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

FILED

Aug 16, 2024, 2:50 pm

OFFICE OF FAIR HEARINGS

[redacted]

PETITIONER,

AHCA Case No.: 24-FH1492

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 25, 2024, at 9:05 a.m. EST.

APPEARANCES

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

For the Respondent: Marielisa Amador
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], BCBA ("[redacted]"), appeared and testified on behalf of the Petitioner. [redacted], BCaBA, ("[redacted]") testified on behalf of the Petitioner. [redacted], the recipient's [redacted] testified on behalf of the Petitioner.

Marielisa Amador, 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. Joseph Darling, ("Dr. Darling") 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.

Leslie, #385261 appeared to provide translator services.

Ivan, #390918 appeared to provide translator services.

Petitioner did not introduce any documents as evidence for the Fair Hearing.

Prior to the hearing, Respondent sent to the Office of Fair Hearings and Petitioner a two hundred and ninety-eight (298)-page evidence packet. The packet appears in the Office of Fair Hearings' case management system as "[redacted] FH 07.25.2024 1-89.pdf," "[redacted] FH 07.25.2024 90-133.pdf," "[redacted] FH 07.25.2024 134-197.pdf," "[redacted] FH 07.25.2024 198-243.pdf," "[redacted] FH 07.25.2024 244-295.pdf," and "[redacted] FH 07.25.2024 296-298.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-FH1492 AHCA Evidence (Pages1-49 of 49).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 22. The Petitioner has been diagnosed with [redacted]. *Id.* at 26. The Petitioner has exhibited maladaptive behaviors including [redacted], [redacted], [redacted], [redacted], [redacted], [redacted], [redacted], [redacted], [redacted], [redacted], [redacted], [redacted], [redacted] and [redacted]. *Id.* at 73-74.

3. Petitioner requested the following BA services: 3,120 units of code 97153, 104 units of code 97155, 312 units of 97155HN and 208 units of code 97156HN for the certification period of April 23, 2024, through October 19, 2024. *Id*. at 30.

4. On April 18, 2024, Respondent issued a Notice of Outcome ("NOO"), terminating Petitioner's BA services. *Id.* at 30-32. 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 NOO further provided:

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

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

Id. at 30-31.

5. Petitioner requested reconsideration of the Respondent's decision. On May 3, 2024, Respondent issued a Notice of Reconsideration Determination ("NRD") upholding its decision. *Id.* at 42-43. 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.
> 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. According to the Florida Medicaid State Plan (page 8, 6.2.3), the data provided must show evidence that the frequency of the maladaptive behavior(s) has decreased since the last review and, if not, that there is a modification of the behavior plan. The recommendations for procedural modifications include: additions/changes to treatment plan to impact behaviors targeted for reduction.

> Procedural modifications should include one or more of the following: antecedent manipulation modifications, modifications of prompting procedures used in acquisition, modifications in consequence-based strategies—ones that either reduce maladaptive behavior or reinforce replacement behavior (e.g., manipulation of reinforcement schedules, switch to a different decelerative procedure), or if lack of progress was due to therapist error (e.g., poor data collection or poor training on intervention methods), how you will address human error. The provider has not addressed the lack of progress during the last observation period and did not amend the treatment plan in relation to the lack of progress or the proposed changes have little chance at improving behavior. The information submitted does not meet standards of care within the field of behavior analysis. This denial is upheld.

Id. at 42-43.

6. Dr. Darling 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. Darling asserted that Petitioner's services were denied because the treatment plan is not consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational and therefore does not meet the conditions of being medically necessary. Dr. Darling testified that the treatment plan and services have not met the conditions of medical necessity and the treatment has not been effective.

7. Dr. Darling explained the review process that is followed by eQhealth. In this review, Dr. Darling testified that the 1st level reviewer found that the recipient had been diagnosed with [redacted] and the provider was requesting 34 hours per week of services. *Id.* at 25. 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 first reviewer found that the treatment plan could not be approved as submitted and referred the matter to a second level reviewer. *Id* at 26. 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. Darling testified that the second reviewer wrote that the data must show evidence that the frequency of the maladaptive behavior(s) has decreased since the last review and, if not, that there is a modification of the behavior plan. *Id.* 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 provider had not addressed the lack of progress during the last observation period and did not amend the treatment plan in relation to the lack of progress *Id.* at 26. The prior denial was upheld. *Id.* at 26.

8. Dr. Darling 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. Dr. Darling testified that the recipient needs the benefits of ABA services. However, Dr. Darling testified that this provider has failed to establish a Treatment Plan that will accomplish the purpose of ABA and provide this recipient with effective ABA treatment.

9. Dr. Darling reviewed the generally accepted professional standards found at page 28 of RCE 2. Dr. Darling stated that ABA is based upon reliable scientific evidence. The standards of care are reviewed by three different agencies. First is the Behavior Analyst Certification Board, next the Association of Professional Behavior Analysts and also by the Council of Autism Service

Providers. Also, later in Dr. Darlings rebuttal testimony, he referenced additional professional standards materials such as: Applied Behavior Analysis 3rd Edition by Cooper, Heron, and Heward; Handbook of Applied Behavior Analysis 2nd Edition by Fisher, Piazza and Roane; and other publications on Behavior Modification. Dr. Darling sought to establish through his testimony that there are several avenues to learn the professional standards in ABA services.

10. Dr. Darling reviewed the treatment plan submitted for review. Dr. Darling began with the treatment plan graphs for maladaptive behaviors. There are twelve listed maladaptive behaviors. The first graph is for [redacted]. Dr. Darling testified as the graph is reviewed from left to right and there is very little change in the behavior throughout the treatment authorization period nor are there any modifications or interventions noted by the behavior analyst. *Id.* at 192. The data on the graph begins in late [redacted] and continues until [redacted] which is the last authorization period. The data points in [redacted] begin at [redacted] and end in [redacted] at [redacted]. This graph demonstrates that very little reduction in the maladaptive behavior occurred during this authorization period. Dr. Darling testified that in this type of situation, the lead analyst should be making modification adjustments to the treatment plan and reflect those modifications on the graph every three (3) or four (4) data points to promote additional reduction in the maladaptive behavior. The next graph for review was [redacted]. This graph is very similar to the graph for [redacted]. The [redacted] graph also begins in late [redacted] and runs to the beginning of [redacted]. As previously stated, this time period represents the last authorization period. The data points in [redacted] are [redacted] and the data points in [redacted] are [redacted]. *Id.* at 193. Dr. Darling testified that this graph reflects very little improvement in reducing the maladaptive behavior.

There are several points where the behavior drops substantially. As pointed out by Dr. Darling, these reductions occurred when the recipient was not attending services and an accurate full accounting of the behaviors did not occur. These time periods were for school or holiday breaks or when the regular RBT was not present. The next maladaptive behavior graph reviewed is for [redacted]. This graph actually shows an increase in the behavior during the authorization period. The data begins in [redacted] and ends in [redacted] *Id.* at 196. The sharp reduction in behavior occurs when the recipient did not attend sessions during school breaks or illnesses and a full accounting of the behavior did not occur. Dr. Darling testified that the denial of the providers request for behavior analysis services was based upon the lack of progress in reducing the maladaptive behaviors and the lack of modifications during the authorization period.

11. In summary, Dr. Darling testified that the treatment plan showed a lack of progress in reducing the maladaptive behaviors after a period of six months and there were no interventions or modifications noted on the graphs during the same six months. Dr. Darling found the treatment plan to be ineffective and the lack of progress in reducing the maladaptive behaviors and the lack of timely modifications was the basis for the denial of the request for services. The treatment plan was not consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational and therefore did not meet the requirements of being medically necessary.

12. [redacted], the Petitioner's BCBA, testified on behalf of the Petitioner. [redacted] gave a general description of the recipient and the fact that [redacted] did not communicate. The recipient had been in services since [redacted]. [redacted]

[redacted] believed that the recipient should have been in ABA services much earlier and the younger an individual receives ABA services the better the result. Older recipients can prove to be more difficult in modifying the maladaptive behaviors. [redacted] extensively concerning the treatment plan and how adjustments were made during the authorization period. In the past, services had been reduced during prior Fair Hearings. [redacted] stated that there is no specific number to identify a lack of progress and [redacted] felt that the recipient did show progress on the graphs included in the treatment plan. [redacted] testified that some changes were made to the treatment plan before the denial of services was issued and changes made after the denial were intended to comply with the reviewers' observations. [redacted] pointed to changes made to the behavioral program contained in the treatment plan. *Id.* at 70. [redacted] identified [redacted] and [redacted] requiring interventions or changes. [redacted] also identified a new maladaptive behavior, [redacted]. [redacted] believed that the recipient was making progress under the treatment plan.

13. [redacted], BCaBA testified on behalf of the recipient. [redacted] testified that the recipient was making progress in all areas. [redacted] outlined the percentage of improvement for each of the maladaptive behaviors. *Id.* at 79-80. The chart setting forth the percentage of improvement is found on pages 79-80 of RCE 1 and begins with the initial baseline in [redacted]. [redacted] stated that the [redacted] had shown improvement due to the establishment of a new baseline on December 16, 2023 after new

behaviors had been observed. [redacted] stated that progress had been made in all of the maladaptive behaviors since [redacted]. [redacted] testified that even in the new behavior of [redacted], even in a short time period, some improvement had been made.

14. [redacted]

15. Dr. Darling testified on rebuttal that there are twelve (12) listed maladaptive behaviors and there has been a lack of progress in the last six (6) months which is the last authorization period. When a re-authorization is made, the review is for the last authorization period, which in this case was from [redacted] to [redacted]. In considering the changes to the behavioral program listed at page 70 of RCE 1 by the provider, Dr. Darling noted it only lists two existing behaviors and one new maladaptive behavior. Under the [redacted], no modification was made or listed. As for [redacted], the definition was changed but there was no modification made to reduce the maladaptive behavior. Also, there are nine (9) other behaviors that were not modified during the treatment period. Interventions and modifications should occur during the treatment period and not at the end of the period.

CONCLUSIONS OF LAW

16. 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).

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

18. 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.).

19. 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).

20. 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.

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

22. 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.

23. 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

24. 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 no 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 much be delivered to reduce maladaptive behaviors and assist the recipient reach the best possible function level for that individual. Services include:

- Adaptive behavior treatment by protocol - behavior analysis services provided according to the authorized treatment protocol
  - Services may be provided by Lead Analyst, BCaBA, or RBT
- Adaptive behavior treatment with protocol modification – behavior analysis services provided with modifications to the authorized treatment protocol to address behavior and/or response changes or progress
  - Services may be provided by Lead Analyst or BCaBA
- Group adaptive behavior treatment by protocol – behavior analysis services provided in a group setting according to the authorized treatment protocol
  - Maximum group size is six recipients
  - Services may be provided by Lead Analyst, BCaBA, or RBT
- Group adaptive behavior treatment with protocol modification – behavior analysis services provided in a group setting with modifications to the authorized treatment protocol to address behavior and/or response changes or progress
  - Maximum group size is six recipients
  - Services may be provided by Lead Analyst or BCaBA
- Family adaptive behavior treatment guidance – parent, guardian, and/or caregiver training on the implementation of the behavior plan and intervention strategies
  - The recipient may or may not be present depending upon clinical appropriateness.
  - Services may be provided by Lead Analyst or BCaBA
  - The Lead Analyst may provide up to two hours per week of training to parents or guardians via telemedicine in accordance with Rule 59G-1.057, Florida Administrative Code (F.A.C.)

. . .

4.2.4 Discharge

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

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

4.3 Early and Periodic Screening, Diagnosis, and Treatment

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

. . .

5.0 Exclusion

5.1 General Non-Covered Criteria

Services related to this policy are not covered when any of the following apply:

- The service does not meet the medical necessity criteria listed in section 1.0
- The recipient does not meet the eligibility requirements listed in section 2.0
- The service unnecessarily duplicates another provider's service

5.2 Specific Non-Covered Criteria

Florida Medicaid does not cover the following as part of this service benefit:

- Any procedure or physical crisis management technique that involves the use of seclusion or manual, technical, or chemical restraint utilized to control behaviors
- Services for the delivery of recipient supervision, personal care assistance (e.g., acting as a 1:1 aid), companion, chaperone, or shadow regardless of activity or setting. This may include supports and services that are reimbursed through a different Florida Medicaid service benefit or are able to be provided by individuals without professional skills or training.
- Caregiver or childcare services

- Psychological testing, neuropsychology, psychotherapy, cognitive therapy, sex therapy, psychoanalysis, hypnotherapy, or long-term counseling
- Services funded under section 110 of the Rehabilitation Act of 1973
- Services not listed on the fee schedule
- Services on the same day as behavioral health overlay services*
- Services on the same day as therapeutic behavioral on-site services*
- Services on the same day as therapeutic group care services*
- Services provided simultaneously by more than one BA provider, unless determined to be medically necessary, prior authorized, and indicated in the approved behavior plan
- Travel Time

* These services include behavior analysis treatment.

Florida Medicaid may cover some services listed in this section through a different service benefit.

6.0 Documentation

6.2 Specific Criteria

Providers must maintain the following documentation in the recipient's file:

6.2.1 Referral Information

Original referral documentation must be maintained in the recipient's medical record.

6.2.2 Behavior Assessment and Behavior Plan

The behavior assessment and behavior plan must be signed by the Lead Analyst and the recipient's parent or guardian. Each behavior assessment and behavior plan must include:

- Patient information
- Reason for referral
- Medical and developmental history, including medications prescribed to ameliorate behaviors
- Relevant family history
- Clinical interview
- Review of recent assessments/reports (file review)
- Assessment procedures and results
- Behavior plan
    - Treatment setting(s)
    - Proposed treatment targets, goals, and objectives related to medically necessary behavioral interventions
    - For each:
        - Definition in observable, measurable terms
        - Direct observation and measurement procedures
        - Current level (baseline)
        - Behavior reduction or acquisition procedures

        - Condition(s) under which behavior is to be demonstrated and mastery criteria
        - Date of introduction
        - Estimated date of mastery
        - Plan for generalization
        - Timely reporting of progress, including statements as to whether goal or objective is met; not met; or, modified (with explanation)
    - Parent/guardian/caregiver training
        - Proposed targets, goals, and objectives (as above)
        - Training procedures
        - Date of introduction
        - Estimated date of mastery
    - Number of units requested
        - Number of units for each billing code
        - Medical necessity for units requested
    - Supervision plan, including name(s) of authorized supervisor(s)
    - Care coordination with parents/caregivers, schools, state disability programs, and others as applicable
    - Transition (fading) plan
    - Crisis management plan
    - Discharge plan

6.2.3 Assessment and Behavior Plan for Reauthorization and Continuation of Services

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

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

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

. . .

Pages 1 – 8 of BA Policy.

25. 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.

26. In this case, Respondent 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 "[c]onsistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational" and 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.

27. As provided in the BA policy and the EPSDT requirements, the recipient must 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 "consistent with generally accepted professional medical standards." As outlined above, Dr. Darling 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 did not show any decrease in maladaptive behaviors or increase in replacement behaviors and the provider failed to make necessary interventions or modifications to the treatment plan in order to effectively reduce maladaptive behaviors and increase replacement behaviors. *See* supra ¶ 7, 9, 10. Thus, Respondent demonstrated that, based on the information in the record, the requested BA

services are not "consistent with generally accepted professional medical standards." Because the services are not consistent with generally accepted professional medical standards, the critical element of medical necessity is not met. *See* supra ¶ 6.

28. 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 ¶ 23.

29. 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.

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 Respondent proved by a preponderance of the evidence that Respondent's termination of BA services was correct.

DECISION

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

DONE and **ORDERED** this 16th day of August 2024, in Tallahassee, Leon County, Florida.

George L. Winslow, Jr.
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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]

AHCA Medicaid Hearing Unit
MedicaidHearingUnit@ahca.myflorida.com