

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



FILED

Feb 03, 2023, 3:15 pm
OFFICE OF FAIR HEARINGS

[REDACTED]

PETITIONER,

AHCA Case No.: 22-FH1714

vs.

AGENCY FOR HEALTH CARE
ADMINISTRATION,

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic Fair Hearing in the above-styled case on November 1, 2023, at 9:32 a.m. Eastern Standard Time ("EST").

APPEARANCES

For the Petitioner:

[REDACTED]

Petitioner's Authorized Representative

For the Respondent:

Linda Latson
Registered Nurse Specialist
Agency for Health Care Administration

STATEMENT OF ISSUES

The issue is whether Respondent proved by a preponderance of the evidence that Respondent's termination of Petitioner's Behavior Analysis ("BA") Services was correct.

PRELIMINARY STATEMENT

All parties and witnesses appeared telephonically. [REDACTED]

Petitioner's Authorized Representative and [REDACTED] testified on behalf of Petitioner. Olga

Betancourt, Licensed Mental Health Counselor, and Maria Medina, CEO, at [REDACTED] appeared as witnesses for Petitioner.

Linda Latson, Registered Nurse Specialist for the Agency for Health Care Administration (“Agency” or “AHCA”), appeared as a representative for Respondent. Dr. David Bicard (“Dr. Bicard”), Board Certified Behavior Analyst and the doctoral level (“BCBA-D”) and Director of Clinical Operations at eQHealth Solutions, Inc. – Florida Division (“eQHealth”), appeared as a witness for Respondent.

Interpreter George, ID No. 31578792, with Global Interpreting Network, provided translation services for Petitioner.

Petitioner did not introduce any exhibits at the hearing. Prior to the hearing, Respondent sent to the Office of Fair Hearings and Petitioner a three hundred and fifteen (315)-page evidence packet. The evidence packet is maintained in the Office of Fair Hearings’ case management system as “[REDACTED] FH 11.01.2022 1-167.pdf,” “[REDACTED] FH 11.01.2022 168-308.pdf,” and “[REDACTED] FH 11.01.2022 309-315.pdf.” Absent an objection from Petitioner, the undersigned admitted the evidence packet into evidence as Respondent’s Composite Exhibit 1.

Respondent also sent to the Office of Fair Hearings and Petitioner a forty-nine (49) page evidence packet. The evidence packet is maintained in the Office of Fair Hearings’ case management system as “22-FH1714 AHCA Evidence BA Svcs 49 Pages.pdf.” Absent an objection from Petitioner, the undersigned admitted the evidence packet into evidence as Respondent’s Composite Exhibit 2.

FINDINGS OF FACT

1. Petitioner receives Medicaid services on a fee-for-service basis from the Agency. See Respondent's Composite Exhibit 1 at page 21. eQHealth is a Quality Improvement Organization ("QIO") contracted by the Agency to review prior authorization requests for services. See Respondent's Composite Exhibit 2 at page 2. The Agency, through contractual agreement, authorized eQHealth to make Medical Necessity determinations for services requiring prior authorizations, including Behavior Analysis services. *Id.*

2. As of the date of the Fair Hearing, Petitioner is [REDACTED] years old and diagnosed with [REDACTED]. See Respondent's Composite Exhibit 1 at page 21. Petitioner receives BA services from [REDACTED]. *Id.* Petitioner's Behavior Analysis Assessment, updated August 5, 2022, ("Treatment Plan"), identifies the following maladaptive behaviors for reduction: [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED] *Id.* at 255-264.

3. On August 8, 2022, Petitioner requested a continuation of BA services. *Id.* at 21. For the certification period of August 8, 2022, through February 3, 2023, Petitioner requested 312 units of code 97155 Intervention with Protocol Modification, per 15 minutes; 208 units of code 97156 Family Training, per 15 minutes, Lead Analyst; and 3,120 units of code 97153 Intervention Without Protocol Modification, per 15 minutes, Lead Analyst, BCaBA, or RBT, *Id.* at 24-25.

4. On August 11, 2022, and August 22, 2022, eQHealth sent Petitioner's provider Request for Additional Information letters. *Id.* at 50-52. The August 11, 2022, request asked for a copy of Petitioner's Individualized Education Plan ("IEP"). *Id.* at 52. The August 22, 2022, requested additional information pertaining to the data in the Treatment Plan, which "displays minimal

progress in both behavior reduction and skill acquisition goals since the last review period, many of which have been in the same STO or LTO status for over two review periods.” *Id.* at 51.

5. On September 1, 2022, eQHealth issued a Notice of Outcome (“NOO”) letter that denied Petitioner’s request and thereby terminated BA services. *Id.* at 28-29. The NOO explained that the requested services were terminated because they are not medically necessary, and stated as follows:

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

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

The rationale for our decision is as follows:

...

Requested services are denied because documentation is neither showing [i]mprovement nor support for maintenance.

PR Clinical Rationale – Denial: s recipient has received services since June of 2018;. According to the Florida Medicaid State Plan (Appendix 9.3.b), 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 behavior reduction goals and skill acquisition goals have been in progress on the same STO since the previous review period or two; with most recent progress dating back to 2021 and 2020. The provider was requested to submit additional information on treatment modification to determine the medical necessity of this request and the submitted does not meet standards of care within the field of behavior analysis. This request is denied.

Id. at 28-29.

6. Dr. Bicard established that data graphs for maladaptive behaviors in the Treatment Plan should show the following: looking at the data from left to right on the graphs, the value of the

data should be *decreasing* if progress is being made in treatment. The value of the data for [REDACTED] is unchanged and shows no progress, and Petitioner has been working on the same Short Term Objective (“STO”) since [REDACTED], with no progress. *Id.* at 255-256. The value of the data for [REDACTED] show no progress, and Petitioner has been working on same STO since [REDACTED]. *Id.* at 256-257. The data for “[REDACTED]” show Petitioner is engaging in [REDACTED] 40-50% of the time during last authorization period with no improvement. *Id.* at 257-258. The data for “[REDACTED]” is variable but shows no progress, and Petitioner has been working on the same STO since [REDACTED]. *Id.* at 258-259. The data for “[REDACTED]” shows Petitioner is engaging in the behavior approximately 40% of the time with no progress, and Petitioner is still working on a STO initiated in [REDACTED]. *Id.* at 259-260. The data for “[REDACTED]” shows no improvement, and Petitioner has been working on the same STO [REDACTED]. *Id.* at 260-261. The data for “[REDACTED]” show no improvement and Petitioner has been working on the same goal since [REDACTED]. *Id.* at 261-262. The data for [REDACTED] are variable but show no overall progress, and Petitioner is working on a STO initiated [REDACTED]. *Id.* at 262-263.

7. Dr. Bicard established that data graphs for replacement behaviors in the Treatment Plan should show the following: looking at the data from left to right on the graphs, the value of the data should be *increasing* if progress is being made in treatment. The data for “[REDACTED]” is variable between 40 to 60% with no improvement, and Petitioner is still working on an STO initiated in [REDACTED]. *Id.* at 281-282. The data for “[REDACTED]” is variable at approximately 50% with no improvement. *Id.* 282-283. The data for “[REDACTED]” are variable between 50-60% with no improvement, and Petitioner is still working on a goal that was

initiated in [REDACTED]. *Id.* at 283-284. The data for “[REDACTED]” are variable between 50-60% with no improvement, and Petitioner is still working on the same goal since [REDACTED]. *Id.* at 284-285. The data for “[REDACTED]” are around 60% and the recipient has been working on the same goal since [REDACTED]. *Id.* at 285-286. The data for “[REDACTED]” are variable with no real improvement. *Id.* at 286-287. The data for “[REDACTED]” are around 50% with no improvement, and Petitioner has been working on the same goal since [REDACTED]. *Id.* at 287-288. The data for “[REDACTED]” are around 50% with no improvement, and Petitioner has been working on goal since [REDACTED]. *Id.* at 288-289. The data for “[REDACTED]” and “[REDACTED]” are at or below 50% with no improvement, and Petitioner has been working on the same goal since [REDACTED]. *Id.* at 289-291. The data for “[REDACTED]” show no improvement and are mostly below 50%, or chance level, after [REDACTED] of treatment. *Id.* at 291-292. The data for “[REDACTED]” hover around 50% with no improvement after [REDACTED] therapy. *Id.* at 292-293. The data for “[REDACTED]” are below chance level after [REDACTED] of treatment. *Id.* at 293-294.

8. On September 8, 2022, Petitioner requested reconsideration. *Id.* at 39. On September 15, 2022, eQHealth issued a Notice of Reconsideration Determination (“NRD”) upholding the termination of Petitioner’s BA services. *Id.* at 39-40. The NRD explained as follows:

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

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.

The rationale for our decision is as follows:

PR Recon Determination: At reconsideration all documents were carefully reviewed. This recipient has participated in BA services since June, 2018. According to the Florida Behavior Analysis Services coverage Policy ((.5.c), one of the criteria for discharge from behavior analysis services is that data provided show the recipient has made no progress toward any goals in the last 12 consecutive months. A review of the treatment plans from the previous 12 months shows no progress. The recommendations for treatment modification are insufficient to support continued care. This reconsideration request have been reviewed, reconsidered and the denial is upheld.

Id.

9. On September 14, 2022, Petitioner requested a Fair Hearing due to the termination of BA services. *Id.* at 8. The undersigned scheduled the hearing for November 1, 2022, at 9:30 a.m. EST, and all parties were duly notified. *Id.* at 8-11. Petitioner received administrative approval or continuation of benefits pending the outcome of the Fair Hearing. *Id.* at 24.

10. At the hearing, Dr. Bicard provided credible and persuasive testimony concerning professional standards of applied behavior analysis. Dr. Bicard established that in order to continue treatment at the present level, the data provided to eQHealth must show progress toward identified goals for maladaptive behaviors and replacement behaviors. The BA provider must submit evidence that the frequency of the maladaptive behaviors has decreased since the last review period and, if not, that there is a modification of the behavior plan to address the lack of progress. The ensures that progress is ongoing and that action is taken to ameliorate maladaptive behaviors. Based on the data graphs in the Treatment Plan, *supra* ¶¶ 6-7, Dr. Bicard testified that the documentation submitted by the BA provider failed to show progress on maladaptive behaviors and replacement behaviors for the past 12 consecutive months (and

beyond). Moreover, in the face of no improvement, the provider made no interventions to address the lack of progress. Further, the data for several of Petitioner's replacement behaviors [REDACTED] are well under 50% or well under what could be considered "chance" level. Dr. Bicard established that this is important because anything at 50% or below, means that the behavior could just be due to chance. In other words, the provider has not identified the environmental variables that are affecting the Petitioner's behavior. A skill such as "asking someone to stop doing something or to be able to leave the area" is an important skill because it is directly tied to maladaptive behavior. If Petitioner is unable to ask for escape appropriately he is likely to engage in maladaptive behaviors. Treatment failure is part of BA. But it is a temporary part because, in BA, when the recipient does not respond to treatment the provider makes change until the recipient does respond to treatment. That is a minimum standard of care within the field of BA. The documents submitted for review show the provider has not met the minimum standard of care for BA. Therefore, the treatment is not effective.

CONCLUSIONS OF LAW

11. 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. This order is the final administrative decision of AHCA under section 409.285(2)(a).

12. This hearing was held as a de novo proceeding pursuant to Florida Administrative Code Rule ("Fla. Admin. Code R.") 59G-1.100(17)(b), which states "[e]ach fair hearing shall be a de

novo, evidentiary proceeding, and shall be conducted in a manner that meets the requirements of this rule.”

13. The burden of proof in this proceeding is governed by Fla. Admin. Code R. 59G-1.100(17)(g), which provides as follows:

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

14. In the instant case, Respondent terminated an already-approved service. As such, Fla. Admin. Code R. 59G-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.).

15. The Florida Medicaid policy that applies to the requested services is the Behavior Analysis Services Coverage Policy (October 2017) (“BA Coverage Policy”). The BA Coverage Policy has been incorporated, by reference, into Fla. Admin. Code R. 59G-4.125. The BA Coverage 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.

1.1 Florida Medicaid Policies

This policy is intended for use by providers that render BA services to eligible Florida Medicaid recipients. It must be used in conjunction with Florida Medicaid’s General Policies (as defined in section 1.3) and any applicable service-specific and claim reimbursement policies with which providers must comply.

Note: All Florida Medicaid policies are promulgated in Rule Division 59G, Florida Administrative Code (F.A.C.). Coverage policies are available on the Agency's Web site at <http://ahca.myflorida.com/Medicaid/review/index.shtml>.

...

2.2 Who Can Receive

Florida Medicaid recipients under the age of 21 years requiring medically necessary BA services. 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:

...

4.2.2 Behavior Analysis

Up to 40 hours per week, per recipient, consisting of services identified on the recipient's behavior plan in order to reduce maladaptive behaviors and to restore the recipient to his or her best possible functional level. Services include:

- Implementing behavior analysis interventions, and monitoring and assessing the recipient's progress towards goals in the behavior plan;
- Behavior analysis interventions, for example, discrete trial teaching, task analysis training, differential reinforcement, non-contingent reinforcement, conducting task analyses of complex responses, and teaching using chaining, prompting, fading, shaping, response cost, and extinction; and
- Training the recipient's family, caregiver(s), and other involved persons on the implementation of the behavior plan and intervention strategies (the recipient must be present when clinically appropriate)

4.2.3 Behavior Reassessment

Up to three per fiscal year, per recipient

BA Coverage Policy at pages 1-3.

16. The BA Coverage Policy contains the following additional review criteria for behavior analysis Services:

Review Criteria for Behavior Analysis Services

Behavior analysis (BA) services are considered as either the treatment of choice or as an adjunct treatment modality for a variety of conditions and disorders where maladaptive behaviors are part of the recipient's clinical presentation, including behavioral manifestations of diagnoses such as Autism Spectrum Disorder and other behavioral health conditions.

...

Critical Elements Necessary for ANY Type of Behavior Analysis Service:

The following critical elements **MUST** be satisfied to qualify for BA services:

- a. Eligibility – The recipient must meet all criteria for BA services as outlined in the Behavior Analysis Services Coverage Policy, Rule 59G-4.125, F.A.C.
- b. Medical necessity – The recipient must meet medical necessity criteria as outlined in in Rule 59G-1.010, F.A.C.
- c. The recipient currently engages in maladaptive behaviors
- d. These maladaptive behaviors interfere with the recipient's daily functioning

1. Criteria for Initial Behavior Analysis Assessment – BOTH of the following **MUST** be satisfied:

- a. **ALL** critical elements are met
- b. Provider submits a valid written physician's order as stipulated in the Behavior Analysis Services Coverage Policy, Rule 59G-4.125, F.A.C.

2. Criteria for Behavior Analysis Services and Reassessments - ALL of the following **MUST** be satisfied:

- a. ALL critical elements are met
- b. An assessment or, if applicable, a reassessment, authored by a lead analyst, is provided. An assessment of the maladaptive behavior(s) is a necessary element of the process of identifying the frequency and magnitude of the behaviors as well as the variables associated with the occurrence of the maladaptive behavior(s). This helps in defining what are the functional consequences of the problem behavior(s) so that an adequate behavior plan can be implemented. This (re)assessment **MUST** include, at a minimum, ALL of the following:
 - i. A clear operational description of the maladaptive behavior(s)
 - ii. Baseline and/or updated treatment data (if reassessment)
 - iii. Progress toward identified goals (if a reassessment)
 - iv. Identification of the events, times, and situations that appear to be associated to the occurrence of the maladaptive behavior(s)
 - v. Identification of the functional consequences of the maladaptive behavior(s)
 - vi. Development of hypotheses and summary statements that describe the maladaptive behavior(s) and its(their) functions
 - vii. Summary and recommendations
- c. A behavior plan authored or updated by a lead analyst. The behavior plan is the cornerstone of the delivery of behavior analysis services and it is

based on the information obtained in the assessment. It proposes specific interventions to reduce or eliminate the maladaptive behavior. These interventions take into consideration the variables, both present before the behavior, as well as after the behavior, that influence the occurrence of the maladaptive behavior(s). This plan also includes replacement appropriate behaviors for the recipient to engage in instead of the maladaptive behaviors in order to obtain the same function. The plan must be detailed enough to warrant the requested services and include mechanisms to monitor its effectiveness. This MUST include, at a minimum, ALL of the following:

- i. Observable and measurable descriptions of the maladaptive behavior(s)
- ii. Identified function of the maladaptive behavior(s) behavior as a result of the assessment or reassessment conducted Goals and strategies for changing the maladaptive behavior(s)
- iii. Written detailed description of when, where, and how often these goals will be addressed and proposed strategies will be implemented System for monitoring and evaluating the effectiveness of the plan Safety and crisis plan, if applicable Summary and recommendations Discharge criteria Transition Plan (if applicable)

NOTE: Although the assessment and behavior plan were addressed separately in section 2, both of them can be submitted as a single document.

...

3. Criteria for Continuation of Treatment at the Present Level and/or Using Current Methods: Providers must ensure that **ALL** of the following criteria are met to request continuation of treatment at the present level or using the current methods. **If criteria for 3a is met, but criteria for 3b and/or 3c are not met, then a reduction of the treatment level and/or change of treatment methods may be warranted.**

- a. **ALL** criteria listed in 2a, 2b, and 2c regarding critical elements, assessment or reassessment, and behavior plan, are met.
- b. 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.
- c. The level of functional impairment justifies continuation of BA services. The reviewer utilizes the information provided below as a guide as it relates to the level of functional impairment as expressed through the following behaviors:
 - i. Safety – aggression, self-injury, property destruction, elopement
 - ii. Communication – problems with expressive/receptive language, poor understanding or use of non-verbal communications, stereotyped, repetitive language Self-stimulating, abnormal, inflexible, or intense preoccupations

- iii. Self-care – difficulty recognizing risks or danger, grooming, eating, or toileting
- iv. Other – behaviors not identified above

...

4. Criteria to Assess the Intensity of Behavior Analysis Services: Providers may request up to 40 hours of BA services per week, per recipient, based upon the following:

As a rule, higher number of maladaptive behaviors, higher severity and frequency of behaviors, as well as the multiplicity of settings where the behaviors occur, would usually justify a higher number of services hours. The greater the number of goals targeted to reduce maladaptive behaviors, the more the likelihood that a higher number of services hours could also be warranted.

Providers **MUST** ensure that proper justification for the requested hours of services is adequately documented in the behavior plan. Based on the information provided in the assessment, behavior plan, and any other supporting documentation, the reviewer utilizes the information provided below as a guide as it relates to the level of functional impairment as expressed through the following behaviors:

- i. Safety – aggression, self-injury, property destruction, elopement
- ii. Communication – problems with expressive/receptive language, poor understanding or use of non-verbal communications, stereotyped, repetitive language
- iii. Self-stimulating, abnormal, inflexible, or intense preoccupations
- iv. Self-care – difficulty recognizing risks or danger, grooming, eating, or toileting
- v. Other – behaviors not identified above

BA Coverage Policy, Appendix 9.0, at pages 6-8.

17. The BA Coverage Policy states the following with respect to documentation requirements for behavior analysis services:

6.0 Documentation

6.1 General Criteria

For information on general documentation requirements, please refer to Florida Medicaid's General Policies on recordkeeping and documentation.

...

6.2 Specific Criteria

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

- Behavior assessment, and assessment review that must be reviewed and signed by a lead analyst;

- Behavior plan, and behavior plan review that must be reviewed and signed by a lead analyst;
- Notations when the recipient’s family or caregiver is not able to participate in BA services, and instances when it was clinically inappropriate for the recipient to be present during training services; and
- Written physician’s order.

BA Coverage Policy at page 4.

18. The BA Coverage Policy states the following with respect to authorization requirements of behavior analysis services:

7.0 Authorization

7.1 General Criteria

The authorization information described below is applicable to the fee-for-service delivery system. For more information on general authorization requirements, please refer to Florida Medicaid’s General Policies on authorization requirements.

7.2 Specific Criteria

Providers must obtain authorization from the quality improvement organization (QIO) prior to the initiation of BA services and at least every 180 days thereafter.

Providers may request authorization more frequently upon a change in the recipient’s condition requiring an increase or decrease in services.

The QIO uses the review criteria specified in section 9.0 for the first level review. For more information on how the QIO uses the criteria in the review process, please refer to Florida Medicaid’s General Policies on authorization requirements.

BA Coverage Policy at page 4.

19. The Florida Medicaid Authorization Requirements Policy (June 2016) (“Authorization Requirements Policy”), incorporated by Fla. Admin. Code R. 59G-1.053, provides general requirements for providers to obtain authorization to render Florida Medicaid services. It states the following:

1.2 Definitions

The following definitions are applicable to this policy. For additional definitions that are applicable to all sections of Rule Division 59G, F.A.C., please refer to the Florida Medicaid definitions policy.

...

1.3.1 Authorization

The process of obtaining approval for reimbursement of a service based on medical necessity.

...

1.3.6 Provider

The term used to describe any entity, facility, person, or group that has been approved for enrollment or registered with Florida Medicaid.

1.3.7 Quality Improvement Organization

Entity designated to perform utilization review, quality assurance, and quality improvement activities for Florida Medicaid-covered services rendered by fee-for-service providers (also known as the QIO).

...

2.0 Authorization Requirements

...

2.4.2 Requests for Additional Information

The QIO may request additional information, as necessary, to determine medical necessity.

...

3.0 Determination Process

3.1 Review Criteria

The QIO may use a national standardized set of criteria, or other set of criteria, approved by AHCA, as a guide for authorizations performed at the first review level. If services cannot be approved at the first level review, the QIO's physician peer reviewer will determine medical necessity using his or her clinical judgment, acceptable standards of care, state and federal laws, and AHCA's medical necessity definition.

3.2 Review Process

The QIO will review each authorization request and will approve, deny, or request additional information. The QIO may deny a portion of the requested units of service if it cannot substantiate medical necessity based upon the information submitted.

3.2.1 Continued Authorization Requests

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

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

20. States must provide Early and Periodic Screening, Diagnostic, and Treatment (“EPSDT”) services to Medicaid-eligible children under age 21 when requested under the Medicaid state plan. See 42 U.S.C. § 1396a(a)(43); 42 U.S.C. § 1396d(a)(4). According to 42 U.S.C. § 1396d(r)(5), EPSDT services mean, in relevant part, the following items and services:

Such other necessary health care, diagnostic services, treatment, and other measures described in subsection (a) of this section to correct or ameliorate defects and physical and mental illness and conditions discovered by the screen services, whether or not such services are covered under the state plan.

21. A state may place medical necessity limitations on EPSDT services. See 42 C.F.R. §§ 440.230(a), (b), (d). Pursuant to section 409.905(2), Florida Statutes:

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. Once it is determined that EPSDT applies to a request for a service, the Florida Medicaid program determines the amount or necessity for that service based on the State of Florida’s published definition of medical necessity. The Florida Medicaid Definitions Policy, which is incorporated by reference in Fla. Admin. Code R. 59G-1.010, defines “medically necessary or medical necessity” as follows:

2.83 Medically Necessary or Medical Necessity

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

- Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain
- Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient’s needs

- Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational
- Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available statewide
- Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider

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

23. In the instant case, Petitioner is under the age of 21 and therefore EPSDT applies to request for services. See supra ¶ 2. Petitioner's provider submitted a request to eQHealth for the continuation of Petitioner's BA services for the certification period of August 8, 2022, through February 3, 2023. See supra ¶ 3. As established on the record, eQHealth terminated Petitioner's BA services because Petitioner's provider failed to submit sufficient documentation to establish that the requested services were medically necessary. See supra ¶ 5, 7.

24. Pursuant to the BA Coverage Policy, the critical elements necessary for any type of BA service are: (a) eligibility – the recipient must meet all criteria for BA services as outlined in the Behavior Analysis Services Coverage Policy, Rule 59G-4.125, F.A.C; (b) medical necessity – the recipient must meet medical necessity criteria as outlined in in Rule 59G-1.010, F.A.C; (c) the recipient currently engages in maladaptive behaviors; and (d) these maladaptive behaviors interfere with the recipient's daily functioning. See supra ¶ 15.

25. Pursuant to section 2.83 of the Definitions Policy, the five (5) conditions of medical necessity must be met in order for "medical or allied care, goods, or services furnished or ordered" to be determined medically necessary. See supra ¶ 22. Accordingly, all five (5) of the conditions must be met in order for eQHealth to approve requested BA services.

26. The termination of BA services is warranted in this case as the Treatment Plan submitted to eQHealth by Petitioner's provider is ineffective and does not conform to generally accepted professional medical standards within the field of applied BA. See supra ¶¶ 5-8, 10. Dr. Bicard, a Board-Certified Behavior Analyst at the doctoral level provided credible and persuasive testimony that Petitioner has not made progress on maladaptive behaviors and replacement behaviors over the past 12 consecutive months (and beyond) based on the data graphs provided. See supra ¶¶ 6-7, 10. Additionally, the provider failed to address the lack of progress. See supra ¶¶ 10. For the above reasons, the Treatment Plan is ineffective and does not meet standards of care in applied behavior analysis. Accordingly, the record demonstrates that Treatment Plan is not individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment and is not consistent with generally accepted professional medical standards as determined by the Medicaid program. Based on the foregoing, Respondent demonstrated that the BA services at issue are not medically necessary. Therefore, the Petitioner will not gain any additional benefit by continuing BA services at the current level under this Treatment Plan.

27. Looking at all of the evidence relevant to the particular needs of Petitioner, Respondent demonstrated that the requested BA services are not necessary to correct or ameliorate defects and physical and mental illness and conditions discovered by the screen services. Therefore, in light of the both parties' testimony, Respondent's Composite Exhibit 1, Respondent's Composite Exhibit 2, and the applicable laws and policies, the undersigned Hearing Officer finds that Respondent proved by a preponderance of the evidence that Respondent's termination of Petitioner's BA services was correct.

DECISION


Respondent's termination of Petitioner's Behavior Analysis Services is **AFFIRMED**.

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

DONE and **ORDERED** this 3rd day of February 2023, in Tallahassee, Leon County, Florida.

Laura Gallagher

22-FH1714

 2023.02.03

15:06:31 -05'00'

LAURA GALLAGHER, Hearing Officer
Agency for Health Care Administration
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NOTICE OF A RIGHT TO JUDICIAL REVIEW

A PARTY WHO IS ADVERSELY AFFECTED BY THIS FINAL ORDER IS ENTITLED TO JUDICIAL REVIEW, WHICH SHALL BE INSTITUTED BY FILING THE ORIGINAL NOTICE OF APPEAL WITH THE AGENCY CLERK OF AHCA, AND A COPY, ALONG WITH THE FILING FEE PRESCRIBED BY LAW, WITH THE DISTRICT COURT OF APPEAL IN THE APPELLATE DISTRICT WHERE THE AGENCY MAINTAINS ITS HEADQUARTERS OR WHERE A PARTY RESIDES. REVIEW PROCEEDINGS SHALL BE CONDUCTED IN ACCORDANCE WITH THE FLORIDA APPELLATE RULES. THE NOTICE OF APPEAL MUST BE FILED WITHIN 30 DAYS OF THE RENDITION OF THE ORDER TO BE REVIEWED.

COPIES FURNISHED TO:



AHCA Medicaid Hearing Unit
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