

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



FILED

Jul 22, 2024, 12:10 pm  
OFFICE OF FAIR HEARINGS

[REDACTED]

PETITIONER,

AHCA Case No.: 24-FH1156

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 July 9, 2024, at 1:00 p.m. EST.

**APPEARANCES**

For the Petitioner:

[REDACTED]

Petitioner's Authorized Representative

For the Respondent:

Diana Hearod  
Medical Health Care Provider Analyst  
Fair Hearing Liaison  
Agency for Health Care Administration

**STATEMENT OF ISSUE**

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

**PRELIMINARY STATEMENT**

All parties and witnesses appeared telephonically. Petitioner's Authorized Representative [REDACTED], PhD, BCBA-D, LMHC, (" [REDACTED]"), appeared on behalf of the Petitioner. [REDACTED], (" [REDACTED]") Petitioner's [REDACTED] appeared on [REDACTED] behalf.

Diana Hearod, 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. Kathy Hurley, ("Dr. Hurley") Board Certified Behavior Analyst at the doctoral level (BCBA-D), Florida Licensed Mental Health Counselor (LMHC), 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 three hundred and thirty-eight (338)-page evidence packet. The packet appears in the Office of Fair Hearings' case management system as "24-FH1156 Emailed Evidence.pdf," "24-FH1156 Emailed Evidence(2).pdf," "24-FH1156 Emailed Evidence(3).pdf," "24-FH1156 Emailed Evidence(4).pdf," and "24-FH1156 Emailed Evidence(5).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, Respondent sent to the Office of Fair Hearings and Petitioner a one hundred and eighty-three (183)-page evidence packet. The packet appears in the Office of Fair Hearings' case management system as "[REDACTED] FH 06.05.2024 1-78.pdf," "[REDACTED] FH 06.05.2024 79-109.pdf," "[REDACTED] FH 06.05.2024 110-141.pdf," "[REDACTED] FH 06.05.2024 142-172.pdf," and "[REDACTED] FH 06.05.2024 173-183.pdf." Absent an objection from the Petitioner, the undersigned admitted the evidence packet into evidence as Respondent's Composite Exhibit 1.



Furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caregiver or the provider.

Not duplicative of services being rendered by another party.

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

...

The NOO further provided:

The service is denied because it duplicates services furnished by another provider.

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

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

PR Clinical Rationale – Denial: Provider, there are minimal group goals listed for the group requested services. The provider indicates group request is based upon staffing, not group goals. The request for group is in excess of medical necessity criteria.

Provider, there are no baseline graphs for multiple new goals (fine motor and time missing graphs). The information submitted does not meet standards of care within the field of behavior analysis. According to the Florida Medicaid State Plan (page 7, 6.2.2), assessment results must be present in the plan. The provider did not include all baseline graphs for new goals added to the plan.

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. The goals include [REDACTED]. The request for services is denied.

*Id.* at 28-29.

5. Petitioner requested reconsideration of the Respondent's decision. On April 11, 2024, Respondent issued a Notice of Reconsideration Determination ("NRD") upholding its decision. *Id.* at 40-41. The NRD states, in pertinent part as follows:

Specifically, the services must be:

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

Not duplicative of services being rendered by another party.

Furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caregiver, or the provider.

...

PR Recon Determination: At reconsideration, all documents were carefully reviewed. The Provider has listed non covered goals in this treatment plan. According to the Behavior Analysis Services Coverage Policy (page 4, 4.1), these goals are not covered. The goals are not necessary to protect life, to prevent significant illness, significant disability, or to alleviate severe pain. That are not 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 recipient, the recipient's caretaker, or the provider. Additionally, the provider has listed goals with overlapping topographies ("██████████" and "██████████"), goals without adequate behavioral definitions (e.g, "██████"), and has requested services that appear to be in excess of medical necessity criteria. The request for services appears to be largely based on staffing needs and not based on medical necessity criteria. This denial is upheld.

*Id.* at 41.

6. Dr. Hurley 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. Hurley asserted that Petitioner's services were denied because the treatment plan services must (1) be necessary to protect life, to prevent significant illness or significant disability or to alleviate severe pain; (2) 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; (3) 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.

7. Dr. Hurley explained the review process that is followed by eQhealth. In this review, Dr. Hurley testified that the 1<sup>st</sup> level reviewer found that the recipient had been diagnosed with autism spectrum disorder and the provider was requesting an increase to 33.5 hours per week of services that would include 22.5 of code 91154 group therapy. *Id.* at 22. Further, the 1<sup>st</sup> level reviewer stated that the requested units for code 97154 may be excessive considering the goals stated. *Id.* Also, the 1<sup>st</sup> level reviewer found that the maladaptive behaviors and the data did not warrant the hours requested. *Id.* at 22. The 1<sup>st</sup> level reviewer also recommended speech therapy and occupational therapy. *Id.* As the provider was increasing the requested units under code 97154, group therapy, Dr. Hurley explained that group therapy must be structured and have clear therapeutic goals. 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. Hurley testified that the second reviewer wrote that the treatment plan contained goals that did not meet medical necessity requirements, such as fine motor and telling time skills. *Id.* at 24. Further, these goals do not require an ABA trained analyst to teach. These goals can be taught in a less costly but equal manner. *Id.* at 24. The second level reviewer denied the request for behavior analysis services based upon the documentation submitted. *Id.* at 24. 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 contained goals that are

non-covered goals under medical necessity. *Id.* at 24. The goals can be learned in a less costly manner by someone not specifically trained in ABA. *Id.* at 24. Also, the treatment plan includes goals with overlapping topographies and goals with inadequate behavioral definitions. *Id.* at 24. The prior denial was upheld. *Id.*

8. Dr. Hurley established that an effective treatment plan is built around maladaptive behaviors (which decrease in frequency) and replacement skills to be acquired (which increase in frequency) over the course of treatment. Dr. Hurley testified as to specific areas of the treatment plan. The Treatment Plan indicates that questions concerning time, days, weeks, and months as well as concepts of time such as morning, afternoon, or lunch are included in the group session. *Id.* at 137. These are examples for which someone other than an ABA trained individual can teach the concepts in a less costly but equally efficient manner. Another area in the treatment plan involves increasing the recipient's hand strength. Dr. Hurley testified that such a goal is clearly out of the realm of ABA therapy. *Id.* at 173. Dr. Hurley stated that such a goal may be best referred to an occupational therapist.

9. ██████████ sought to challenge the position taken by Dr. Hurley that all aspects of an ABA therapy, including the treatment plan, must meet medical necessity. ██████████ suggested that if due to a patient's behavior, an outside therapist, such as an occupational therapist would not become involved with the patient, then the BCBA or the BCBA-D should undertake action for items such as ██████████ or ██████████ even though such actions are not areas of ABA or that such items can be taught by someone not specifically trained in ABA. ██████████ did not agree with applying medical necessity in that type of circumstance. ██████████ also questioned the statements made by the reviewers that the number of group

goals were minimal. [REDACTED] inquired what number of goals would be enough. Dr. Hurley indicated that determining the goals for an individual or group is a professional function for the BCBA or BCBA-D. Some goals may be accomplished quickly and with very little time. Others may be more complex and require repeated training. Dr. Hurley stated that the best way a professional could support the selected goals is to provide sufficient detail as to the specific goal, its purpose and the potential time that is required to achieve the goal. In this case, Dr. Hurley testified that the various reviewers found that based upon the documentation provided that the goals represented minimal objectives.

10. [REDACTED] testified on behalf of the Petitioner. [REDACTED] testified that [REDACTED] was required to be at school the entire day with [REDACTED]. The current program with [REDACTED] was the only option available for [REDACTED]. Obtaining other therapists to handle non-ABA matters has not been possible. [REDACTED] stated that [REDACTED] behavior was such that [REDACTED] could not even [REDACTED]. There would need to be another adult present to help handle [REDACTED].

11. [REDACTED] testified that during [REDACTED] group sessions, data is being collected all during the day and that a patient may be moved in and out of a group depending on that patients conduct that day. [REDACTED]. This Petitioner is not currently enrolled in a school, however that is part of [REDACTED]'s approach with [REDACTED] to get [REDACTED] prepared to return to a school setting. [REDACTED] testified that there are no specific requirements for group settings. [REDACTED] explained the various goals used in the group setting. [REDACTED] explained that some of the goals have been described as academic and could be taught by someone other than an ABA trained individual. [REDACTED]

disagrees because at the time when these skills would have been learned, the Petitioner was not capable of learning. Further, neither [REDACTED] nor the Petitioner's [REDACTED] have been able to secure the services of an occupational therapist. [REDACTED] also took exception with the statement that there are general standards of care. [REDACTED] stated that there are no general standards of care when referring to ABA. [REDACTED] testified that just because a skill does not meet medical necessity should not prevent [REDACTED] office from teaching that skill if it improved a quality-of-life issue. [REDACTED] expressed [REDACTED] disagreement with the medical necessity requirements as established by the legislature.

12. Dr. Hurley testified on rebuttal that based upon the data presented and the treatment plan there are goals of the treatment plan that do not meet medical necessity as required by the current law.

#### **CONCLUSIONS OF LAW**

13. 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).

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

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

16. States must provide Early and Periodic Screening, Diagnostic, and Treatment (“EPSDT”) services to Medicaid-eligible children under age 21 when requested under the Medicaid state plan. *See* 42 U.S.C. § 1396a(a)(43); 42 U.S.C. § 1396d(a)(4).

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

19. 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.

20. 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

21. 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.

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**1.4.6 Medically Necessary/Medical Necessity**

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

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**2.0 Eligible Recipient**

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**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.

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#### **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.)

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#### **4.2.4 Discharge**

Recipients receiving Florida Medicaid BA services who meet one or more of the following will be considered for discharge from services:

- The recipient is no longer eligible for BA services as outlined in the Florida Medicaid Behavior Analysis Services Coverage Policy, incorporated by reference in Rule 59G-4.125, F.A.C.
- The recipient no longer meets medical necessity criteria as defined in Rule 59G-1.010, F.A.C.
- The recipient no longer engages in maladaptive behaviors.
- Data indicates the frequency and severity of maladaptive behavior(s) or level functional impairment no longer poses a barrier to the recipient's ability to function in his/her environment.
- The level of functional impairment as expressed through behaviors no longer justifies continued BA services.
- Parent or guardian withdraws consent for treatment

#### **4.3 Early and Periodic Screening, Diagnosis, and Treatment**

As required by federal law, Florida Medicaid provides services to eligible recipients under the age of 21 years, if such services are medically necessary to correct or ameliorate a defect, a condition, or a physical or mental illness. Included are

diagnostic services, treatment, equipment, supplies, and other measures described in sectioned 1905(a) of the Social Security Act, codified in Title 42 of the United States Code 1396d(a). As such, services for recipients under the age of 21 years exceeding the coverage described within this policy or the associated fee schedule may be approved, if medically necessary. For more information, please refer to Florida Medicaid's Authorization Requirements Policy.

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## **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.

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Pages 1 – 8 of BA Policy.

22. 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.

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Page 3 of Authorization Policy.

23. In this case, Respondent denied Petitioner's BA services. The NOO and NRD explained that Petitioner's request for services and treatment plan did not meet medical necessity as defined by Fla. Admin. Code R. 59G-1.010.

24. As provided in the BA policy and the EPSDT requirements, the recipient must meet the meet the medical necessity criteria as outlined in Fla. Admin. Code R. 59G-1.010. A component of medical necessity is that services must be "necessary to protect life, to prevent significant illness or significant disability, or 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," and "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." See supra ¶ 20. As outlined above, Dr. Hurley provided credible and persuasive testimony identifying several instances where the revised Treatment Plan did not follow generally accepted standards of ABA. For example, the documentation provided for review included goals that do not meet medical necessity and therefore are not covered goals. Further, there are skills being taught that do not require someone trained in ABA services. The skills could be taught in a less costly and equally effective manner. See supra ¶ 7. Thus, Respondent demonstrated that, based on the information in the record, the requested BA services do not meet the requirement of being medically necessary. Because the services are not consistent with medically necessary standards, a critical element for authorization is not met. See supra ¶ 6.

25. In this case, Petitioner's provider recommended the continuation of BA services. However, the fact that a provider has prescribed, recommended, or approved medical or allied

care, goods, or services does not, in itself, make such care, goods or services medically necessary or a medical necessity or a covered service. See supra ¶ 20.


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

27. Upon consideration of the testimony provided, Petitioner's Composite Exhibit 1, Respondent's Composite Exhibit 1, Respondent's Composite Exhibit 2, and the applicable law and policies, the undersigned finds that Respondent proved by a preponderance of the evidence that Respondent's denial of BA services was correct.

**DECISION**

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

**DONE** and **ORDERED** this 22<sup>nd</sup> day of July 2024, in Tallahassee, Leon County, Florida.

  
George L. Winslow, Jr.  
24-FH1156  
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**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**