



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

FILED

Mar 13, 2023, 10:35 am

OFFICE OF FAIR HEARINGS

[REDACTED]

PETITIONER,

AHCA Case No.: 22-FH2102

vs.

AGENCY FOR HEALTH CARE
ADMINISTRATION,

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic Fair Hearing on the instant case on February 3, 2023, at 9:01 a.m. Eastern Standard Time ("EST").

APPEARANCES

For the Petitioner:

[REDACTED]

Petitioner's Authorized Representative

For the Respondent:

Suzanne Chillari
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 reduce Petitioner's Behavior Analysis ("BA" or "ABA") services was correct.

PRELIMINARY STATEMENT

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

Suzanne Chillari, Medical/Health Care Program Analyst for the Agency for Health Care Administration (“Agency” or “AHCA”), appeared on behalf of Respondent. Dr. David Bicard (“Dr. Bicard”), Board Certified Behavior Analyst and Director of Clinical Operations for eQHealth Solutions Inc. (“eQHealth”), appeared as a witness for Respondent. Sandra Durden, Medical/Health Care Program Analyst with the Agency, appeared as an observer.

Prior to the hearing, Petitioner sent to the Office of Fair Hearings and Respondent a fifty-four (54)-page evidence packet. The evidence packet appears in the Office of Fair Hearings’ document management system as the file titles “22-FH2102 – Additional Hearing Evidence.pdf”, “22-FH2102 Additional Hearing Evidence(2).pdf”, “22-FH2102 – Additional Hearing Evidence2.pdf”, “22-FH2102 Emailed Evidence.pdf”, “22-FH2102 Evidence (2).pdf”, and “22-FH2102 Email Correspondence (2).pdf”. Absent an objection from the Respondent, the undersigned admitted the fifty-four (54)-page evidence packet into evidence as Petitioner’s Composite Exhibit 1 (“PCE 1”).

Prior to the hearing, Respondent sent to the Office of Fair Hearings and Petitioner a ninety-two (92)-page evidence packet and a forty-nine (49)-page evidence packet. The ninety-two (92)-page packet appears in the Office of Fair Hearings’ document management system as the file title “[REDACTED] FH 02.03.2023.pdf”. The forty-nine (49)-page evidence packet appears in the Office of Fair Hearings’ document management system as the file title “Agency Evidence_Legal Authorities 22-FH2102.pdf”. Absent an objection from the Petitioner, the undersigned admitted the ninety-two (92)-page evidence packet into evidence as Respondent’s Composite Exhibit 1 (“RCE 1”) and the forty-nine (49)-page evidence packet into evidence as Respondent’s Composite Exhibit 2 (“RCE 2”).

FINDINGS OF FACT

1. Petitioner receives Medicaid services on a fee-for-service basis from the Agency. eQHealth is a Quality Improvement Organization contracted by the Agency to review prior authorization requests for services. See page 2 of RCE 2.

2. Petitioner is [REDACTED]. See page 16 of RCE 1. Petitioner is diagnosed with [REDACTED].
Id.

3. As provided in the Behavior Analysis Reassessment (“Treatment Plan”), Petitioner is engaging in the following maladaptive behaviors: [REDACTED]; [REDACTED]; [REDACTED]; [REDACTED]; [REDACTED]; [REDACTED]; [REDACTED]; and [REDACTED]. *Id.* at 47-49. As provided in the Treatment Plan, Petitioner’s incidents of maladaptive behaviors are as follows: for [REDACTED], Petitioner’s incidents remained at approximately [REDACTED]; for [REDACTED], Petitioner’s incidents decreased from approximately [REDACTED]; for [REDACTED], Petitioner’s incidents remained at approximately [REDACTED]; for [REDACTED], Petitioner’s incidents increased from [REDACTED] per month; for [REDACTED], Petitioner’s incidents increased from approximately [REDACTED] per month; for [REDACTED], Petitioner’s incidents increased from approximately [REDACTED] per month; for [REDACTED], Petitioner’s incidents increased from approximately [REDACTED] per month, for [REDACTED] and [REDACTED], Petitioner’s incidents remained at approximately [REDACTED]. *Id.* at 47 – 48.

4. Petitioner successfully engages in [REDACTED] replacement behaviors at the following rates: for [REDACTED], between [REDACTED] for [REDACTED]

[REDACTED], between [REDACTED] for [REDACTED],
between [REDACTED] for [REDACTED], between [REDACTED] for [REDACTED]
[REDACTED], between [REDACTED] for [REDACTED]
[REDACTED], between [REDACTED] for [REDACTED]
[REDACTED], between [REDACTED]; and for [REDACTED] between [REDACTED]
[REDACTED] *Id.* at 50.

5. Petitioner requested continuation of BA services; specifically, 832 units of code 97153; 520 units of code 97155; and 416 units of code 97156. In a Notice of Outcome (“NOO”), dated October 26, 2022, Respondent approved 832 units of code 97153; 208 units of code 97155; and 104 units of 97156, but denied the remaining units. The NOO explained the basis for the reduction as follows:

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

Individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness under treatment, and not in excess of the patient’s needs.

The NOO further provided:

PR Clinical Rationale – Denial: According to Behavior Analysis Services Coverage Policy requests for services must be based on the medical necessity of the recipient’s maladaptive behaviors. The recipient is engaging in problem behaviors that threaten access to typical environments and negatively affects activities of daily living. The provider is using a tiered service delivery model and has not made a compelling justification for services at the intensity requested. The requested hours of BA services are more than medical necessity.

...

Pages 21 – 22 of RCE 1.

6. Petitioner requested reconsideration of the Respondent's decision. In a Notice of Reconsideration Determination ("NRD"), dated November 14, 2022, Respondent upheld its decision. *Id.* at 33. The NRD explained the basis for the decision as follows:

PR Recon Determination: 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 the 97153-billing code. This reconsideration request has been reviewed, reconsidered and the denial is upheld.

...

Pages 33 – 34 of RCE 1.

7. On November 9, 2022, Petitioner requested a Fair Hearing to challenge the reduction of ABA services. On January 10, 2023, the undersigned issued an Order Scheduling Fair Hearing and Prehearing Instructions, setting the hearing for February 3, 2023, at 9:00 a.m. EST.

8. [REDACTED] is the [REDACTED] of the Petitioner. [REDACTED] testified to the following at the Fair Hearing:

- a. Petitioner suffered a [REDACTED] and developed [REDACTED] [REDACTED].
- b. Maladaptive behaviors increased after Petitioner's [REDACTED].
- c. Petitioner did not have a registered behavior technician for three years.
- d. [REDACTED] requires more parent training to compensate for treatments not being consistently provided.

9. Dr. Bicard is a Board Certified Behavior Analyst at the doctoral level. Dr. Bicard testified to the following at the Fair Hearing:

- a. Petitioner has been receiving services since [REDACTED]. Dr. Bicard characterized these services as “low frequency/high ratio services” – meaning that the services are occurring at a lower frequency than what is typical, but the ratio of different types of services are very high.
- b. The approved units of code 97153 (the therapy code) provide Petitioner with eight (8) hours of ABA therapy per week. This code is the “anchor” to which all other services are tied.
- c. Code 97155 is the code used to monitor the treatment and provide changes to the treatment plan related to the recipient’s response to treatment. The standards of care for ABA provide for a 2:10 ratio of case management to therapy. The approved units of code 97155 exceed the standard 2:10 ratio between case management activities/protocol modification and therapy services and give the provider two (2) hours of protocol modification per week. More units could be intended for the convenience of the provider.
- d. Code 97156 is the code for parent training. The approved units of code 97156 provide [REDACTED] with one (1) hour of parent training per week. More units are not medically necessary. There are four (4) parent training goals in the treatment plan – so it is difficult to see why units requested are necessary.
- e. Petitioner’s behavior has not been improving or worsening over last authorization period. Maladaptive behavior data do not demonstrate a downward trend in maladaptive behaviors. Petitioner has not demonstrated much improvement

regarding replacement behaviors. The data are flat, and no protocol modifications or interventions were submitted for the treatment plan.

- f. As no modifications have been made, it is unclear what the provider has used the approved units of 97155 for.

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 (2019). This order is the final administrative decision of AHCA under section 409.285(2)(a).

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

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

13. The Florida Medicaid 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.

...

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 service
- Meet the criteria as specified in this policy

4.2 Specific Criteria

Florida Medicaid covers the following BA services in accordance with the applicable Florida Medicaid fee schedule(s), or as specified in this policy:

4.2.1 Behavior Assessment

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

14. 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

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)
 - ...
- 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

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 age 21, 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 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.

18. The Florida Medicaid Authorization Requirements Policy ("Authorization Policy"), incorporated by reference in Fla. Admin. Code R. 59G-1.053, provides as follows:

3.2.1 Continued Authorization 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 error or omissions in prior certifications.
- There is a documented improvement in the recipient's medical condition.
- There is a documented change in the recipient's circumstances.
- The reviewing physician determines the recipient will not gain any additional benefit by continuing services at the current level.

19. In the instant case, Respondent reduced Petitioner's ABA services. See ¶ X. In the NOO dated October 26, 2022, Respondent explained that continuing services at the prior level was not medically necessary, specifically, that it did not meet the requirement that 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." *Id.* Respondent further explained that the "requested hours of BA services are more than medical necessity." *Id.*

20. As provided by the EPSDT requirements, the recipient must meet the medical necessity criteria as outlined in Fla. Admin. Code R. 59G-1.010. As provided in section 2.83 of the Definitions

Policy, a component of medical necessity is that 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.” As shown by the record, Petitioner requested to receive 832 units of therapy (code 97153) and a combined 936 units of case management (codes 97155 and 97156). See ¶ 5. As testified to by Dr. Bicard, the standards of ABA call for a ratio of 2:10 of case management to therapy. See ¶ 9. Thus, the requested services are outside of the standards of ABA. Moreover, as shown by the record Petitioner is not making progress under the current treatment plan. See ¶¶ 3, 8. As explained by Dr. Bicard, it does not appear that the provider is using code 97155 for its intended purpose. See ¶ 9. As such, it appears that the reduction of services is warranted.


21. As QIO for the Agency, eQHealth is authorized to reduce services when it is determined that “the recipient will not gain any additional benefit by continuing services at the current level.” See ¶ 17. As discussed, *supra* ¶ 20, Petitioner’s provider is not using services at the appropriate ratio, nor has Petitioner made progress. Accordingly, the record supports the reduction of Petitioner’s services.

22. Upon consideration of the testimony provided, evidence submitted, and applicable polices, the undersigned concludes that Respondent proved by a preponderance of the evidence that the reduction of ABA services was necessary. Looking at all the evidence relevant to the particular needs of Petitioner, Respondent has demonstrated that the previously authorized services, based on the treatment plan at issue in this case, are not necessary to correct or ameliorate a defect or a physical and mental illness or condition. Accordingly, Respondent proved by a preponderance of the evidence that Respondent’s reduction of ABA services was correct.

IT IS HEREBY ORDERED AND ADJUDGED THAT:

Respondent's reduction of ABA services is **AFFIRMED**. Petitioner's appeal based on Respondent's reduction is **DENIED**.

DONE and **ORDERED** this 13th day of March, 2023, in Tallahassee, Leon County, Florida.

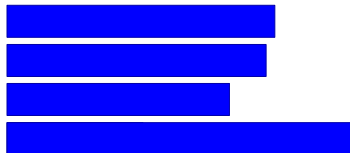
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NOTICE OF A RIGHT TO JUDICIAL REVIEW

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:



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