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

FILED
May 17, 2023, 1:18 pm
OFFICE OF FAIR HEARINGS

[redacted],

PETITIONER, **AHCA Case No.: 23-FH0179**

vs.

AGENCY FOR HEALTH CARE ADMINISTRATION,

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, a Hearing Officer with the Office of Fair hearings convened a telephonic Fair Hearing on the instant case on March 30, 2023, at 8:30 a.m. EST.

APPEARANCES

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

For the Respondent: Chrissie Simmons
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]"), appeared on behalf of the Petitioner. Nancy Gonzalez ("Ms. Gonzalez"), Board Certified Behavior Analyst with [redacted], attended as a witness for Petitioner.

Chrissie Simmons, 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 at the Doctoral Level and Director of Clinical Operations for eQHealth Solutions, Inc. ("eQHealth"), attended as a witness for Respondent.

Joseph, interpreter number 31579212 with Global Interpreting Network, provided translation services for the Petitioner.

Prior to the hearing, Petitioner sent to the Office of Fair Hearings a fourteen (14)-page evidence packet. The packet appears in the Office of Fair Hearings' case management system as "Fair Hearing Request [Petitioner].pdf." Absent an objection from Respondent, the undersigned admitted the fourteen (14)-page evidence packet into evidence as Petitioner's Exhibit 1.

Prior to the hearing, Respondent sent to the Office of Fair Hearings and Petitioner a one hundred and thirty-seven (137)-page evidence packet. The packet appears in the Office of Fair Hearings' case management system as "[redacted] FH 03.20.2023 1-115.pdf" and "[redacted] FH 03.20.2023 116-137.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 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 "23-FH0179_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 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 Fair Hearing, Petitioner is [redacted] old diagnosed with [redacted]. *See* Respondent's Composite Exhibit 1 at page 22. As Dr. Bicard testified, Petitioner has participated in BA services with the current provider since [redacted]. *Id*. The Treatment Package dated [redacted], ("Treatment Plan") at issue in this case, identified the following maladaptive behaviors: [redacted]. *Id*. at 59.

3. Petitioner requested the following BA services: 2,288 units of code 97153, 312 units of code 97155, and 104 units of code 97156 for the authorization period of January 17, 2023, through July 15, 2023. *Id*. at 24.

4. The Treatment Plan data graphs show the following regarding Petitioner's maladaptive behaviors: [redacted] occur at approximately [redacted] incidents per week throughout treatment with no interventions; [redacted] occur at approximately [redacted] or [redacted] incidents per week with no interventions; [redacted] occur at approximately [redacted] or [redacted] per week and have at least [redacted] data points where there was no progress and

no interventions; [redacted] occur at approximately [redacted] to [redacted] per week and have at least [redacted] data points or more where there was no progress and no interventions; [redacted] occur at approximately [redacted] incidents per week throughout treatment with no interventions; [redacted] occur at approximately [redacted] per week throughout treatment with at least [redacted] data points where there was no progress and no intervention; [redacted] hover at around [redacted] incidents per week with no interventions; [redacted] hover at around [redacted] incidents per week throughout treatment with no interventions; [redacted] hover at around [redacted] incidents per week throughout treatment with no interventions; incidents of [redacted] hover at around [redacted] incidents per week throughout treatment with no interventions; and incidents of [redacted] hover at around [redacted] incidents per week with at least [redacted] data points where there was no progress and no interventions were made. *Id*. at 78-82.

5. The Treatment Plan data graphs show the following regarding Petitioner's replacement behaviors: [redacted] increased from approximately [redacted] to [redacted] [redacted] increased from approximately [redacted] to [redacted] [redacted] increased from approximately [redacted] to [redacted], [redacted], [redacted], and [redacted], increased from approximately [redacted] to [redacted] increased from approximately [redacted] to [redacted] [redacted] increased from [redacted] to [redacted] and [redacted] increased from approximately [redacted] to [redacted] *Id*. at 82-85.

6. In a Notice of Outcome ("NOO"), dated January 21, 2023, Respondent reduced Petitioner's BA services. *Id.* at 28-29. 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:

> Submitted information does not support the medical necessity for requested frequency and\or duration.
>
> PR Clinical Rationale – Denial: According to Behavior Analysis Services Coverage Policy requests for service 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 services requested. 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 in excess of medical necessity.

Id. at 29.

7. Petitioner requested reconsideration of the Respondent's decision. In a Notice of Reconsideration Determination ("NRD"), dated January 30, 2023, the Respondent approved 312 additional units of code 97153 and denied the balance of the units at issue (832 units of code 97153). *Id.* at 39-40. The NRD states, in pertinent part as follows:

> At reconsideration all documents were carefully reviewed. Based on the information submitted for review at reconsideration, additional units of services are approved. However, the current requested is in excess of medically necessary for BA services. Although the recipient is engaging in topographies of maladaptive behaviors, the frequency and intensity of the maladaptive do not support the request for services.

Id. at 40.

8. Dr. Bicard 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 behavior analysis. eQHealth reviewed the Treatment Plan submitted in this case to determine whether all five (5) conditions of medical necessity are met. Dr. Bicard asserted that Petitioner's BA services were reduced because the Treatment Plan is not "individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness under treatment, and not in excess of the patient's needs." Specifically, Dr. Bicard testified that the request services requested are in excess of Petitioner's needs based on the data in the Treatment Plan.

9. Dr. Bicard established that the Treatment Plan data graphs for maladaptive behaviors do not show that the behaviors have decreased since the last review, nor were there any modifications of the Treatment Plan to address the lack of progress. As Dr. Bicard testified, the values of the data graphs for maladaptive behaviors should decrease over the course of treatment if treatment is effective. As Dr. Bicard established, the data graphs for [redacted] do not show progress through treatment and are relatively flat data graphs. *Id*. at 78-82. Further, the data graphs do not show that any modifications were made to address the lack of progress on maladaptive behaviors. *Id*. Finally, Dr. Bicard asserted that the level of functional impairment did not justify the continuation of BA services. Specifically, [redacted] (described in the Treatment Plan as [redacted]) is stated to occur at a "low" level. *Id*. at 68. [redacted] also occurs at a "low" level, is not [redacted] according to Dr. Bicard, and should not be included in the Treatment Plan because this can be easily corrected with a

child lock. The provider identified [redacted] as "low" intensity behaviors. *Id*. at 71-72.

10. Dr. Bicard testified that data graphs for replacement behaviors should increase over the course of treatment is treatment is effective. Referring to the Treatment Plan data graphs for replacement behaviors, Dr. Bicard established that Petitioner shows "slow and steady progress" on each replacement behavior. *Id*. at 82-85. Based on the documentation, it was determined that a reduction is appropriate for Petitioner based on [redacted] progress. Based on the data in the Treatment Plan, Dr. Bicard opined that BA services continue to be medically necessary but the level of services requested is in excess of Petitioner's need.

11. [redacted] testified that some of Petitioner's behaviors have slightly improved. However, [redacted] asserted that Petitioner is engaging in new behaviors lately that are of concern. [redacted] referred to [redacted] and documentation from [redacted] to assert that the intensity of Petitioner's behaviors justifies the requested level of BA services. *See* Petitioner's Composite Exhibit 1. [redacted] did not assert that any of this information was covered in Petitioner's Treatment Plan at issue.

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 Respondent reduced 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.).

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).

16. 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.

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

18. 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.

19. The Florida Medicaid 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.

Respondent's Composite Exhibit 2 at page 23.

20. 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.
. . .
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

Respondent's Composite Exhibit 2 at page 40, 42.

21. 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 than 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.

22. The Florida Medicaid Authorization Requirements Policy ("Authorization Requirements Policy") (June 2016), 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.

Respondent's Composite Exhibit 2 at page 32-34.

23. In this case, Respondent reduced Petitioner's BA services. The NOO and NRD explained that Petitioner's request for continuation of services did not meet medical necessity as the Treatment Plan did not meeting the following criteria "[i]ndividualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs." *See* supra ¶ 6-7.

24. 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 not be "in excess of the recipient's needs." *See* supra ¶ 19. Further, "[t]he behavior plan is the cornerstone of the delivery of behavior analysis services and it is based on the information obtained in the assessment." *See* supra ¶ 21. To continue treatment at the present level and/or using current methods, the data provided must also show evidence that the frequency of the maladaptive behavior(s) has decreased since the last review and, if not, that there is a modification of the behavior plan. *See* supra ¶ 21. As outlined above, Dr. Bicard provided credible and persuasive testimony that the data shows Petitioner made no progress on maladaptive behaviors and no interventions were made to address the lack of progress. *See* supra ¶ 4, 9. Therefore, the Treatment Plan does not meet Criteria 3b for the continuation of BA services at the current level. *See* supra ¶ 21.

25. To continue treatment at the present level and/or using current methods, the data provided must also show that the level of functional impairment justifies continuation of the BA services at issue. *See* supra ¶ 21. As discussed above, Dr. Bicard provided credible and persuasive testimony that Petitioner's replacement behaviors show slow and steady improvement through treatment. *See* supra ¶ 5, 10. Further, as Dr. Bicard established, the level of functional impairment specified in the Treatment Plan was not demonstrated to justify the requested intensity of services. *See* supra ¶ 9. Specifically, the Treatment Plans reflects the following: [redacted] occur at "low" levels; [redacted] should not be considered [redacted], or included in the Treatment Plan, because this can be easily corrected with a child lock; and [redacted] and [redacted] are also described as "low" intensity behaviors. *See* supra ¶ 9. Based on the

Treatment Plan at issue, the record reflects that the Criteria 3c is not met because the level of functional impairment does not justify continuation of BA services at the level requested.

26. In this case, Petitioner's provider recommended the continuation of BA services. Further [redacted] asserted that Petitioner is engaging in new behaviors lately that are of concern. *See* supra ¶ 11. 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 ¶ 19. Moreover, the behavior plan is the cornerstone of the delivery of behavior analysis services and it is based on the information obtained in the assessment. *See* supra ¶ 21. In this case, the Treatment Plan does not mention or address the new behaviors raised by [redacted]

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

28. Upon consideration of the testimony, Petitioner's Composite Exhibit 1, Respondent's Composite Exhibit 1, Respondent's Composite Exhibit 2, and applicable laws and policies, the undersigned finds that Respondent proved by a preponderance of the evidence that Respondent's reduction of Petitioner's BA services was correct.

DECISION

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

DONE and **ORDERED** this 17th day of May 2023, in Tallahassee, Leon County, Florida.

Laura Gallagher
23-FH0179
2023.05.17
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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:

[redacted]

AHCA Medicaid Hearing Unit
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