhibit 1 at pages 22, 276. Petitioner's BA service provider, [REDACTED], identified the following behaviors as maladaptive:

[REDACTED], [REDACTED], [REDACTED], [REDACTED], [REDACTED], [REDACTED], [REDACTED], [REDACTED], and [REDACTED]. *Id.* at 220.

4. On November 17, 2023, Respondent issued a Notice of Outcome ("NOO") initially terminating Petitioner's Behavior Analysis services based on medical necessity criteria. *Id.* at 28-

29. The NOO states as follows:

Code: 97155 Intervention with protocol modification, per 15 minutes
From: 11/5/2023
Thru: 5/2/2024
Total Units: Denied – 208

Code: 97156 Family training, per 15 minutes, Lead Analyst
From: 11/5/2023
Thru: 5/2/2024
Total Units: Denied -208

Code 97153 Intervention without protocol modification, per 15 minutes, Lead Analyst, BCaBA, or RBT
From: 11/5/2023
Thru: 5/2/2024

Total Units: Denied – 2,912

The request for services is denied in whole or in part because they are not medically necessary as defined in Rule 59G-1.010, Florida Administrative Code. Specifically, the requested services are not medically necessary under the following standard(s):

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

The rationale for our decision is as follows:

...

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

PR Clinical Rationale – Denial: According to the Florid 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 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 28 - 29.

5. Petitioner appealed the Agency’s decision. On January 5, 2024, Respondent issued a Notice of Reconsideration Determination (“NRD”) modifying its decision based on medical necessity criteria. *Id.* at 40-42. The NRD authorizes some of the requested BA services and states as follows, in pertinent part:

Code: 97155 Intervention with protocol modification, per 15 minutes
From: 11/5/2023
Thru: 5/2/2024
Total Units: Units added at recon – 208
Reversed

Code: 97156 Family training, per 15 minutes, Lead Analyst
From: 11/5/2023
Thru: 5/2/2024
Total Units: Units added at recon -208
Reversed

Code 97153 Intervention without protocol modification, per 15 minutes, Lead Analyst, BCaBA, or RBT
From: 11/5/2023
Thru: 5/2/2024
Total Units: Denied 2,912
Total Units: Units added at recon – 1,768
Modified

The reason for the denial is that the services are not medically necessary as defined in 59G-1.010, Florida Administrative Code. 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.

The rationale for our decision is as follows:

PR Recon Determination: At reconsideration all documents were carefully reviewed. The provider submitted new documentation that supports the medical necessity of this request. 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 service. The current request is in excess of medically necessary BA services, but BA services are approved at a lower level than requested.

Id. at 40-41. The undersigned accepts the testimony of Dr. Switzer that the approved number of BA units in the NRD are identical to the approved number of units in the prior certification period, a total of approximately 20 hours per week of BA services. The undersigned further accepts the

testimony of Dr. Switzer that Petitioner requested an additional 8 hours of BA services that were denied in the NRD.

6. On February 8, 2024, Petitioner requested a Fair Hearing due to Respondent's decision. *Id.* at 8. The undersigned issued a Scheduling Order scheduling the hearing to be conducted by telephone on March 27, 2024, at 9:00 a.m. EST. *Id.* at 8-19. Administrative approval of BA services was granted pending the outcome of the Fair Hearing. *Id.* at 24.

7. At the Fair Hearing, Dr. Switzer clarified that eQHealth approved less BA services than requested by Petitioner. Dr. Switzer testified that 20 hours per week of BA services were authorized for the last certification period and that, based on additional documentation provided at reconsideration, 20 hours per week of BA services were authorized for the current certification period. Thus, Petitioner's overall BA service hours are unchanged as a result of the NRD. Dr. Switzer clarified that Petitioner's provider initially requested an additional 8 hours per week of BA services that were denied as "in excess of Petitioner's needs" based on the Treatment Plan and level of progress achieved. Dr. Switzer agreed with the three previous eQHealth reviewers that the intensity and frequency of Petitioner's maladaptive behaviors does not justify the additional units requested in the Treatment Plan, or a total of approximately 28 hours per week of BA services.

8. Dr. Switzer testified that the Treatment Plan presented at reconsideration contains graphs containing the most recent data on Petitioner's maladaptive behaviors, which were targeted for reduction by the provider. The data graphs demonstrate that Petitioner has reduced all maladaptive behaviors by at least [REDACTED] over the course of BA treatment. For example: compared to baseline, incidents of [REDACTED] show an [REDACTED] reduction in frequency; compared to

baseline, incidents of [REDACTED] show a [REDACTED] reduction in frequency; compared to baseline, incidents of [REDACTED] show a [REDACTED] reduction in frequency; and compared to baseline, incidents of [REDACTED] show a [REDACTED] reduction in frequency. *Id.* at 228-236.

9. Dr. Switzer testified that the data graphs for replacement behaviors similarly show that Petitioner has increased all replacement behaviors by [REDACTED] over the course of treatment. For example: [REDACTED] improved by [REDACTED] over baseline; [REDACTED] improved by [REDACTED] over baseline; and [REDACTED] improved by [REDACTED] over baseline. *Id.* at 240 – 259.

10. Based on Petitioner’s significant progress on maladaptive behaviors and replacement behaviors, Dr. Switzer concluded that the Treatment Plan at issue can be effectively implemented with the approved number of units, which are unchanged from the last certification period. Further, based on the improvement shown, Petitioner’s provider did not demonstrate why additional hours BA services are warranted under the Treatment Plan at issue.

11. [REDACTED] testified that Petitioner is not requesting an increase in BA services; rather, [REDACTED] would like for Petitioner to keep the same level of BA services, 20 hours per week, that were previously authorized and should not be reduced. [REDACTED] asserted that Petitioner is making progress under the Treatment Plan and [REDACTED] services should not be changed.

CONCLUSIONS OF LAW

12. Pursuant to section 409.285(2), Florida Statutes (2019), the Agency’s Office of Fair Hearings has jurisdiction over the subject matter of this proceeding. This Final Order is the final administrative decision of the Agency.

13. Pursuant to Rule 59G-1.100(17)(b), Florida Administrative Code (“F.A.C.”), this hearing was held as a *de novo* proceeding.

14. Pursuant to Rule 59G-1.100(17)(g), F.A.C., the burden of proof is as follows:

The burden of proof is on the party asserting the affirmative of an issue, except as otherwise required by statute. The burden of proof is on the Agency or plan, whichever is applicable, when the issue presented is the suspension, reduction, or reduction of a previously authorized service. The burden of proof is on the recipient or enrollee, when the issue presented is the denial or a limited authorization of a service. The party with the burden of proof shall establish its position to the satisfaction of the Hearing Officer by a preponderance of the evidence.

15. At the start of the hearing, the parties incorrectly agreed that the issue is whether Respondent proved by a preponderance of the evidence that Respondent’s reduction of Petitioner’s Behavior Analysis services was correct. The undersigned assigned the burden of proof to the Respondent as to any reduction of services. *See* Rule 59G-1.100(17)(g), F.A.C. Based on the testimony of Dr. Switzer, it became apparent that Respondent approved an identical level of BA services for the current authorization period. Petitioner’s provider had requested an additional 8 hours per week of BA services that were denied. The burden of proof is assigned to the Petitioner as to a request for additional BA services requested; however, as discussed below, the late identification of this additional issue did not change the outcome of the case. The standard of proof in an administrative hearing is a preponderance of the evidence. *Id.* The preponderance of the evidence standard requires proof by “the greater weight of the evidence” (Black’s Law Dictionary at 1201, 7th Ed.).

16. The Florida Medicaid Behavior Analysis Services Coverage Policy (September 2023) (“BA Policy”), incorporated by reference in Fla. Admin. Code. R. 59G-4.125, governs BA services available under Florida Medicaid. The BA Policy provides as follows:

1.0 Introduction

Behavior analysis (BA) services are highly structured interventions, strategies, and approaches provided to decrease maladaptive behaviors and increase or reinforce appropriate behaviors.

...

1.4.6 Medically Necessary/Medical Necessity

As defined in Rule 59G-1.010, F.A.C.

...

2.0 Eligible Recipient

...

2.2 Who Can Receive

Florida Medicaid recipients under the age of 21 years requiring BA services that are medically necessary to address behavior that impairs a recipient's ability to perform a major life activity. Such functional impairment is expressed through the following behaviors:

- Safety – aggression, self-injury, property destruction, elopement
- Communication – problems with expressive/receptive language, poor understanding or use of non-verbal communications, stereotyped, repetitive language
- Self-stimulating – abnormal, inflexible, or intense preoccupations
- Self-care – difficulty recognizing risks or danger, grooming, eating, or toileting
- Other behaviors not identified above but not limited to complexity of treatment, programming, or environmental variables

The recipient must be referred by an independent physician or practitioner qualified to assess and diagnose disorders related to functional impairment, including:

- Primary care physician with family practice, internal medicine, or pediatric specialty
- Board certified or board eligible physician with specialty in developmental behavioral pediatrics, neurodevelopmental pediatrics, pediatric neurology, adult or child psychiatry
- Child psychologist

The referral must include a comprehensive diagnostic evaluation (CDE) performed according to national evidence-based practice standards. CDEs may be performed by a multidisciplinary team or individual practitioner. In either case, the CDE must be led by a licensed practitioner working within their scope of practice. The CDE must include assessment findings and treatment recommendations appropriate to the recipient. For example, the CDE may include data from behavioral reports by parents, guardians, and/or teachers; diagnostic testing related to recipients'

development, behavior, hearing, and/or vision; genetic testing; and/or other neurological and/or medical testing.

Some services may be subject to additional coverage criteria as specified in section 4.0.

...

4.0 Coverage Information

4.1 General Criteria

Florida Medicaid covers services that meet all of the following:

- Are determined medically necessary
- Do not duplicate another service
- Meet the criteria as specified in this policy

4.2 Specific Criteria

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

4.2.1 Behavior Assessment and Behavior Plan

A behavior assessment must be conducted prior to the initiation of behavior analysis interventions. The assessment must identify behavioral deficits that interfere with a major life activity including the events and subsequent interactions that elicit and sustain targeted behavior.

The initial assessment must include the administration, scoring, and reporting of two core standardized behavior instruments, as follows:

- Vineland-3 Comprehensive Parent Interview Form Including Maladaptive Behavior Domain, for all recipients
- Behavior Assessment System for Children, Third Edition, Parenting Relationship Questionnaire (BASC-3 PRQ), for all recipients 2 years old and less than 19 years old

The complete scoring report, including outcome measure scores, must be submitted with service prior authorization requests. Additional assessment tools may be used at the Lead Analyst's discretion.

The behavior plan identifies intervention strategies that are likely to eliminate, mitigate or replace the behavior to produce change sufficient to reengage the recipient in the major life activity. The plan must include specific behavior goal(s), intervention strategies for each goal, anticipated timeframes that are of sufficient duration to address the targeted behavior, and how the ongoing progress of intervention strategies will be reported.

The behavior plan must reflect the requested authorization period (up to six months).

A reassessment and updated behavior plan to renew prior authorization for continued services must be completed at least every six months. The core instruments must be included with reassessments every 12 months.

More frequent assessments must be conducted when:

- New behavior emerges that interferes with a recipient's participation in a major life activity
- Additional BA services are medically necessary and are likely to address the emergent behavior

A full reassessment may be requested if there is a change in provider; however, a change of a practitioner status (e.g., an RBT becoming certified as a BCaBA) is not grounds for conducting a reassessment or updating a behavior plan.

4.2.2 Behavior Analysis Interventions

Florida Medicaid covers up to 40 hours per week of BA intervention services as indicated in the recipient's prior-authorized behavior plan. These services must be delivered to reduce maladaptive behaviors and assist the recipient reach the best possible function level for that individual. Services include:

- Adaptive behavior treatment by protocol - behavior analysis services provided according to the authorized treatment protocol
 - Services may be provided by Lead Analyst, BCaBA, or RBT
- Adaptive behavior treatment with protocol modification – behavior analysis services provided with modifications to the authorized treatment protocol to address behavior and/or response changes or progress
 - 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.

...

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). 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.

18. Petitioner is under age 21, and therefore eligible for EPSDT services. However, a state may place appropriate limits on a service based on medical necessity. *See* 42 C.F.R. §§ 440.230(a), (b), (d). 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.

19. The Florida Medicaid Definitions Policy (“Definitions Policy”) (August 2017), which is incorporated by reference in Rule 59G-1.010, F.A.C. defines Medically Necessary or Medical Necessity as:

2.83 Medically Necessary or Medical Necessity

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 severe 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.

20. The Florida Medicaid Authorization Requirements Policy (“Authorization Requirements Policy”) (June 2016), incorporated by reference in Rule 59G-1.053, F.A.C., provides general requirements for providers to obtain authorization to render Florida Medicaid services. The Authorization Requirements Policy states:

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.

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.

...

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 page 31.

21. Petitioner is under the age of 21 years and diagnosed with ADHD. *See supra* ¶ 3. Petitioner currently engages in maladaptive behaviors that interfere with ■ daily functioning. *See supra* ¶

3. Respondent agrees that Petitioner should receive Behavior Analysis services but argues that the Behavior Analysis provider submitted insufficient documentation to justify the level of services requested. *See supra* ¶ 4 – 5, and 7 - 10.

22. Respondent decisions concerning Petitioner's request for Behavior Analysis services are based on medical necessity criteria. *See supra* ¶ 4 - 5, and 7 - 10. Respondent determined that the submitted Treatment Plan (requesting an additional 8 hours per week of BA services) did not meet the following medical necessity standard: 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. *See supra* ¶ 4 - 5. This medical necessity standard is expressly outlined in section 2.83 of the Definitions Policy. *See supra* ¶ 19. The BA Policy mandates that the behavior plan must be detailed enough to warrant the requested services and include mechanisms to monitor its effectiveness. *See supra* ¶ 16. Further, the Authorization Requirement Policy permits eQHealth to reduce the amount or frequency of a service when there is a documented improvement in the recipient's medical condition or the reviewing physician determines that the recipient will not gain any additional benefit by continuing services at the current level. *See supra* ¶ 22.

23. In this case, Dr. Switzer provided credible and persuasive testimony that the previously approved level of BA service is sufficient to implement the Treatment Plan at issue and that the additional services requested by the provider were "in excess of Petitioner's needs" based on the Treatment Plan and progress made. *See supra* ¶ 8. Dr. Switzer agreed with three eQHealth reviewers that the documentation provided shows that Petitioner has made significant progress during the course of BA treatment. *See supra* ¶ 7. For example, the data graphs demonstrate that Petitioner has reduced all maladaptive behaviors by at least [REDACTED] over the course of BA treatment. *See supra* ¶ 9. Replacement behaviors similarly show improvement of [REDACTED] over baseline over the course of treatment. *See supra* ¶ 9. Based on the NRD and Dr. Switzer's testimony, Petitioner's BA services were not reduced and remained at the level of 20 hours per week of services for the authorization period. Therefore, there was no reduction in Petitioner's BA services.

24. In this case, Dr. Switzer also testified that the BA provider recommended an increase over the previously approved level of BA services. *See supra* ¶ 9. [REDACTED] testified that [REDACTED] would

like for Petitioner to receive 20 hours per week of BA services and that the additional 8 hours of BA services were not requested. See supra ¶ 11. As stated above, the fact that Petitioner's provider has prescribed, recommended, or approved medical or allied care, goods, or additional services does not, in itself, make such care, goods or services medically necessary or a medical necessity or a covered service. See supra ¶ 16.

25. Accordingly, because 20 hours of BA services were approved in the NRD, were supported by Petitioner's progress in the treatment Plan, and because [REDACTED] advocated for 20 hours per week, the record does not reflect that an additional 8 hours per week of BA services are individualized and specific to Petitioner and are not in excess of Petitioner's needs. Therefore, the requested additional BA services do not meet medical necessity criteria. Looking at all the evidence relevant to the particular needs of Petitioner, the additional BA services at issue are not necessary to correct or ameliorate a defect or a physical and mental illness or condition. Therefore, the additional BA services are not medically necessary.

26. Accordingly, upon consideration of Respondent's Composite Exhibit 1, Respondent's Composite Exhibit 2, the parties' sworn testimony, and the applicable laws and policies, the undersigned concludes that Respondent proved by a preponderance of the evidence that its decision to continue Petitioner's Behavior Analysis services at the current level of 20 hours per week, and deny an additional 8 hours per week, was correct.

DECISION

Respondent's decision to continue Petitioner's Behavior Analysis services at the current level of 20 hours per week, and deny an additional 8 hours per week, is **AFFIRMED**. Petitioner's appeal based on Respondent's determination is **DENIED**.

DONE and ORDERED this 8th day of July 2024, in Tallahassee, Leon County, Florida.

Laura Gallagher
24-FH0501



2024.07.08 08:43:38
-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
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