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

FILED
Mar 03, 2023, 3:31 pm
OFFICE OF FAIR HEARINGS

[redacted],

PETITIONER,

AHCA Case No.: 22-FH1952

vs.

AGENCY FOR HEALTH CARE ADMINISTRATION,

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, Hearing Officer Caylen Darbouze convened a telephonic Fair Hearing in the instant case on January 6, 2023, at 12:02 p.m. Eastern Standard Time ("EST").

APPEARANCES

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

For the Respondent: Marielisa Amador
Medical Health Care Program Analyst
Agency for Health Care Administration

STATEMENT OF ISSUE

The issue is whether Petitioner proved by a preponderance of the evidence that Respondent's denial of additional Behavior Analysis services was incorrect.

PRELIMINARY STATEMENT

All parties and witnesses appeared for the scheduled Fair Hearing telephonically. [redacted] ("[redacted]"), Petitioner's Authorized Representative and [redacted], appeared for the Fair

Hearing on behalf of Petitioner and provided testimony. The following persons appeared for the Fair Hearing as witnesses for Petitioner: Tiara Carey ("Ms. Carey"), a Board-Certified Behavior Analyst ("BCBA") for [redacted]; Bradley O'Brien ("Mr. O'Brien"), a Board-Certified Assistant Behavior Analyst ("BCaBA") for [redacted]

Marielisa Amador, 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 representative for Respondent. Dr. David Bicard ("Dr. Bicard"), a Board-Certified Behavior Analyst at the doctoral level ("BCBA-D") and the Director of Clinical Operations for eQHealth Solutions, appeared for the Fair Hearing as a witness for Respondent.

Prior to the Fair Hearing, Petitioner filed with the Office of Fair Hearings an 11-page evidence packet. The evidence packet appears in the Office of Fair Hearings' case management system as "22-FH1952 Evidence.pdf." Absent an objection, the evidence packet was admitted into evidence as Petitioner's Composite Exhibit 1.

Prior to the Fair Hearing, Petitioner filed with the Office of Fair Hearings a 7-page evidence packet. The evidence packet appears in the Office of Fair Hearings' case management system as "22-FH1952 Evidence (2).pdf." Absent an objection, the evidence packet was admitted into evidence as Petitioner's Composite Exhibit 2.

Prior to the Fair Hearing, Petitioner filed with the Office of Fair Hearings a video recording, which appears in the Office of Fair Hearings' case management system as "[redacted].mp4." Absent an objection, the video was admitted into evidence as Petitioner's Exhibit 3.

Prior to the Fair Hearing, Petitioner filed with the Office of Fair Hearings a video recording, which appears in the Office of Fair Hearings' case management system as "Video 2.mp4." Absent an objection, the video was admitted into evidence as Petitioner's Exhibit 4.

Prior to the Fair Hearing, Petitioner filed with the Office of Fair Hearings a 6-page evidence packet. The evidence packet appears in the Office of Fair Hearings' case management system as 22-FH1952 Evidence (3).pdf." Absent an objection, the evidence packet was admitted into evidence as Petitioner's Composite Exhibit 5.

Prior to the Fair Hearing, Petitioner filed with the Office of Fair Hearings a 5-page evidence packet. The evidence packet appears in the Office of Fair Hearings' case management system as "22-FH1952 Evidence (4).pdf." Absent an objection, the evidence packet was admitted into evidence as Petitioner's Composite Exhibit 6.

Prior to the Fair Hearing, Petitioner filed with the Office of Fair Hearings a 7-page evidence packet. The evidence packet appears in the Office of Fair Hearings' case management system as "22-FH1952 Additional Evidence.pdf." Absent an objection, the evidence packet was admitted into evidence as Petitioner's Composite Exhibit 7.

Prior to the Fair Hearing, Petitioner filed with the Office of Fair Hearings a 7-page evidence packet. The evidence packet appears in the Office of Fair Hearings' case management system as "22-FH1952 Additional Evidence(2).pdf." Absent an objection, the evidence packet was admitted into evidence as Petitioner's Composite Exhibit 8.

Prior to the Fair Hearing, Petitioner filed with the Office of Fair Hearings a 14-page evidence packet. The evidence packet appears in the Office of Fair Hearings' case management

system as “22-FH1952 Additional Evidence(3).pdf.” Absent an objection, the evidence packet was admitted into evidence as Petitioner’s Composite Exhibit 9.

Prior to the Fair Hearing, Petitioner filed with the Office of Fair Hearings a 6-page evidence packet. The evidence packet appears in the Office of Fair Hearings’ case management system as “22-FH1952 Additional Evidence(4).pdf.” Absent an objection, the evidence packet was admitted into evidence as Petitioner’s Composite Exhibit 10.

Prior to the Fair Hearing, Petitioner filed with the Office of Fair Hearings a 7-page evidence packet. The evidence packet appears in the Office of Fair Hearings’ case management system as “Case Number 22-FH1952 Email with Attachments 4a-7.pdf.” Absent an objection, the evidence packet was admitted into evidence as Petitioner’s Composite Exhibit 11.

Prior to the Fair Hearing, Petitioner filed with the Office of Fair hearings a 7-page evidence packet. The evidence packet appears in the Office of Fair Hearings’ case management system as “Case Number 22-FH1952 Another Email with Attachments.pdf.” Absent an objection, the evidence packet was admitted into evidence as Petitioner’s Composite Exhibit 12.

Prior to the Fair Hearing, Petitioner filed with the Office of Fair Hearings a video recording, which appears in the Office of Fair Hearings’ case management system as “video 3.mp4.” Absent an objection, the video was admitted into evidence as Petitioner’s Exhibit 13.

Prior to the Fair Hearing, Respondent filed with the Office of Fair Hearings a 114-page evidence packet. The evidence packet appears in the Office of Fair Hearings’ case management system as “[redacted] FH 01.06.2023.pdf.” Absent an objection, the evidence packet was admitted into evidence as Respondent’s Composite Exhibit 1.

Prior to the Fair Hearing, Respondent filed with the Office of Fair Hearings a 49-page evidence packet. The evidence packet appears in the Office of Fair Hearings' case management system as "22-FH1952 AHCA Evidence (Pages 1-49 of 49).pdf." Absent an objection, the evidence packet was admitted into evidence as Respondent's Composite Exhibit 2.

FINDINGS OF FACT

1. Petitioner receives Medicaid services on a fee-for-service basis through the Agency. *See* Respondent's Composite Exhibit 1, pages 16. eQHealth is a Quality Improvement Organization contracted by the Agency to review prior authorization requests for Medicaid services, including Behavior Analysis ("BA") 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]. *See* Respondent's Composite Exhibit 1, pages 16, 44. Petitioner's BA provider is [redacted] *Id*. at 16, 44. Dr. Bicard established that Petitioner has received BA services since [redacted] and BA services from the current provider since [redacted]. Petitioner submitted a BA Reassessment ("Modification Request") for 42 hours per week of BA services. *Id*. at 17, 44-103.

3. The Modification Request shows that Petitioner engages in the following maladaptive behaviors: [redacted]; [redacted]; [redacted]; [redacted] or [redacted]; [redacted]; [redacted]; [redacted]; [redacted]; [redacted]; and [redacted]. *Id*. at 52-61. The data graphs for each maladaptive behavior show high levels of variability. *Id.* Dr. Bicard established that the behaviors of [redacted], [redacted], [redacted], [redacted], [redacted] and [redacted], [redacted], [redacted], [redacted], and [redacted] occur are

variable in that they occur on one or two dates, and then they do not occur at all for several days at a time. As Dr. Bicard testified, the data graphs show that these these maladaptive behaviors are "episodic." *Id.* at 52-56. The data graphs for [redacted] and [redacted] show variability. *Id.* at 57, 61.

4. On September 16, 2022, Respondent issued a Notice of Outcome ("NOO") denying Petitioner's request for additional BA services and terminating Petitioner's existing BA services. *Id*. at 22-23. The Notice states the following, in pertinent part:

Code:	97153
Description:	Intervention without protocol modification, per 15 minutes, Lead Analyst, BCaBA, or RBT
From:	8/29/22
Thru:	2/24/23
Total Units:	Denied – 1,248

Code:	97156
Description:	Family training, per 15 minutes, Lead Analyst
From:	8/29/22
Thru:	2/24/23
Total Units:	Denied – 104

Code:	97155
Description:	Intervention without protocol modification, per 15 minutes,
From:	8/29/22
Thru:	2/24/23
Total Units:	Denied – 104

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 or injury under treatment, and not in excess of the patient's needs.

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 Behavior Analysis Services Coverage Policy, all requested services must be based on maladaptive behaviors emitted by the recipient. Services cannot be approved on a speculative basis and services cannot be approved based on the convenience of the provider, the availability of the recipient, or the recipient's caretaker. The data submitted by the provider does not support this request for modification of services. The request for modification of treatment units is denied.

Respondent's Composite Exhibit 1, pages 22-23.

5. On October 12, 2022, Petitioner's BA provider requested a reconsideration review. *Id*. at 33-34. The Agency's Outpatient Review History states the following, in pertinent part, concerning the reconsideration request:

RECON ADMIN INFO: [Petitioner's] behavior has been incredibly variable over the past 6 months. [Petitioner's] maladaptive behavior has included [redacted] toward adults and peers with and without disabilities, [redacted], and [redacted].

- [redacted] toward adults and peers with and without disabilities and [redacted] currently pose the highest level of risk of significant harm to [redacted] and others and continue to occur with significant variability and intensity.
- [redacted].
- Maladaptive behaviors were more likely to occur when the environment is [redacted].
- New goals have been added to include [redacted], [redacted], and [redacted], to increase the client's potential for success and independence but remain at an extremely high level of support required to make progress.
- Currently [Petitioner] is unable to [redacted]

- [redacted].
- [redacted] lack of generalization means that there is only one RBT on [redacted] case and new staff are not able to cover or be added at this time. This is a major deficit that will need to be addressed in the future to ensure that [Petitioner] can return to a typical academic environment and participate in naturally occurring routines without direct support.

Respondent's Composite Exhibit 1, pages 17-18. (Emphasis added).

6. On October 17, 2022, Respondent issued a Notice of Reconsideration Determination ("NRD") upholding the denial of additional BA services, and reinstating Petitioner's previously authorized level of BA services. *Id*. at 33-34. The NRD states the following, in pertinent part:

Code:	97153
Description:	Intervention without protocol modification, per 15 minutes, Lead Analyst, BCaBA, or RBT
From:	8/29/22
Thru:	2/24/23
Total Units:	Denied – 1,248 Units added at recon – 520

Code:	97156
Description:	Family training, per 15 minutes, Lead Analyst
From:	8/29/22
Thru:	2/24/23
Total Units:	Denied – 104 Units added at recon – 104

Code:	97155
Description:	Intervention without protocol modification, per 15 minutes,
From:	8/29/22
Thru:	2/24/23
Total Units:	Denied – 104 Units added at recon – 104

> 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:
>
> > 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[.]
>
> The rationale for our decision is as follows:
>
> PR Recon Determination:
> At reconsideration, all documents were carefully reviewed. The provider submitted new documentation that supports the medical necessity of this request. According to The Behavior Analysis Services Coverage Policy, (page 6, 9.0.c-d) the recipient of ABA therapy services must engage in maladaptive behavior that interferes with the recipient's daily functioning. Although the recipient is engaging in topographies of maladaptive behaviors, the frequency and intensity of the maladaptive do not support the request for services. The current request is in excess of medically necessary BA services, but BA services are approved at a lower level than requested.

Respondent's Composite Exhibit 1, pages 33-34.

7. October 21, 2022, [redacted] requested a Fair Hearing on behalf Petitioner to dispute Respondent's denial of additional BA services. *See* Respondent's Composite Exhibit 1, page 18. On November 21, 2022, the undersigned Hearing Officer issued a Scheduling Order to all parties of record scheduling the Fair Hearing to be conducted by telephone on January 6, 2023, at 12:00 p.m. EST. *Id*. at 8-14.

8. Based on [redacted]' testimony presented at the Fair Hearing, [redacted] referenced Petitioner's submitted documents, videos, and photographs, as evidence to the severity and frequency of Petitioner's maladaptive behaviors. [redacted] attributes Petitioner's lack of consistent progress due to Petitioner growing older and becoming more difficult. [redacted] is requesting BA services to accompany the Petitioner continuously during school hours.

9. Based on Ms. Carey's testimony presented at the Fair Hearing, Ms. Carey argued that the Hearing Officer should apply significant weight to the assessment, judgement, and recommendation of the BA provider who treats the Petitioner on a weekly basis over Respondent's decision based on medical necessity criteria. The hours that were denied were for the frequency and intensity of behaviors. Ms. Carey argued that Petitioner is dangerous to [redacted] and others.

10. Dr. Bicard testified that, on reconsideration, Petitioner was approved to continue the same level of BA services that [redacted] received during the previous authorization period. Dr. Bicard testified that the data in the graphs show a high level of variability in Petitioner's maladaptive behaviors, and that the behaviors occur episodically. Dr. Bicard testified that it was not clear that the provider has established why the maladaptive behaviors are occurring at high levels when they were previously occurring at low levels or not at all. Further, the episodic nature of the behaviors suggests that there is some instability in the environment that has not been identified by the provider. Dr. Bicard explained that it is incumbent on the provider to make a proper justification for the services that have been requested. Respondent determined it was medically necessary to continue the intensity of BA services that the Petitioner received last authorization period, but not medically necessary to increase the intensity of BA services.

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.

(Emphasis added).

14. In the instant case, Petitioner requested new services. As such, Fla. Admin. Code R. 59G-1.100(17)(g) assigns the burden of proof to the Petitioner. The standard of proof in an administrative hearing is a preponderance of the evidence. The preponderance of the evidence standard requires proof by "the greater weight of the evidence" (Black's Law Dictionary at 1201, 7th Ed.).

15. The Florida Medicaid BA Policy, incorporated by reference in Fla. Admin. Code. R. 59G-4.125, establishes the provision for BA services available to Medicaid recipients under the age of 21 years. *See* Respondent's Composite Exhibit 2, pages 38-47. The Florida Medicaid BA 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 no 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 his or her 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.

16. 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 than 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

. . .

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

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 his/her 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).

17. 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.

18. 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.

19. 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 Definitions Policy states as follows, in pertinent part:

> **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).

20. The 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 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.

21. In the instant case, Petitioner is under the age of 21 and therefore EPSDT applies to [redacted] request for the authorization of an additional 6-7 hours per week of BA services ("Intervention without protocol modification, per 15 minutes, Lead Analyst, BCaBA, or RBT") at issue. Petitioner's BA provider submitted a request to eQHealth to increase the intensity of Petitioner's BA services for the certification period of August 29, 2022, through February 24, 2023. *See* supra ¶ 4, 6. As established on the record, eQHealth approved Petitioner to continue receiving BA services at the same intensity as last certification period, but denied Petitioner's request to increase the intensity after determining that the recipient does not need more intensive BA services and the provider has not made a compelling justification for the increase in intensity. *See* supra ¶ 4, 6, 10.

22. 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 BA 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 ¶ 15-16. 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 service hours. *See* supra ¶ 16. Thus, as the frequency of maladaptive behaviors decrease, then the number of service hours would decrease. 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. *See* supra ¶ 16. Thus, as the recipient's maladaptive behaviors decrease in frequency and positive

reinforcement behaviors increase in frequency, service hours will decrease accordingly. However, the BA Policy does not speak directly to what happens when the recipient shows inconsistent, episodic results from treatment. BA providers have the burden to ensure that proper justification for the requested intensity of services is adequately documented in the BA Reassessment. *See* supra ¶ 16. Dr. Bicard, testified that Petitioner met the Criteria for Continuation of Treatment at the Present Level and/or Using Current Methods, but did not qualify for increasing the intensity of services. *See* supra ¶ 10. Simply, the BA provider has not made a compelling justification for services at the intensity requested. *See* supra ¶ 4, 6.

23. Pursuant to section 2.83 of the Florida Medicaid Definitions Policy, the five (5) conditions of Medical Necessity must be met for "medical . . . services furnished or ordered" to be determined medically necessary. *See* supra ¶ 21. Accordingly, all five (5) of the conditions must be met for eQHealth to approve requested BA services. In this case, Respondent determined that the request to increase the intensity of BA services is in excess of Petitioner's needs and not consistent with generally accepted professional standards based on the BA Policy's criteria in relation to the BA Reassessment. *See* supra ¶ 2-6, 10. Petitioner's BA provider, Ms. Carey, asserted the Hearing Officer apply significant weight to the assessment, judgement, and recommendation of the BA provider. *See* supra ¶ 9. Florida Medicaid mandates, "[t]he fact that a provider . . .recommended . . . services does not, in itself, make such . . . services medically necessary." *See* supra ¶ 19. Simply, just because the BA provider recommends a specific number of hours per week of a service does not mean that services are automatically approved without peer review. The provider *must prove* that the services are medically necessary beyond relying on their credentials as the treating provider and their professional

recommendation. Nonetheless, the undersigned Hearing Officer took into consideration the recommendation of Ms. Carey on behalf of the BA provider.

24. Respondent and the Behavior Analyst provider agree that the Petitioner currently engages in maladaptive behaviors, these maladaptive behaviors interfere with the recipient's daily functioning, and BA services are medically necessary for the Petitioner. *See* supra ¶ 2-5, 8-10. Respondent continued Petitioner's BA services at the same intensity level because the submitted documentation did not establish the medical necessity of the requested level of intensity of BA services. *See* supra ¶ 4, 6. Specifically, both parties agree to the inconsistent and varying progressions along with regressions of the Petitioner from receiving treatment. *See* supra ¶ 3. At the Fair Hearing, it should be noted that Ms. Carey did not address the underlying reasons for this inconsistent progress. Based on the record, Respondent determined that the documentation did not meet the following medical necessity standard: individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs; and consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational. *See* supra ¶ 4, 6, 10. These medical necessity standards are expressly outlined in § 2.83 of the Definitions Policy and a critical element for BA services reassessments. *See* supra ¶ 19. The BA Policy mandates that the behavior plan (e.g., BA Reassessment) must be detailed enough to warrant the requested intensity of BA services and include mechanisms to monitor and evaluate its effectiveness. *See* supra ¶ 15-16.

25. Dr. Bicard, a Board-Certified Behavior Analyst at the Doctoral level ("BCBA-D"), testified that the requested increase in BA services is "in excess of Petitioner's needs," and not consistent

with the standards established by the Florida Medicaid program. *See* supra ¶ 10. The BA Reassessment from the BA provider was reviewed by eQHealth who agreed that Petitioner's BA provider did not provide sufficient justification for the requested increase of BA service units. *See* supra ¶ 2, 4, 6, 10. Dr. Bicard and the BA provider both agree that the recipient has episodic and varying progress toward the goals set forth in the BA Reassessment. *See* supra ¶ 8-10. [redacted] and Ms. Carey provided no testimony with respect to the criteria set forth in the Florida Medicaid BA Policy. *See* supra ¶ 8 - 9. Petitioner's case rests on [redacted]' personal observations regarding the severity of Petitioner's maladaptive behaviors and Ms. Carey's professional judgement regarding the recommendation for treatment intensity.

26. An effective treatment plan is built around maladaptive behaviors (which decrease in frequency) and replacement behaviors (which increase in frequency) over the course of treatment, as evidenced in data graphs. *See* supra ¶ 15-16. Further, the effectiveness of a treatment plan is determined by reference to data graphs, which visually depict a child's progress over the course of treatment. *See* supra ¶ 15-16. Both Respondent and the BA provider agree on Petitioner's episodic and inconsistent progress over the course of treatment. *See* supra ¶ 2-3, 8-10. The undersigned Hearing Officer found Dr. Bicard's testimony regarding the BA Reassessment and Petitioner's condition to be credible. The undersigned Hearing Officer found [redacted]' and Ms. Carey's testimony regarding the severity and frequency of Petitioner's maladaptive behaviors to be credible. However, neither [redacted] nor Ms. Carey addressed how Petitioner's needs could not be met with the current approved BA services. It should be emphasized this case is not about the Petitioner receiving or not receiving services. All parties agree that the Petitioner should and will receive some intensity of BA services. The disagreement is whether the provider

should continue the same level of intensity or increase the intensity. Here, [redacted] and Ms. Carey did not fulfill their burden of showing why it is medically necessary to increase the intensity.

27. Outside of Ms. Carey's professional recommendation, there was no evidence presented that increasing treatment intensity by 6-7 hours per week meets the following medical necessity criteria for increasing the intensity of BA services: individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs; and consistent with generally accepted medical standards. There was no testimony or evidence presented by Ms. Carey as to how she calculated the need for an additional 6-7 hours per week of treatment. [redacted] did however mention a desire to have BA services rendered in a manner that mirrors Petitioner's school schedule. *See* supra ¶ 8. Based on this information, services would be intended to accommodate the school setting (having someone on a 1:1 basis monitor the Petitioner throughout the school day) as opposed to demonstrating Petitioner's specific need for the treatment intensity. As a result, services furnished in a manner primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider cannot be approved as medically necessary. *See* supra ¶ 19. Approving services to, in essence, give the Petitioner a full-time school aide without demonstrating Petitioner's specific need for increasing treatment intensity appears to be made out of convenience, not necessity.

28. Accordingly, though Petitioner continues to need BA services, Petitioner *has not* met their burden of proof to show that continuation of BA services at a higher intensity is medically necessary. Looking at all the evidence relevant to the particular needs of Petitioner, the requested intensity of BA services at issue is not necessary to correct or ameliorate a defect or a physical and mental illness or condition.

29. Therefore, in light of both parties' testimony, both parties' admitted evidence, and the applicable laws and policies, the undersigned Hearing Officer finds that Petitioner *has not* proven by a preponderance of the evidence that Respondent's denial of additional BA services was incorrect.

IT IS HEREBY ORDERED AND ADJUDGED THAT:

Respondent's denial of additional Behavior Analysis services from August 29, 2022, through February 24, 2023, is hereby **AFFIRMED**. Petitioner's request for relief is **DENIED**.

DONE AND ORDERED this 3rd day of March, 2023, in Tallahassee, Leon County, Florida.

Joseph Mabry
22-FH1952
2023.03.03
15:26:27 -05'00'

_____

***for* CAYLEN DARBOUZE, Hearing Officer**
Agency for Health Care Administration
Office of Fair Hearings
2727 Mahan Drive, Mail Stop # 11
Tallahassee, FL 32308-5407

NOTICE OF A RIGHT TO JUDICIAL REVIEW

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

COPIES FURNISHED TO:

[redacted]

[redacted]

AHCA Medicaid Hearing Unit
MedicaidHearingUnit@ahca.myflorida.com.