



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

FILED

May 10, 2024, 1:11 pm
OFFICE OF FAIR HEARINGS

[REDACTED]

PETITIONER,

AHCA Case No.: 24-FH0642

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 23, 2024, at 9:00 a.m. EST.

APPEARANCES

For the Petitioner:

[REDACTED]

Petitioner's Authorized Representative

For the Respondent:

Sandra Durden
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] [REDACTED], BCBA for the recipient, appeared as a witness on behalf of the Petitioner. [REDACTED] [REDACTED], BCBA and owner of [REDACTED], LLC appeared as a witness on behalf of the Petitioner.

Sandra Durden, 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. David Bicard, ("Dr. Bicard") Board Certified Behavior Analyst at the doctoral level (BCBA-D) and Director of Clinical Operations for eQHealth Solutions, Inc. ("eQHealth"), attended as a witness for Respondent.

Petitioner did file with the Office of Fair Hearings a fifty-six (56)-page packet on April 22, 2024 at 3:52 p.m. for the Fair Hearing scheduled for April 23, 2024 at 9:00 a.m. Upon inquiry by the Hearing Officer, neither the Agency nor Dr. Bicard received the fifty-six-page packet. The packet was not filed in accordance with the Scheduling Order which requires any documents to be offered as evidence to be filed ten (10) days prior to the scheduled hearing. The Hearing Officer did not admit the fifty-six (56)-page packet into evidence.

Prior to the hearing, Respondent sent to the Office of Fair Hearings and Petitioner a hundred and eighty-eight (188)-page evidence packet. The packet appears in the Office of Fair Hearings' case management system as "[REDACTED] FH 04.23.2024 1-111.pdf," "[REDACTED] FH 04.23.2024 112-157.pdf," and "[REDACTED] FH 04.23.2024 158-188.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-FH0642 AHCA EVIDENCE PKT.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] [REDACTED]. *Id.* at 16,18. The Petitioner has exhibited maladaptive behaviors including [REDACTED], [REDACTED], [REDACTED], [REDACTED] and [REDACTED]. *Id.* at 49. The recipient transferred to this provider during the last authorization period. The recipient began with this provider in [REDACTED]. *Id.* at 16,18.

3. The following table sets forth the prior, requested, and approved authorization for services for this recipient.

Code	Prior Authorization	Requested Authorization	Approved Authorization
97153	2,496 units	3,120 units	2,496 units

97155	208 units	520 units	520 units
97156	520 units	104 units	104 units

The new provider, [REDACTED], LLC took over the prior authorization in [REDACTED] and submitted the above requested authorization for ABA services for the certification period of January 23, 2024 through July 20, 2024. The Respondent approved the requested authorization for Code 97155 and Code 97156 as requested. However, the Respondent denied the requested authorization of 3,120 units of Code 97153 but approved 2,496 units of Code 97153. The approval of Code 97153 for 2,496 units for the authorization period of January 23, 2024 through July 20, 2024 is the same amount of units as the prior approval.

4. On February 6, 2024, Respondent issued a Notice of Outcome (“NOO”), denying Petitioner’s requested increase of BA services. *Id.* at 23-24. The NOO explained the basis for the denial as follows:

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

Individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness under treatment, and not in excess of the patient’s needs.
 . . .

The NOO further provided:

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

PR Clinical Rationale – Denial: According to Behavior Analysis Services Coverage Policy (page 3, 2.2) request for services must be based on the medical necessity of the recipient’s maladaptive behaviors and skill deficits. The recipient is engaging in problem behaviors that threaten access to typical environments and negatively affects activities of daily living. However, the frequency, intensity, or severity of the recipient’s maladaptive behaviors does not justify the requested units of services. the requested units of BA services are in excess of medical necessity.

Id. at 23-24.

5. Petitioner requested reconsideration of the Respondent’s decision. On February 21, 2024, Respondent issued a Notice of Reconsideration Determination (“NRD”) upholding its decision. *Id.* at 34-35. The NRD states, in pertinent part as follows:

Specifically, the services must be:

Individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness under treatment, and not in excess of the patient’s needs.

...

PR Recon Determination: At reconsideration all documents were carefully reviewed. The provider did not submit any 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 services. This reconsideration request has been reviewed, reconsidered, and the partial denial is upheld.

Id. at 34-35.

6. The Petitioner requested a Medicaid Fair Hearing on February 28, 2024. The Office of Fair Hearings prepared and sent to all parties an Order Scheduling Fair Hearing by Telephone and Prehearing Instructions for a hearing date of April 23, 2024, at 9:00 a.m. EST. *Id.* 8-14.

7. [REDACTED], the BCBA for the recipient testified on [REDACTED] behalf. [REDACTED] testified that [REDACTED] became the recipient’s provider in [REDACTED] after [REDACTED] changed providers. [REDACTED] testified that there was only a short time left in the authorization period when they began to work with the recipient. [REDACTED] testified that there were medication changes that took place at the time of the change of providers and that affected the recipient. Also, the recipient’s behaviors intensified with the change of providers.

The behaviors involving [REDACTED] and [REDACTED] along with [REDACTED] increased. This is why additional service units had been requested. [REDACTED] acknowledged that some progress was now being made. [REDACTED] testified that the additional service units was based on the recipient's needs.

8. [REDACTED] also testified on behalf of the recipient. As a transfer recipient, the new provider had to work with the existing authorization and provide the best services possible even though the new provider believed that additional service units were needed. The center where the recipient now receives services maintains a crises team due to the severity and intensity of the behaviors of the individuals at the center. [REDACTED] does not believe that this recipient would be able to be accepted in a less restrictive center due to the level of [REDACTED] maladaptive behaviors. The individuals at the [REDACTED] center are children that could not function in a public or private school setting.

9. [REDACTED] also testified concerning [REDACTED]. [REDACTED] testified that [REDACTED] behaviors began developing at a very young age, approximately at [REDACTED]. [REDACTED] testified that [REDACTED] had participated in physical, occupational and speech therapies and upon entering school [REDACTED] received an individual education plan (IEP). At school, the behaviors were evident. There were [REDACTED], [REDACTED] and [REDACTED]. In the classroom, as long as [REDACTED] stayed by [REDACTED] or in a corner of the classroom and was quiet, the teacher would not teach [REDACTED] because of [REDACTED] potential behaviors. [REDACTED] behavior at school became more aggressive and dangerous to [REDACTED] and others. [REDACTED] removed [REDACTED] from public school and enrolled [REDACTED] in a private school for individuals with special needs. Unfortunately, the private school was not able to meet the needs of [REDACTED]. Thereafter, [REDACTED] was accepted by [REDACTED]. [REDACTED] also

expressed a concern that [REDACTED] is growing and becoming stronger and with [REDACTED] [REDACTED]. At times, both [REDACTED] and [REDACTED] must work together to control [REDACTED]. [REDACTED] also testified that it has become unsafe to take [REDACTED] to public areas because of [REDACTED] behaviors.

10. Dr. Bicard 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 reviews the Treatment Plans submitted by providers to determine whether all five (5) conditions of medical necessity are met. Dr. Bicard asserted that Petitioner’s request to increase services was 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. As the data documentation would show, the increase of requested service units under Code 97153 were in excess of the recipient’s needs and therefore did not meet the conditions of being medically necessary. Thus, an increase in Code 97153 was denied, while Codes 97155 and 97156 were approved as requested.

11. Dr. Bicard explained the review process that is followed by eQhealth. In this review, Dr. Bicard testified that the 1st level reviewer found that the recipient had been diagnosed with several medical conditions. (See ¶ 2). Further, the 1st level reviewer considering the documentation submitted and found 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.* at 18. 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.

Bicard testified the second level reviewer denied the increase 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). The third reviewer wrote “Although the recipient is engaging in topographies of maladaptive behaviors, the frequency and intensity of the maladaptive do not support the request for services.” The denial was upheld. *Id.* at 20.

12. Dr. Bicard testified that after the reconsideration was completed by the third reviewer, [REDACTED] was assigned the case for the Fair Hearing. Dr. Bicard reviewed the data submitted and [REDACTED] is in agreement with the three previous reviews conducted in this matter. ABA services are medically necessary but only at the levels as approved. As part of [REDACTED] review, Dr. Bicard reviewed graphs involving maladaptive behavior. The first graph is for [REDACTED]. This graph shows a significant downward trend and there are periods of time with no reported [REDACTED]. *Id.* at 148. The next graph is for [REDACTED]. This graph shows this behavior occurring at low levels and overall the behavior appears under control. *Id.* at 149. The next graph is for [REDACTED]. This behavior is a lower level behavior in the scope of safety issues. This behavior appears to be well under control with this provider. *Id.* at 151. The next graph for review is [REDACTED]. This graph depicts low levels in the behavior but does show an increase near the end of the authorization period. *Id.* at 152. The next graph is for [REDACTED]. This behavior is not a safety concern. It appears that this behavior is well under control with some spikes at the end of the authorization period. *Id.* at 153.

13. Dr. Bicard also reviewed the Treatment Plan concerning replacement behaviors. Dr. Bicard testified that [REDACTED] would not review each graph but overall the treatment plan is appropriate and the recipient is making progress on the replacement behaviors identified by the provider.

14. Dr. Bicard testified that based upon the documentation reviewed, the authorization of 2,496 units of Code 97153 was the appropriate number of services units for this recipient. Further, Dr. Bicard testified that because the data presented shows that the recipient is making progress in reducing the maladaptive behaviors and increasing the replacement skills under the current authorization, it is appropriate and medically necessary to continue the authorization of 2,496 units of Code 97153 for the next authorization period. The requested increase in units of Code 97153 would be in excess of the patient's needs and therefore not medically necessary.

CONCLUSIONS OF LAW

15. 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).

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

17. 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.).

18. 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).

19. 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.

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

21. 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.

22. 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

23. 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
 - o 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
 - o Maximum group size is six recipients
 - o 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
 - o Maximum group size is six recipients
 - o 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
 - o The recipient may or may not be present depending upon clinical appropriateness.
 - o Services may be provided by Lead Analyst or BCaBA
 - o 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.

24. 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.

25. In this case, Respondent denied Petitioner’s request to increase 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.

26. The testimony of the witnesses on behalf of the recipient 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. The data documentation shows that under the current authorization, the recipient is making progress in reducing maladaptive behaviors and increasing skill replacement behaviors. See supra ¶ 12-14.

27. As outlined above, Dr. Bicard provided credible and persuasive testimony identifying several instances where the Treatment Plan did result in effective treatment of the recipient's maladaptive and replacement skills behaviors. For example, the documentation provided for review did show decreases in maladaptive behaviors and increases in replacement behaviors. See supra ¶ 12-13. Dr. Bicard testified that the reduction in maladaptive behaviors did reflect a steady decline in the behaviors and that many of the behaviors were under control. See supra ¶ 12. Dr. Bicard also testified that the skill replacement behaviors as outlined by the provider were appropriate and the recipient was showing progress with those replacement skills. See supra ¶ 13. Thus, Dr. Bicard testified that based on the data in the record, the re-authorization of services at the existing level of 2,496 units of Code 97153, 520 units of Code 97155 as requested and 104 units of Code 97156 as requested was a correct determination of the services necessary for this recipient and such services were medically necessary. See supra ¶ 14. However, Dr. Bicard 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* ¶ 14.

28. 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* ¶ 22.


29. Accordingly, Petitioner has failed to established 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.

30. Upon consideration of the testimony provided, Respondent's Composite Exhibit 1, Respondent's Composite Exhibit 2, 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 10th day of May 2024, in Tallahassee, Leon County, Florida.

 George L. Winslow, Jr.
24-FH0642
2024.05.10 10:28:24
-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:



AHCA Medicaid Hearing Unit
MedicaidHearingUnit@ahca.myflorida.com