

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



FILED

Jan 30, 2023, 10:45 am  
OFFICE OF FAIR HEARINGS

[REDACTED]

PETITIONER,

AHCA Case No.: 22-FH1827

vs.

AGENCY FOR HEALTH CARE ADMINISTRATION,

RESPONDENT.

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**FINAL ORDER**

Pursuant to notice, Hearing Officer Caylen Darbouze convened a telephonic Fair Hearing in the instant case on December 14, 2022, at 8:31 a.m. Eastern Standard Time (“EST”).

**APPEARANCES**

For the Petitioner:

[REDACTED]

Authorized Representative

For the Respondent:

Marielisa Amador  
Medical Health Care Program Analyst  
Agency for Health Care Administration

**STATEMENT OF ISSUE**

The issue is whether Respondent proved by a preponderance of the evidence that Respondent’s termination of Behavior Analysis (“BA”) services was correct.

**PRELIMINARY STATEMENT**

All parties and witnesses appeared for the scheduled Fair Hearing telephonically. [REDACTED]

[REDACTED] (“[REDACTED]”), Petitioner’s Authorized Representative and [REDACTED], appeared for the

Fair Hearing on behalf of Petitioner, provided testimony, and did not call any witnesses.

Marielisa Amador, a Medical Health Care Program Analyst and Fair Hearing Liaison for the Agency for Health Care Administration (“Agency” or “AHCA”), appeared for the Fair Hearing as the representative for Respondent. Dr. David Bicard (“Dr. Bicard”), a Board-Certified Behavior Analyst at the doctoral level (“BCBA-D”) for eQHealth Solutions, appeared for the Fair Hearing as a witness for Respondent. Sydney Herring, a Law Clerk for the Agency, appeared for the Fair Hearing as an observer.

Interpreter Joseph, a Spanish Interpreter for Global Interpreting Network, appeared for the Fair Hearing to provide language translation services on behalf of Petitioner.

Petitioner did not introduce any exhibits at the Fair Hearing. Prior to the Fair Hearing, Respondent filed with the Office of Fair Hearings a 185-page evidence packet, which was admitted into the record as Respondent’s Composite Exhibit 1.<sup>1</sup> Respondent’s Composite Exhibit 1 includes the following documents: a Table of Sections; Fair Hearing Physician Call-in Instructions; an Order Scheduling Fair Hearing by Telephone and Prehearing Instructions (“Scheduling Order”) (dated November 3, 2022) (English and Spanish); Outpatient Review History; a Notice of Outcome – Denial (“Notice”) (dated November 26, 2022); a Behavior Analysis Reassessment (signed on September 8, 2022); a copy of the Notice; a Notice of Reconsideration Determination (“Reconsideration Determination”) (dated October 10, 2022); a Request for Additional Information (dated September 16, 2022, and September 16, 2022); a Behavior Analysis Reassessment (signed on September 8, 2022); a Request for Additional Information (dated September 16, 2022); a Behavior Analysis Reassessment (signed on September 8, 2022); and an Acronym/Abbreviation index.

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<sup>1</sup> Filed with the Office of Fair Hearings (“Office”) on November 4, 2022.

Prior to the Fair Hearing, Respondent filed with the Office of Fair Hearings a 49-page evidence packet, which was admitted into the record as Respondent’s Composite Exhibit 2.<sup>2</sup> Respondent’s Composite Exhibit 2 includes the following documents: a Table of Contents; Memorandum – Fair Hearings Process Authorization for Quality Improvement Organization in Medical Necessity Determinations (dated October 19, 2021); Memorandum – Medical Necessity as a Limitation on Medicaid Services, Including EPSDT (dated August 5, 2014); Florida Statutes (“Fla. Stat.”) § 409.905 (excerpt); Florida Administrative Code Rule (“Fla. Admin. Code R.”) 59G-1.001; Fla. Admin. Code R. 59G-1.010; the Florida Medicaid Definitions Policy (“Definitions Policy”) (August 2017); Fla. Admin. Code R. 59G-1.035; Fla. Admin. Code R. 59G-1.053; the Florida Medicaid Authorization Requirements Policy (“Authorization Requirements Policy”) (June 2016); Fla. Admin. Code R. 59G-4.125; the Florida Medicaid Behavior Analysis Services Coverage Policy (“Behavior Analysis Policy”) (October 2017); and the Behavior Analysis Services Fee Schedule (2021 Promulgated, 2022 Updated).

**FINDINGS OF FACT**

1. Petitioner receives Medicaid services on a fee-for-service basis through the Agency. *See* Respondent’s Composite Exhibit 1, page 21. eQHealth is a Quality Improvement Organization contracted by the Agency to review prior authorization requests for Medicaid services, including Behavior Analysis services, to ensure that the request meets medical necessity. *See* Respondent’s Composite Exhibit 2, page 2.
  
2. As of the date of the Fair Hearing, Petitioner is [REDACTED] and diagnosed with [REDACTED], [REDACTED], [REDACTED], and [REDACTED], and

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<sup>2</sup> Filed with the Office on November 9, 2022.

[REDACTED]. See Respondent's Composite Exhibit 1, pages 21, [REDACTED]-45. Petitioner receives Behavior Analysis services from [REDACTED]. ("BA provider"). *Id.* at 21. The BA provider submitted a Behavior Analysis Reassessment/Support Plan ("Treatment Plan") recommending the continuation of 4 hours per week/416 units of Behavior Analysis Lead Analyst ("Lead Analyst") services and 30 hours per week/3,120 units of Behavior Analysis Technician ("RBT") services. *Id.* at 82.

3. Petitioner engages in the following maladaptive behaviors, which should decrease over the course of treatment: [REDACTED], [REDACTED], [REDACTED], [REDACTED], [REDACTED], [REDACTED], and [REDACTED]. *Id.* at 45, 48-49. The data graphs in the Treatment Plan show the following regarding the changes of these behaviors: [REDACTED] reduced from [REDACTED] incidents per week to [REDACTED] incidents per week; [REDACTED] reduced from [REDACTED] incidents to [REDACTED] incidents per week; [REDACTED] reduced from [REDACTED] incidents to [REDACTED] incidents per week; [REDACTED] reduced from [REDACTED] incidents per week to [REDACTED] incidents per week; [REDACTED] reduced from [REDACTED] incidents per week to [REDACTED] incidents per week; [REDACTED] reduced from [REDACTED] incidents per week to [REDACTED] incidents per week; [REDACTED] reduced from [REDACTED] incidents per week to [REDACTED] incidents per week and [REDACTED] reduced from [REDACTED] incidents per week to [REDACTED] incidents per week. *Id.* at 49-52. In sum, the data graphs demonstrate that all maladaptive behaviors reduced in frequency *minimally* over the previous certification period of [REDACTED]. *Id.* However, over the past 12 months, Petitioner has not shown any progress toward their maladaptive behaviors. *Id.*

4. The Treatment Plan identifies the following acquisition behaviors, which should increase in frequency over the course of treatment: [REDACTED]  
[REDACTED]; [REDACTED]; [REDACTED]; [REDACTED];

[REDACTED]; [REDACTED];  
[REDACTED]; [REDACTED]; [REDACTED];  
[REDACTED]; [REDACTED]; and [REDACTED]. *Id.* at 72-74. The following acquisition behaviors increased in frequency over the previous certification period: [REDACTED]  
[REDACTED], [REDACTED], [REDACTED], and [REDACTED]. *Id.* at 61-74. The following acquisition behaviors showed no change in frequency over the previous certification period: [REDACTED], [REDACTED]  
[REDACTED], [REDACTED], [REDACTED], [REDACTED], and [REDACTED]. *Id.* at 72-74. Over the past 12 months, Petitioner has not shown any progress toward their replacement behaviors. *Id.*

5. On September 7, 2022, Respondent issued a Notice terminating Petitioner’s Behavior Analysis services. See Respondent’s Composite Exhibit 1, pages 28-29. The Notice states the following, in pertinent part:

Code: 97153  
Description: Intervention without protocol modification, per 15 minutes, Lead Analyst, BCaBA, or RBT  
From: 9/18/22  
Thru: 3/16/23  
Total Units: Denied – 3,120

Code: 97156  
Description: Family training, per 15 minutes, Lead Analyst  
From: 9/18/22  
Thru: 3/16/23  
Total Units: Denied – 208

Code: 97155  
Description: Intervention without protocol modification, per 15 minutes  
From: 9/18/22  
Thru: 3/16/23

Total Units: Denied – 312

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 are not medically necessary under the following standards:

**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:

PR Principal Reason - Denial:

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

PR Clinical Rationale - Denial: 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 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.** The provider was requested to submit additional information on treatment modifications to determine the medical necessity of this request and the provider has either failed to submit this information or the information submitted does not meet standards of care within the field of behavior analysis or the information submitted is insufficient to address the lack of progress indicated. This request for BA services is denied.

Respondent's Composite Exhibit 1, pages 27-28. (Emphasis added).

6. On October 7, 2022, Respondent issued a Reconsideration Determination upholding the termination of Behavior Analysis services. *Id.* at 89-90. The Reconsideration Determination states the following, in pertinent part:

The rationale for our decision is as follows:

PR Recon Determination: At reconsideration all documents were carefully reviewed. 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 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 the provider will address human error. **The recommendations are insufficient to support continued care.** This reconsideration request has been reviewed, reconsidered and the denial is upheld.

Respondent's Composite Exhibit 1, pages 89-90. (Emphasis added).

7. On October 7, 2022, [REDACTED] requested a Fair Hearing on behalf Petitioner to dispute the termination of BA services. *Id.* at 24. On November 3, 2022, the undersigned Hearing Officer issued a Scheduling Order to the parties of record scheduling the Fair Hearing on December 14, 2022, at 8:30 a.m. EST. *Id.* at 8-19.

8. Based on Dr. Bicard's testimony<sup>3</sup> presented at the Fair Hearing, Respondent terminated Petitioner's Behavior Analysis services because the Treatment Plan was not "[c]onsistent with generally accepted professional medical standards as determined by the Medicaid program." Specifically, the Florida Medicaid program mandates that, "[t]he 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." *See supra* ¶ 15. Dr. Bicard relied

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<sup>3</sup> Fair Hearing audio timestamp: 19:40 – 51:00.

upon the Criteria for Discharge from Behavior Analysis Services in determining whether to terminate Petitioner's Behavior Analysis services. See Respondent's Composite Exhibit 2, pages 45-47. The effectiveness of BA therapy is determined by a visual interpretation of data graphs. The maladaptive data graphs should be descending linear (decreasing through the course of treatment) while the acquisition behaviors should be ascending linear (increasing through the course of treatment). Dr. Bicard asserted that the data graphs demonstrate that Petitioner has not made any progress through treatment over the past 12 months of receiving treatment. Dr. Bicard opined that the Treatment Plan modifications are not sufficient to ensure the Petitioner makes progress in the future.

9. Based on [REDACTED]'s testimony<sup>4</sup> presented at the Fair Hearing, Petitioner is a [REDACTED] [REDACTED] and takes longer than others to respond to treatment. No explanation was provided why Petitioner has not made progress towards their goals over the past 12 months. [REDACTED] argued that Petitioner would be better off receiving services than not receiving services. Petitioner's Behavior Analysis provider was not present at the Fair Hearing to offer any testimony with respect to the Treatment Plan, its effectiveness, and how the proposed Treatment Plan modifications would improve Petitioner's ability to make progress.

#### **CONCLUSIONS OF LAW**

10. 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).

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<sup>4</sup> Fair Hearing audio timestamp: 52:00 – 1:05:00.

11. 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.”

12. Because Respondent is terminating an existing service, Fla. Admin. Code R. 59G-1.100(17)(g) assigns the burden of proof to 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.).

13. The Florida Medicaid Behavior Analysis Policy, incorporated by reference in Fla. Admin. Code R. 59G-4.125, establishes the provision for Behavior Analysis services available to Medicaid recipients under the age of 21 years. *See* Respondent’s Composite Exhibit 2, pages 38-47. The Florida Medicaid Behavior Analysis Policy provides as follows, in pertinent part:

**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.

...

**1.4.5 Medically Necessary/Medical Necessity**

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

...

**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
- 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**

One per fiscal year, per recipient, when completed within 30 days of the start of the assessment.

#### **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 ■■■ or ■■■ best 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
- 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)

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

As required by federal law, Florida Medicaid provides services to be 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 year 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 General Policies on authorization requirements.

Respondent's Composite Exhibit 2, pages 38-47.

14. Appendix 9.0 of the BA Policy provides the Review Criteria for Behavior Analysis Services.

See Respondent's Composite Exhibit 2, pages 45-47. The Review Criteria state as follows:

#### **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 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. Provide 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 behaviors

...

- 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
- iii. Goals and strategies for changing the maladaptive behavior(s)
- iv. Written detailed description of when, where, and how often these goals will be addressed and proposed strategies will be implemented
- v. System for monitoring and evaluating the effectiveness of the plan
- vi. Safety and crisis plan, if applicable
- vii. Summary and recommendations
- viii. Discharge criteria
- ix. 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 treatments 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
  - 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

...

**5. Criteria for Discharge from Behavior Analysis Services - ONE or MORE of the following MUST be satisfied:**

- a. The critical elements are no longer met.
- b. The data provided shows that the frequency and severity of maladaptive behavior(s) has declined to the point that they no longer pose a barrier to the child’s ability to function in [redacted]/[redacted] environment.
- c. The data provided shows the recipient has made no progress toward any goals in the last 12 consecutive months.**
- d. The level of functional impairment as expressed through behaviors no longer justifies continued BA services.
- e. Parent/guardian withdraws consent for treatment.

Respondent’s Composite Exhibit 2, pages 45-47. (Emphasis added).

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

16. Petitioner is under the age of 21 years, and therefore EPSDT applies to [redacted] request for services. However, a state may place medical necessity limitations on EPSDT services. *See* 42 C.F.R. §§ 440.230(a), (b), (d). Fla. Stat. § 409.905(2) 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.

17. The Florida Medicaid Definitions Policy, incorporated by reference in Fla. Admin. Code R. 59G-1.010, provides definitions of commonly used terms that are applicable to all sections of Rule Division 59G, Florida Administrative Code (F.A.C.), unless specifically stated otherwise in a service-specific coverage policy or rule. See Respondent's Composite Exhibit 2, pages 16-27. The Florida Medicaid Definitions Policy defines "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 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, page 23. (Emphasis added).

18. The Florida Medicaid 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. See Respondent's Composite Exhibit 2, pages 30-37. The Florida Medicaid Authorization Requirements Policy 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.**

Respondent's Composite Exhibit 2, pages 30-36. (Emphasis added).

19. In the instant case, Petitioner is under the age of 21 and therefore EPSDT applies to [REDACTED] request for the reinstatement of Behavior Analysis services. Petitioner's provider submitted a request to eQHealth for the continuation of Petitioner's Behavior Analysis services for the certification period of [REDACTED]. See supra ¶ 5-6. As established on the record, eQHealth terminated Petitioner's Behavior Analysis services after determining that the recipient has not made progress over the past 12 consecutive months and that the current treatment plan is ineffective, and thus services are no longer medically necessary. See supra ¶ 5-6, 8.

20. Pursuant to the Behavior Analysis Coverage Policy, the critical elements necessary for any type of BA service are: (a) eligibility – the recipient must meet all criteria for Behavior Analysis 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 ¶ 14. Further, the Behavior Analysis Policy mandates that services can be discharged when, "[t]he data provided shows the recipient has made no progress toward any goals in the last 12 consecutive months." See supra ¶ 14. Dr. Bicard, on behalf of eQHealth, is authorized to deny the amount, frequency, or duration of a service that is already being provided, if "[t]he reviewing physician determines

the recipient will not gain any additional benefit by continuing services at the current level.” See supra ¶ 18.

21. 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 ¶ 18. Accordingly, all five (5) of the conditions must be met in order for eQHealth to approve requested Behavior Analysis services. In this case, Respondent determined that the continuation of Behavior Analysis services is *not* consistent with generally accepted professional medical standards as determined by the Medicaid program because the Petitioner has not made no progress toward any goals in the last 12 consecutive months. See supra ¶ 5-6, 8.

22. The termination of Behavior Analysis services *is* warranted in this case, as the Treatment Plan submitted to eQHealth by Petitioner’s provider in support of the request for services contains maladaptive behaviors and replacement behaviors shows that the recipient has 12 consecutive months of not making progress towards reducing maladaptive behaviors and increasing replacement behaviors. The crux of this case rests on the data graphs and the data graphs’ interpretation. Respondent determined that Petitioner made no progress over the past 12 consecutive months. Neither Petitioner’s [REDACTED] nor Petitioner’s Behavior Analysis provider disputed that Petitioner made no progress over the past 12 consecutive months. Also neither Petitioner’s [REDACTED] nor Petitioner’s Behavior Analysis provider disputed Respondent’s assessment that the Treatment Plan is ineffective. Thus, upon review of the data graphs, the undersigned Hearing Officer finds Respondent’s interpretation of the data graphs and the effectiveness of the Treatment Plan to be credible and reliable. Although Petitioner may benefit

from BA services, either the Behavior Analysis provider is ineffective at in treating the Petitioner or the Treatment Plan is ineffective in creating the framework for decreasing Petitioner's maladaptive behaviors and increasing Petitioner's replacement behaviors.

23. Respondent's decision to terminate Petitioner's Behavior Analysis services conforms to generally accepted professional medical standards within the field of applied Behavior Analysis services as expressly stated in the Florida Medicaid Behavior Analysis Policy. Respondent submitted sufficient evidence to support their decision that complies with the applicable Florida Medicaid Behavior Analysis Policy (Criteria for Discharge from Behavior Analysis Services). Respondent *has* shown that the Behavior Analysis provider has provided ineffective services for the past twelve (12) consecutive months. Although the Behavior Analysis provider modified the Treatment Plan, there is no evidence in the record that the Petitioner would receive effective treatment from the Behavior Analysis provider or the submitted Treatment Plan. The data graphs clearly indicate that the Treatment Plan has shown no progress in decreasing the frequency of maladaptive behaviors, and/or increasing the frequency of replacement behaviors. Therefore, the termination (also referred to as "discharge") of Behavior Analysis services complies with the Florida Medicaid Behavior Analysis Policy. Accordingly, Respondent *has* demonstrated that the Behavior Analysis services at issue are no longer medically necessary.

24. Looking at all the evidence relevant to the particular needs of Petitioner, Respondent *has* demonstrated that the requested continuation of Behavior Analysis services is *no longer* necessary for "health care, diagnostic services, treatment, and other measures . . . to correct or ameliorate defects and physical and mental illness and conditions discovered by the screen services." Therefore, in light of both parties' testimony, both parties' admitted evidence, and the

applicable laws and policies, the undersigned Hearing Officer finds that Respondent *has* proven by a preponderance of the evidence that Respondent's termination of Petitioner's Behavior Analysis services was correct.

**IT IS HEREBY ORDERED AND ADJUDGED THAT:**

Respondent's termination of Behavior Analysis services from September 18, 2022, through March 16, 2023, is hereby **AFFIRMED**. Petitioner's request for relief is **DENIED**.

**DONE AND ORDERED** this 30th day of January, 2023, in Tallahassee, Leon County, Florida.



Laura Gallagher  
22-FH1827  
2023.01.30 08:08:38 -05'00'

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**LAURA GALLAGHER, Hearing Officer**  
**Agency for Health Care Administration**  
**Office of Fair Hearings**  
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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:**

[REDACTED]  
[REDACTED]  
[REDACTED]

**AHCA Medicaid Hearing Unit  
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