

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



FILED

May 17, 2024, 12:23 pm

OFFICE OF FAIR HEARINGS

[REDACTED]

PETITIONER,

AHCA Case No.: 24-FH0599

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 April 16, 2024, at 12:56 p.m. EST.

**APPEARANCES**

For the Petitioner:

[REDACTED]

Petitioner's Authorized Representative

For the Respondent:

Doris Rivera  
Medical Health Care Provider Analyst  
Fair Hearing Liaison  
Agency for Health Care Administration

**STATEMENT OF ISSUE**

The issue is whether Petitioner proved by a preponderance of the evidence that Respondent's decision to deny Petitioner's request to increase behavior analysis ("BA") services was incorrect.

**PRELIMINARY STATEMENT**

All parties and witnesses appeared telephonically. Petitioner's Authorized Representative and [REDACTED], [REDACTED], (" [REDACTED]"), appeared on behalf of the Petitioner. [REDACTED], BCBA for [REDACTED] appeared as a witness for Petitioner. [REDACTED], BCBA and owner of [REDACTED] appeared as a witness for Petitioner.

Doris Rivera, Medical Health Care Provider Analyst and Fair Hearing Liaison for the Agency for Health Care Administration ("Agency" or "AHCA") appeared on behalf of Respondent. Dr. Alissa Conway, ("Dr. Conway") Board Certified Behavior Analyst at the doctoral level (BCBA-D) and second level reviewer for eQHealth Solutions, Inc. ("eQHealth"), attended as a witness for Respondent.

Prior to the hearing, Petitioner sent to the Office of Fair Hearings and Respondent a forty-five (45)-page evidence packet. The packet appears in the Office of Fair Hearing's case management system as "24-FH0599 Email Correspondence.pdf." Absent an objection from the Respondent, the undersigned admitted the evidence packet into evidence as Petitioner's Composite Exhibit 1.

Prior to the hearing, Petitioner sent to the Office of Fair Hearings and Respondent an eleven (11)-page evidence packet. The packet appears in the Office of Fair Hearing's case management system as "24-FH0599- Pet Email.pdf." Absent an objection from the 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 one hundred and seventy-three (173)-page evidence packet. The packet appears in the Office of Fair Hearings' case management system as "[REDACTED] FH 04.16.2024 1-79.pdf," "[REDACTED] FH

04.16.2024 80-126.pdf,” and “[REDACTED] FH 04.16.2024 127-173.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-FH0599- AHCA BA 47(sic) pgs.pdf.” Absent an objection from the Petitioner, the undersigned admitted the evidence packet into evidence as Respondent’s Composite Exhibit 2.

### **FINDINGS OF FACT**

1. Petitioner receives Medicaid services on a fee-for-service basis from the Agency. eQHealth is a Quality Improvement Organization contracted by the Agency to review prior authorization requests for services. *See* Respondent’s Composite Exhibit 2 at page 2.
2. Petitioner is [REDACTED]. *See* Respondent’s Composite Exhibit 1 at page 16. The Petitioner has been diagnosed with [REDACTED]. The Petitioner has exhibited maladaptive behaviors including [REDACTED], [REDACTED], [REDACTED], [REDACTED], [REDACTED], [REDACTED], [REDACTED], [REDACTED]. *Id.* at 70,72,73,74,76,77,78,80, and 81.
3. The provider requested service units be authorized for Code 97153 with 3,588 units; Code 97155 with 520 units, and Code 97156 with 48 units. The authorization period request was for February 5, 2024 through August 2, 2024. *Id.* at 23.
4. On February 13, 2024, Respondent issued a Notice of Outcome (“NOO”), terminating Petitioner’s BA services. *Id.* at 23-25. The NOO explained the basis for the termination as follows:

[T]he requested services are not medically necessary under the following standard(s):

Individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness under treatment, and not in excess of the patient's needs.  
Consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational.

The service is denied because it is for the convenience of the recipient, recipient's caregiver or the provider.

...

The NOO further provided:

Submitted information does not support the medical necessity for requested frequency and/or duration.

PR Clinical Rationale – Denial: Provider, the maladaptive behavior graphs describing duration do not specify the time unit for measurement (e.g., minutes, seconds, etc.) According to the Florida Medicaid Behavior Analysis Services Coverage Policy (pages 3, 2.2) the recipient of ABA therapy services must engage in maladaptive behavior that interferes with the recipient's daily functioning for which ABA therapy is medically necessary. There are behaviors that do not meet medical necessity criteria ( [REDACTED] ).

The provider has listed goals in this treatment plan that do not meet medical necessity criteria ( [REDACTED] ). According to the Behavior Analysis Services Coverage Policy (page 4, 4.1), these goals are not covered. The goals must be necessary to protect life, to prevent significant illness, significant disability, or to alleviate severe pain and be consistent with the symptoms of any diagnosis for which ABA is medically necessary. These are skills that do not require a behavior analyst to teach. They can be learned in a less costly and equally effective manner by someone not specifically trained in ABA. They are furnished in a manner primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.

[REDACTED]  
[REDACTED] are not empirically supported procedures within the conceptual system of behavior analysis for treating the functions of maladaptive behavior. According to Behavior Analysis Services Coverage Policy (page 2, 1.1), treatment that does not meet generally accepted standards of care within the field of applied behavior analysis are not covered under the behavior analysis service coverage policy.

The supporting documentation does not meet generally accepted practices within the field of applied behavior analysis and standards set forth in the Florida Behavior Analysis Services Coverage Policy. Specifically, the provider has failed to write an intervention plan that upholds the standards of care of applied behavior analysis. The plan lists procedures that include punishment (positive practice) and has not exhausted reinforcement-based strategies. There is no procedural safeguard or fading plan. This request for services is denied.

*Id.* at 23-24.

5. Petitioner requested reconsideration of the Respondent's decision. On March 12, 2024, Respondent issued a Notice of Reconsideration Determination ("NRD") upholding its decision. *Id.* at 35-36. The NRD states, in pertinent part as follows:

Specifically, the services must be:

Individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness under treatment, and not in excess of the patient's needs.  
Consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational.

...

PR Recon Determination: At reconsideration all documents were carefully reviewed. According to the Florida Medicaid Behavior Analysis Services Coverage Policy (page 3, 2.2) the recipient of ABA therapy services must engage in maladaptive behaviors that interferes with the recipient's daily functioning for which ABA therapy is medically necessary. The behaviors identified in this treatment plan include [REDACTED]. Behavior analysis is not the most effective and least costly treatment available to treat the causes of these behaviors. These behaviors are outside the scope of treatment for behavior analysis. This reconsideration request has been reviewed, reconsidered, and the partial denial is upheld.

*Id.* at 35-36.

6. On April 5, 2024, the Respondent issued an additional reconsideration notice which modified and reversed the prior denials of requested services. The additional reconsideration

notice was filed with the Office of Fair Hearings on April 15, 2024, prior to the commencement of the Fair Hearing on April 16, 2024, at 1:00 p.m. The additional reconsideration document can be found in the Office of Fair Hearings case management system at “4/15/2024 2:31:03 PM INTAKE Approval letter for (Recipient’s Name).pdf.” The additional Notice of Reconsideration Determination reversed and modified the prior termination as follows: Code 97153, denial modified, units approved 3,120; Code 97155, denial reversed, units approved as requested at 520, and Code 97156, denial reversed, units approved as requested at 48. Dr. Conway testified that the provider had originally requested 3,588 units of Code 97153 but during the additional reconsideration review, 3,120 units of Code 97153 were approved. Dr. Conway testified that all of the service units approved during the additional reconsideration determination were the same as the previous authorized service units with the exception of Code 97156 which was lowered from 52 units to 48 units at the provider’s request.

7. The Petitioner requested a Medicaid Fair Hearing on February 22, 2024. The undersigned scheduled the Fair Hearing for April 16, 2024 at 1:00 p.m. EST.

8. [REDACTED], the BCBA for the Recipient testified first. [REDACTED] took exception to the portion of the NRD that contained references to [REDACTED]. [REDACTED] stated that as the author of the treatment plan, [REDACTED] did not include any reference to [REDACTED], but did identify [REDACTED] along with [REDACTED]. [REDACTED], the Recipient’s first BCBA and owner of [REDACTED] testified on behalf of the Recipient. [REDACTED] testified that the reason for the increase in service units was because of the [REDACTED] ([REDACTED]) and [REDACTED]. The increase in units would support the interventions being used to reduce maladaptive behaviors. [REDACTED] acknowledged that the Recipient was

improving, but that was based upon the interventions being used. Further, [REDACTED] felt the increase in service units would be used for the safety of the Recipient concerning the [REDACTED].

9. Dr. Conway established that eQHealth reviews behavior analysis cases to ensure that providers are giving quality care consistent with the standards enumerated in the BA Policy as well as professional medical standards of applied behavior analysis (“ABA”). eQHealth reviewed the Treatment Plan submitted in this case to determine whether all five (5) conditions of medical necessity are met. Dr. Conway asserted that Petitioner’s services were denied because 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 and therefore does not meet the conditions of being medically necessary.

10. Dr. Conway explained the review process that is followed by eQhealth. In this review, Dr. Conway testified that the 1<sup>st</sup> level reviewer found that the recipient had been diagnosed with [REDACTED] and the provider was requesting 40.5 hours per week of services. *Id.* at 18. Further, considering the documentation submitted, the request for services 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. *Id.* The request was sent to a second level review. The second level reviewer is a Board-Certified Behavior Analyst at the doctoral level (BCBA-D). Dr. Conway testified that the second reviewer wrote that the treatment plan contained behaviors and goals that do not meet medical necessity criteria. *Id.* at 19. The second level reviewer also found that the treatment plan included punishment procedures but did not contain a safeguard or fading plan. *Id.* at 19. The second level reviewer denied the request

for behavior analysis services based upon the documentation submitted. *Id.* A request was made for reconsideration and a third reviewer reconsidered the previous denial. The third reviewer is also a Board-Certified Behavior Analyst at the doctoral level (BCBA-D). In addition to confirming the previous denial the third reviewer also found that the treatment plan included [REDACTED] [REDACTED] for which behavior analysis is not the best method to treat such behavior. *Id.* at 19. The prior denial was upheld. *Id.* at 19. As previously stated, the provider disputes the statement that the treatment plan contains any [REDACTED]. See supra ¶ 8.

11. Dr. Conway established that an effective treatment plan is built around maladaptive behaviors (which decrease in frequency) and skills to be acquired (which increase in frequency) over the course of treatment. As part of the additional reconsideration determination, Dr. Conway reviewed graphs involving maladaptive behavior. The first graph is for [REDACTED]. This graph shows the occurrences are [REDACTED] for the entire current authorization period. *Id.* at 156. The next graph is for [REDACTED]. This graph shows this behavior occurring at low levels [REDACTED] and is considered a low level behavior. *Id.* at 158. The next graph is for [REDACTED]. As with the previous graph, this behavior is occurring at lower levels and is on a decreasing trend and at the end of the authorization period the behavior would last for less than 5 minutes per session. *Id.* at 160. The next graph for review is [REDACTED]. This graph depicts the behavior [REDACTED] for multiple sessions and at low levels at the end of the authorization period. *Id.* at 162. The next graph is for [REDACTED]. This is a serious behavior; however, the graph shows from [REDACTED] the occurrences are all virtually [REDACTED] per week. *Id.* at 163. The next graph is for [REDACTED]. The data reported shows that this behavior is for the majority of the reported period [REDACTED]. There are a

few isolated occurrences above [REDACTED]. *Id.* at 166. The next behavior graph is for [REDACTED]. This graph depicts that the behavior is [REDACTED] with the exception of a few outliers toward the end of the authorization period. *Id.* at 167. The next graph for review is [REDACTED]. This is a serious behavior; however the data indicates that the occurrences are between [REDACTED] per session during the authorization period. *Id.* at 168. Dr. Conway testified that overall the recipient was still engaging in some maladaptive behaviors but that the service units authorized in the additional reconsideration determination of April 5, 2024 were sufficient to needs of the recipient. Based upon the data presented, Dr. Conway testified that the increase requested by the provider was in excess of the recipient's needs and therefore not medically necessary.

#### **CONCLUSIONS OF LAW**

12. 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).

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

14. Because Petitioner was seeking to increase service, Fla. Admin. Code R. 59-1.100(17)(g) assigns the burden of proof to the Petitioner. The standard of proof in an administrative hearing is a preponderance of the evidence. The preponderance of the evidence standard requires proof by "the greater weight of the evidence" (Black's Law Dictionary at 1201, 7th Ed.).

15. 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).

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

18. 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, incorporated by reference in Fla. Admin. Code R. 59G-1.010, defines “Medically Necessary” or “Medical Necessity” as follows:

The medical or allied care, goods, or services furnished or ordered must meet the following conditions:

- Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate pain
- Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient’s needs
- Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational
- Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available statewide
- Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient’s caretaker, or the provider

The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services does not, in itself, make such care, goods or services medically necessary or a medical necessity or a covered service.

Respondent's Composite Exhibit 2 at page 23

20. 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
  - o Treatment setting(s)
  - o Proposed treatment targets, goals, and objectives related to medically necessary behavioral interventions
  - o 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
  - o Proposed targets, goals, and objectives (as above)
  - o Training procedures
  - o Date of introduction
  - o Estimated date of mastery
- Number of units requested
  - o Number of units for each billing code
  - o Medical necessity for units requested
- Supervision plan, including name(s) of authorized supervisor(s)
- Care coordination with parents/caregivers, schools, state disability programs, and others as applicable
- Transition (fading) plan
- Crisis management plan
- Discharge plan

### **6.2.3 Assessment and Behavior Plan for Reauthorization and Continuation of Services**

In addition to the documentation requirements indicated in 6.2.2, subsequent assessments and behavior plans for reauthorization and continuation of services must include:

- Data reflecting progress of all behaviors targeted for improvement. Each behavior under treatment must have its own data table and corresponding graph.
- A narrative discussion of progress and a statement of justification for continuation of care at the intensity level requested

If significant clinical progress is not made over the course of an authorized period, the provider must explain why clinically significant progress was not made and treatment changes to promote progress.

...

Pages 1 – 8 of BA Policy.

21. The Florida Medicaid Authorization Requirements Policy (“Authorization Policy”), incorporated by reference in Fla. Admin. Code R. 59G-1.053, provides as follows:

### **3.2.1 Continued Authorization Request**

The QIO shall not deny or reduce the amount, frequency, or duration of a service that is already being provided, unless:

- The reduction is to correct for factual error or omissions in prior certifications.
- There is a documented improvement in the recipient’s medical condition.
- There is a documented change in the recipient’s circumstances.
- The reviewing physician determines the recipient will not gain any additional benefit by continuing services at the current level.

...

Page 3 of Authorization Policy.

22. In this case, Respondent initially terminated Petitioner’s BA services. The NOO and NRD explained that Petitioner’s request for services did not meet medical necessity as the treatment plan was not “Individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness under treatment, and not in excess of the patient’s needs.” See supra ¶ 4-5.

23. [REDACTED]’s testimony and that of Petitioner’s witnesses did not prove by a preponderance of the evidence that the behavior analysis services should be increased above the current

authorization. No testimony or evidence was provided that would justify increasing the ABA service units.

24. As outlined above, Dr. Conway provided credible and persuasive testimony identifying several instances where the revised Treatment Plan did result in effective treatment of the recipient's maladaptive behaviors. For example, the documentation provided for review did show decreases in maladaptive behaviors. *See supra* ¶ 11. Dr. Conway testified that the reduction in maladaptive behaviors was effective under the current authorized service units and the re-authorization of those units would be sufficient to meet the patient's needs. *See supra* ¶ 11. Thus, Dr. Conway testified that based on the data in the record, the April 5, 2024 reconsideration determination supported the re-authorization of services at the existing level, to wit: 2,496 units of Code 97153, 260 units of Code 97155 and 208 units of Code 97156. *See supra* ¶ 11. However, Dr. Conway testified that the data did not support an increase in the services units as requested by the provider. An increase in service units would be in excess of the patient's needs and therefore not medically necessary. *See supra* ¶ 11.

25. In this case, Petitioner's provider recommended the continuation and an increase of BA services. However, the fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services does not, in itself, make such care, goods or services medically necessary or a medical necessity or a covered service. *See supra* ¶ 19.


26. Accordingly, Petitioner has failed to establish by a preponderance of the evidence that the requested increase in BA services were medically necessary. Looking at all the evidence relevant to the particular needs of Petitioner, the increase in BA services at issue are not necessary to correct or ameliorate a defect or a physical and mental illness or condition.

27. 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, Respondent's additional Reconsideration Determination of April 5, 2024, and the applicable law and policies, the undersigned finds that Petitioner failed to prove by a preponderance of the evidence that Respondent's denial of the increase BA services was incorrect.

**DECISION**

Respondent's denial of the requested increase in Behavior Analysis services is **AFFIRMED**. Petitioner's appeal based on Respondent's denial of the requested increase in Behavior Analysis services is **DENIED**.

**DONE and ORDERED** this 17th day of May 2024, in Tallahassee, Leon County, Florida.

  
George L. Winslow, Jr.  
24-FH0599  
2024.05.17 10:09:03  
-04'00'

---

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

**NOTICE OF A RIGHT TO JUDICIAL REVIEW**

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

ACCORDANCE WITH THE FLORIDA APPELLATE RULES. THE NOTICE OF APPEAL MUST BE FILED WITHIN 30 DAYS OF THE RENDITION OF THE ORDER TO BE REVIEWED.

**Copies Furnished To:**

[REDACTED]  
[REDACTED]

**AHCA Medicaid Hearing Unit**  
**MedicaidHearingUnit@ahca.myflorida.com**