



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

FILED

Apr 12, 2023, 1:01 pm
OFFICE OF FAIR HEARINGS

[REDACTED],

PETITIONER,

AHCA Case No.: 23-FH0059

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 28, 2023, at 11:00 a.m. Eastern Standard Time (“EST”).

APPEARANCES

For the Petitioner:

[REDACTED]

Petitioner’s Authorized Representative

For the Respondent:

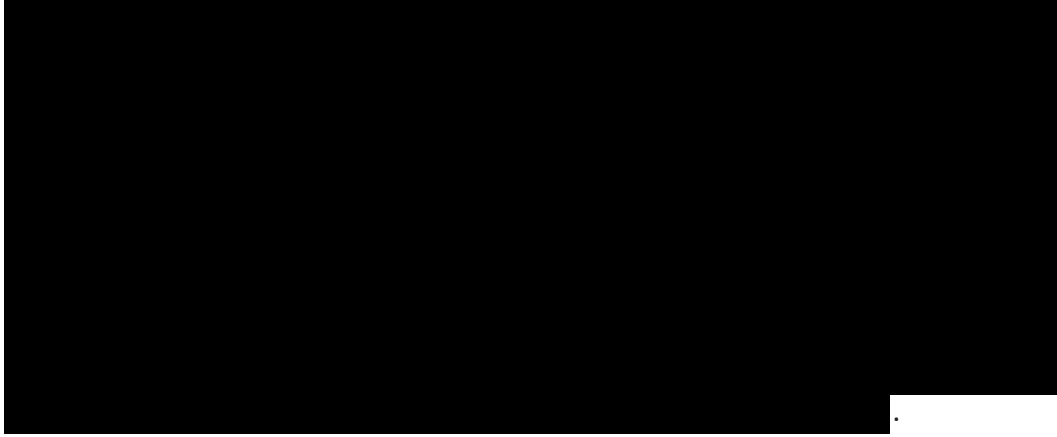
Marielisa Amador
Medical/Health Care Program Analyst
Agency for Health Care Administration

STATEMENT OF ISSUE

The issue is whether Petitioner proved by a preponderance of the evidence that Respondent’s decision to deny Petitioner’s request for additional Behavior Analysis (“BA” or “ABA”) services was incorrect.

PRELIMINARY STATEMENT

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



See page 67 of RCE 1.

4. On December 15, 2022, Petitioner requested an increase in BA services; specifically, 2,496 units of code 97153 (24 hours per week); 208 units of code 97155 (two hours per week); and 104 units of code 97156 (1 hour per week). *Id.* at 39.

5. On December 22, 2022, Respondent submitted a Request for Additional Information to the Provider in order to be able to process the pre-authorization request, requiring the Provider to submit the additional information within two (2) workdays of the notice. *Id.* at 38.

6. On January 4, 2023, Respondent again submitted a Request for Additional Information to the Provider in order to be able to process the pre-authorization request. *Id.* at 36. Respondent explained, as follows:

Provider, eQHealth Solutions is unable to process your request. We require more information. According to the Behavior Analysis Services Coverage Policy (9.2.b) all treatment plans submitted for continuation of care must include updated data for all behaviors under treatment. Please provide graphs and data that show progress for the previous authorization period. Additionally, any target behaviors that are educational or occupational/vocational do not meet medical necessity (per ACHA (sic) Duplication of Services Policy 4.1). Please remove these target behaviors in your behavior plan so we may proceed with the review process. Also, the justification submitted with this treatment is insufficient given the requested units and the recipient's maladaptive behaviors and skill deficits addressed in this treatment plan. This request for services will not be approved with the current configuration of therapy units of service. Please check the request to make sure

the units are correct or review plan and submit therapy hours that reflect standards of care within the field of behavior analysis.

Id. The additional information was to be provided within two (2) workdays of the notice.

7. Subsequently, in a Notice of Outcome – Partial Denial (“NOO”), dated January 9, 2023, Respondent approved 1,560 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 determination as follows:

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

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

The NOO further provided:

PR Principal Reason: Denial:

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

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. However, the intensity of the recipient’s maladaptive behaviors does not justify the intensity of the services requested. I 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 in excess of medical necessity.

...

Pages 25 – 26 of RCE 1.

8. On January 10, 2023, Petitioner requested a Fair Hearing to challenge the denial of additional ABA services. On February 7, 2023, the undersigned issued an Order Scheduling Fair Hearing and Prehearing Instructions, setting the hearing for February 28, 2023, at 11:00 a.m. EST.

9. Petitioner's [REDACTED], appeared at the hearing. [REDACTED] testified that Petitioner has been improving [REDACTED] skills in place of maladaptive behaviors, and that the current treatment plan of ABA services would help [REDACTED] to continue to improve. [REDACTED] acknowledges that Petitioner was set back in [REDACTED] progress due to the pandemic, when [REDACTED] was unable to attend the [REDACTED]. However, [REDACTED] sees marked improvement since [REDACTED] has been able to rejoin [REDACTED] service providers at the facility and [REDACTED] knows that [REDACTED] would continue to improve with [REDACTED] treatment plan of 2,496 units of code 97153; 208 units of code 97155; and 104 units of code 97156. *Id.* at 20 – 21.

10. Dr. Darling is a Board Certified Behavior Analyst at the doctoral level. Dr. Darling testified that the treatment plan was reviewed by three Board Certified Behavioral Analysts who all agreed that more information was needed to determine whether the requested level of BA services was medically necessary. For instance, the final version of the treatment plan contained target behaviors or goals that are educational and occupational/vocational in nature. The reviewers requested that these goals be removed, and Dr. Darling testified that the goals are not necessary to address the symptoms of the confirmed diagnosis of [REDACTED]. For this reason, Dr. Darling asserted that these components of the treatment plan did not justify the level of Behavior Analysis services requested. Further, Dr. Darling established that, in the treatment plan, the values of the data graphs for maladaptive behaviors display the effect of treatment. The rate of maladaptive behaviors should decrease from left to right on the data graphs if progress is being

made. In this case, Dr. Darling asserted that the data graphs provided monthly or cumulative data and do not go into enough detail to determine the level of behavior on a daily basis, what is being done to address the behavior on a daily basis, and whether the requested number of units are medically necessary to implement the treatment plan. The most recently submitted treatment plan included cumulative graphs showing monthly data from [REDACTED] through [REDACTED] that showed Petitioner's average monthly occurrences of certain maladaptive behaviors. For instance, the cumulative graph on Petitioner's [REDACTED] and [REDACTED] only shows that these maladaptive behaviors continue to occur, but the monthly averages do not show what is going on daily and whether there is any progress. See RCE 1 at 222. Likewise, the cumulative graphs on Petitioner's [REDACTED] - [REDACTED] and [REDACTED] problem behaviors also only show monthly averages of occurrences, but not how often they happen each day and what is being done to change or reduce the behavior. *Id.* at 223 and 224.

11. Dr. Darling further testified that the treatment plan was insufficient for not showing what type of skills deficit activities were taking place in the treatment and how long each activity took. For example, the graphs on [REDACTED] [REDACTED] show that these targeted behaviors treatments have been very successful and quick to learn, and that Petitioner has mastery of these skills most of the time. Therefore, the treatment plan should show that Petitioner is moving on from those activities and drills to other ones, and there should be details on how much time each activity and drill should take to effectively deliver the therapy. *Id.* at 241 - 253. Without the treatment plan proposal of specific interventions to reduce or eliminate the maladaptive behavior, it is indeterminable as to whether this request exceeds medically necessary ABA services. When reviewing a treatment plan, what is looked at is whether

maladaptive behaviors are being reduced and whether replacement behaviors are being increased. Measurement of the maladaptive behaviors and their corresponding replacement behaviors should be in small increments to be able to monitor continual improvement. The cumulative graphs do not show such measurement. The submitted information does not support the medical necessity for the requested frequency and/or duration, the continuation of the requested hours of BA services are in excess of medical necessity. *Id.* at 33.

CONCLUSIONS OF LAW

12. 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).

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

14. Because Petitioner requested new services, 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 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
- 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.

16. 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. Provider submits a valid written physician's order as stipulated in the Behavior Analysis Services Coverage Policy, Rule 59G-4.125, F.A.C.

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

- a. **ALL** critical elements are met
- b. An assessment or, if applicable, a reassessment, authored by a lead analyst, is provided. An assessment of the maladaptive behavior(s) is a necessary element of the process of identifying the frequency and magnitude of the behaviors as well as the variables associated with the occurrence of the maladaptive behavior(s). This helps in defining what are the functional consequences of the problem behavior(s) so that an adequate behavior plan can be implemented. This (re)assessment **MUST** include, at a minimum, **ALL** of the following:
 - i. A clear operational description of the maladaptive behavior(s)
 - ...
- 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
 - 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

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 age 21, and therefore EPSDT applies to ■■■ 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 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.

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

3.0 Determination Process

3.1 Review Criteria

The QIQ 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 QIQ’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 QIQ will review each authorization request and will approve, deny, or request additional information. The QIQ 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 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.

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 BA services. Petitioner’s provider submitted a request to increase the intensity of

Petitioner's BA services for the certification period of December 20, 2022 through May 17, 2023. *See supra* ¶ 4. As established on the record, the eQHealth approved Petitioner to continue receiving BA services at the same intensity as the prior certification period. However, eQHealth denied Petitioner's request for additional BA services after determining that the documentation provided does not support the medical necessity of the requested frequency and/or duration of services in the treatment plan. *See supra* ¶ 2-3, 5-7.

22. Pursuant to BA Policy, the critical elements necessary for any type of BA service are: (a) eligibility – the recipient must meet all criteria for Behavioral Analysis services as outlined in the Behavioral Analysis Services Coverage Policy, Rule 59G-4.125, F.A.C; (b) medical necessity – the recipient must meet the medical necessity criteria as outlined in Fla. Admin. Code R. 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. The Treatment Plan is the cornerstone of the delivery of BA services, and BA providers have the burden to ensure that proper justification for the requested intensity of services is adequately documented in the Treatment Plan. *See supra* ¶ 16.

23. As provided by the EPSDT requirements, the recipient must meet the medically 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."

24. In the instant case, the record does not reflect that an increase in BA services is warranted. Respondent denied Petitioner's request for additional BA services and continued

services at the previous authorized level. *See supra* ¶ 7. In the NOO dated January 9, 2023, Respondent explained that additional BA services were 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 under treatment, and not in excess of the patient’s needs.” *Id.* Dr. Darling provided credible and persuasive testimony that the treatment plan contained target behaviors or goals that are educational and occupational/vocational in nature rather than ABA. The provider did not remove these goals as requested by three reviewers at eQHealth, and it was shown that these goals are not necessary to address the symptoms of the confirmed diagnosis of [REDACTED]. *See supra* ¶ 10. Further, the treatment plan data graphs provide insufficient detail for determining whether progress is being made. In this case, Dr. Darling showed that the data graphs provide monthly or cumulative data and do not go into enough detail to determine the level of behavior on a daily basis, what is being done to address the behavior on a daily basis, and whether the requested number of units are medically necessary to implement the treatment plan. *See supra* ¶ 10. Finally, Dr. Darling established that the treatment plan was insufficient for not showing what type of skills deficit activities were taking place in the treatment and how long each activity took. *See supra* ¶ 7. Accordingly, the record does not reflect that the requested additional BA services are not in excess of Petitioner’s needs.

25. Upon consideration of the testimony provided, evidence submitted, and applicable policies, the undersigned concludes that Petitioner did not prove by a preponderance of the evidence that the denial of the additional BA services at issue was medically necessary. Looking at all the evidence relevant to the particular needs of Petitioner, Petitioner has not demonstrated

that the additional BA services at issue are necessary to correct or ameliorate a defect or a physical and mental illness or condition. Accordingly, Petitioner did not prove 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 Petitioner's request for additional BA services is **AFFIRMED**.

Petitioner's appeal based on Respondent's denial is **DENIED**.

DONE and ORDERED this 12th day of April, 2023, in Tallahassee, Leon County, Florida.



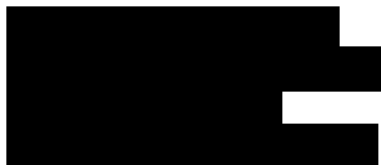
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DEBBIE K. WINICKI, Hearing Officer
Agency for Health Care Administration
Office of Fair Hearings
2727 Mahan Drive, Mail Stop # 11
Tallahassee, FL 32308-5407

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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