



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

FILED

May 02, 2023, 9:54 am
OFFICE OF FAIR HEARINGS

[REDACTED]

PETITIONER,

AHCA Case No.: 22-FH2087

vs.

AGENCY FOR HEALTH CARE
ADMINISTRATION,

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned Hearing Officer convened a telephonic Fair Hearing on the instant case on March 28, 2023, at 12:00 p.m. EST.

APPEARANCES

For the Petitioner:

[REDACTED]

Petitioner's Authorized Representative

For the Respondent:

Lee Ann Williams
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 decision to terminate Petitioner's behavior analysis ("BA") services was correct.

PRELIMINARY STATEMENT

All parties and witnesses appeared telephonically. Petitioner's Authorized Representative and [REDACTED], [REDACTED] ("[REDACTED]"), appeared on behalf of the Petitioner and provided testimony.

Chrissie Simmons, Medical Health Care Program Analyst for the Agency for Health Care Administration ("Agency" or "AHCA"), appeared on behalf of Respondent. Sandra Durden, Medical Health Care Program Analyst for the Agency, appeared as an observer for Respondent. Dr. Joseph Darling ("Dr. Darling"), BCBA at the Doctoral Level ("BCBA-D") and second level reviewer for eQHealth Solutions, Inc. ("eQHealth"), appeared as a witness for Respondent.

George, interpreter ID number 31578792 with Global Interpreting Network, provided translation services for the Petitioner.

Petitioner did not introduce any exhibits at the Fair Hearing.

Prior to the hearing, Respondent sent to the Office of Fair Hearings and Petitioner a one hundred and sixty (160)-page evidence packet. The packet appears in the Office of Fair Hearings' case management system as "[REDACTED] FH 02.21.2023 1-147.pdf" and "[REDACTED] FH 02.21.2023 148-160.pdf." Absent an objection from the Petitioner, the undersigned admitted the evidence packet into evidence as Respondent's Composite Exhibit 1.

Prior to the hearing, Respondent also sent to the Office of Fair Hearings and Petitioner a forty-nine (49)-page evidence packet. The packet appears in the Office of Fair Hearings' case management system as "22-FH2087_Behavior Analysis_AHCA Evidence.pdf." Absent an objection from the Petitioner, the undersigned admitted the evidence packet into evidence as Respondent's Composite Exhibit 2.

FINDINGS OF FACT

1. Petitioner receives Medicaid services on a fee-for-service basis from the Agency. eQHealth is a Quality Improvement Organization (“QIO”) contracted by the agency to review prior authorization requests for services. See Respondent’s Composite Exhibit 2 at page 2.

2. As of the date of the hearing, Petitioner is [REDACTED]. See Respondent’s Composite Exhibit 1 at page 51. Dr. Darling established that Petitioner has participated in BA services with the current provider for approximately [REDACTED].

3. Petitioner requested the continuation of the following BA services: 140 units of code 97153, 1,440 units of units of code 97155 HN, and 1 unit of code 97153. *Id.* at 87.

4. In a Notice of Outcome (“NOO”), dated September 28, 2022, Respondent terminated Petitioner’s BA services. *Id.* at 28-29. The NOO explained the basis for the termination as follows:

[T]he requested services are not medically necessary under the following standard(s):

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

...

The NOO further provided:

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

PR Clinical Rationale – Denial: All requests for ABA services must be approved based on medical necessity to treat the recipient’s presenting maladaptive behaviors. This request does not meet medical necessity requirements specified in the Behavior Analysis Services Coverage Policy. The provider has requested service hours that are not medically necessary. All therapy hours must use 97153-code. This request for services is denied.

Id.

5. On September 21, 2022, eQHealth sent Petitioner’s provider a Request for Additional Information letter asking the provider to clarify the codes and current units desired for treatment. *Id.* at 50.

6. Petitioner requested reconsideration of the Respondent’s decision. In a Notice of Reconsideration Determination (“NRD”), dated October 27, 2022, the Respondent upheld its decision. *Id.* at 39-40. The NRD states, in pertinent part as follows:

Specifically[,] services must be:

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:

...

All requests for ABA services must be approved based on medical necessity to treat the recipient’s presenting maladaptive behaviors. This request does not meet medical necessity requirements specified in the Behavior Analysis Services Coverage Policy. The provider has requested service hours that are not medically necessary. All therapy hours must have the Code: 97153. As such, the denial is upheld.

Id. at 40.

7. On November 4, 2022, Petitioner requested a Fair Hearing. On February 22, 2023, the undersigned issued an Order Scheduling Fair Hearing By Telephone and Prehearing Instructions setting the Fair Hearing for March 28, 2023. *Id.* at 8-12. Petitioner received administrative approval of ■ current level of BA services, or continuation of benefits, pending the outcome of the Fair Hearing. *Id.* at 24.

8. Dr. Darling established that eQHealth reviews behavior analysis cases to ensure that providers are giving quality care consistent with the standards enumerated in the BA Policy as well as professional medical standards of applied behavior analysis. eQHealth reviewed the

Treatment Plan submitted in this case to determine whether all five (5) criteria of medical necessity are met. Dr. Darling asserted that Petitioner's BA services were terminated because the Treatment Plan and documentation does not meet the following criteria: "consistent with generally accepted professional medical standards as determined by the Medicaid program."

9. Dr. Darling testified that in August, 2022, the Medicaid program implemented new BA service codes, which are based on the types of services provided rather than who provide the services. In this case, the BA provider requested a total of one (1) unit, or a total of 15 minutes per week, of code 97153, which relates to the one-on-one BA therapy services provided during the course of treatment. Dr. Darling testified that the Treatment Plan cannot be implemented with only one unit of code 97153 per week. Dr. Darling explained that additional information and clarification was requested from the provider, but the provider's response did not show that the provider understood the proper use of the BA service codes. *Id.* at 150-152. The BA services were denied based on the way the therapy was allocated, and effective treatment could not be provided with the type and number of units requested.

10. [REDACTED] testified that Petitioner needs BA services. [REDACTED] did not present any evidence to rebut Dr. Darling's testimony and stated that [REDACTED] would ask the BA provider to submit a corrected Treatment Plan.

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 (2019). 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 Fla. Admin. Code R. 59G-1.100(17)(b).

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

14. 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).

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

17. Section 409.905(2), Florida Statutes, limits EPSDT services with a medical necessity standard:

The [Agency] shall pay for early and periodic screening and diagnosis of a recipient under age 21 to ascertain physical and mental problems and conditions and all services determined by the agency to be medically necessary for the treatment, correction, or amelioration of these problems and conditions, including personal care, private duty nursing, durable medical equipment, physical therapy, occupational therapy, speech therapy, respiratory therapy, and immunizations.

18. The Florida Medicaid Definitions Policy (August 2017) (“Definitions Policy”), incorporated by reference in Fla. Admin. Code R. 59G-1.010, defines “Medically Necessary” or “Medical Necessity” as follows:

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

- Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate pain
- Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient’s needs
- Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational
- Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available statewide
- Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient’s caretaker, or the provider

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

Definitions Policy at page 7.

19. The Behavior Analysis Services Coverage Policy (October 2017) (“BA Policy”), incorporated by reference in Fla. Admin. Code. R. 59G-4.125, governs BA services available under Florida Medicaid. The BA Policy provides as follows:

1.0 Introduction

Behavior analysis (BA) services are highly structured interventions, strategies, and approaches provided to decrease maladaptive behaviors and increase or reinforce appropriate behaviors.

...

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

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

These 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

...

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

Respondent's Composite Exhibit 2 at pages 45-47.

21. The Florida Medicaid Authorization Requirements Policy (June 2016) ("Authorization Requirements Policy"), incorporated by reference in Fla. Admin. Code R. 59G-1.053, provides general requirements for providers to obtain authorization to render Florida Medicaid services.

The Authorization Requirements Policy states, in pertinent part:

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.

Florida Medicaid Authorization Requirements Policy at pages 1-3.

22. In this case, Respondent denied Petitioner's request for continuation of BA services. The NOO and NRD explained that Petitioner's request for continuation of services did not meet medical necessity as the treatment plan was not "[c]onsistent with generally accepted

professional medical standards as determined by the Medicaid program, and not experimental or investigational.” *See supra* ¶ 4-5.

23. As provided in the BA policy (Appendix 9.0, section (a)), and the EPSDT requirements, the recipient must meet the meet the medical necessity criteria as outlined in Fla. Admin. Code R. 59G-1.010. A component of medical necessity is that services must be “consistent with generally accepted professional medical standards.” As outlined above, Dr. Darling provided unrebutted testimony that the Treatment Plan could not be effectively implemented with the codes and number of units requested. Because the BA services are not consistent with generally accepted professional medical standards, the recipient will not gain any additional benefit by continuing BA services under the Treatment Plan at issue.

24. In this case, Petitioner’s provider recommended the continuation of BA services. However, the fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services does not, in itself, make such care, goods or services medically necessary or a medical necessity or a covered service. *See supra* ¶ 18.

25. Accordingly, Respondent met their burden of proof to show that the BA services at issue are no longer medically necessary. Looking at all the evidence relevant to the particular needs of Petitioner, Respondent demonstrated that the BA services at issue are not necessary to correct or ameliorate a defect or a physical and mental illness or condition.

26. Upon consideration of the testimony provided, evidence submitted, and applicable policies, the undersigned finds that Respondent proved by a preponderance of the evidence that Respondent’s termination of BA services was correct.


DECISION

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

DONE and **ORDERED** this 2nd day of May 2023, in Tallahassee, Leon County, Florida.

Laura Gallagher

22-FH2087

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LAURA GALLAGHER, 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:



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