



FILED

Jun 27, 2023, 9:24 am
OFFICE OF FAIR HEARINGS

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

[REDACTED],

PETITIONER,

AHCA Case No.: 23-FH0192

vs.

**AGENCY FOR HEALTH CARE
ADMINISTRATION,**

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic Fair Hearing on the instant case on March 17, 2023, at 9:05 a.m. Eastern Standard Time (“EST”). Pursuant to notice, the undersigned convened another telephonic Fair Hearing on the instant case on May 12, 2023, at 9:56 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” or “ABA”) services was correct.

PRELIMINARY STATEMENT

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

Linda Latson ("Ms. Latson"), Registered Nurse Specialist for the Agency for Health Care Administration ("Agency" or "AHCA"), appeared on behalf of Respondent for the Fair Hearing convened on March 17, 2023. Chrissie Simmons ("Ms. Simmons"), Medical/Health Care Program Analyst and Fair Hearing Liaison for the Agency, appeared on behalf of Respondent for the hearing convened on May 12, 2023. Dr. Joseph Darling ("Dr. Darling"), Board Certified Behavior Analyst at the doctoral level and Second Level Reviewer for eQHealth Solutions Inc. ("eQHealth") appeared as a witness for Respondent at both hearings.

Diana Hearod ("Ms. Hearod"), Medical/Health Care Program Analyst and Fair Hearing Liaison for the Agency, appeared as an observer.

Petitioner did not introduce any exhibits at the hearing. Prior to the hearing, Respondent sent to the Office of Fair Hearings and Petitioner a two-hundred and twenty (220)-page evidence packet and a forty-nine (49)-page evidence packet. The two-hundred and twenty (220)-page evidence packet appears in the Office of Fair Hearings' document management system as the file titles "[REDACTED] FH 03.17.2023 1-162.pdf" and "[REDACTED] FH 03.17.2023 163-220.pdf". The forty-nine (49)-page evidence packet appears in the Office of Fair Hearings' document management system as the file title "Agency [REDACTED]_Evidence Packet 23-FH0192.pdf". Absent an objection from the Petitioner, the undersigned admitted the two-hundred and twenty (220)-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] ([REDACTED])-years old. 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]. *Id.* at 56-57. As provided in the Treatment Plan, Petitioner’s incidents of maladaptive behaviors, for the period of [REDACTED] [REDACTED], are as follows: for [REDACTED] Petitioner’s incidents remained at [REDACTED] per month; for [REDACTED] Petitioner’s incidents decreased from [REDACTED] to [REDACTED] per month; for [REDACTED], Petitioner’s incidents remained at [REDACTED] per month; for [REDACTED], Petitioner’s incidents decreased from [REDACTED] to [REDACTED] per month; for [REDACTED], Petitioner’s incidents decreased from [REDACTED] to [REDACTED] per month; and for [REDACTED], Petitioner’s incidents increased from [REDACTED] to [REDACTED] per month. *Id.* at 65-72.

4. Petitioner successfully engages in [REDACTED] replacement behaviors, for the period of [REDACTED] [REDACTED], at the following rates: for [REDACTED], Petitioner’s incidents increased from [REDACTED] to [REDACTED] per month; for [REDACTED], Petitioner’s incidents remained at [REDACTED] per month; for [REDACTED], Petitioner’s incidents increased from [REDACTED] to [REDACTED] per month; and for [REDACTED], Petitioner’s incidents increased from [REDACTED] to [REDACTED] per month. *Id.* at 66 – 72. For the period of [REDACTED], Petitioner successfully engaged at the following rates: [REDACTED], Petitioner’s incidents remained at [REDACTED] per month; for [REDACTED], Petitioner’s incidents remained at [REDACTED] per month; for [REDACTED],

██████████, Petitioner’s incidents remained at █ per month; for ██████████, Petitioner’s incidents increased from █ to █ per month; for ██████████, Petitioner’s incidents decreased from █ to █ per month; and for ██████████, Petitioner’s incidents increased from █ to █ per month. For the period of ██████████, for ██████████, Petitioner’s incidents increased from █ to █ per month. *Id.* at 65-73.

5. Petitioner requested continuation of ABA services; specifically, 3,118 units of code 97153; and 312 units of code 97155. Respondent issued a request for information (“PEND”) to Petitioner’s provider stating as follows:

Provider, the justification for this request for services is not clear. eQHealth Solutions requires more information on meditative deep breathing, imagining, calming strategies listed in the plan. Please note that these methods may not conform to standards of care within the field of applied behavior analysis. Please explain all procedures in detail. Also, please submit a rationale for this request for services units. The justification submitted with this treatment is insufficient given the requested units and the recipient’s maladaptive behaviors and skill deficits. 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. at 19.

6. In a Notice of Outcome (“NOO”), dated December 5, 2022, Respondent terminated Petitioner’s ABA services. *Id.* at 24. 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: Required modifications to plan not submitted as requested. The request for services is denied.

...

Id.

7. Petitioner requested reconsideration of the Respondent’s decision. In a Notice of Reconsideration Determination (“NRD”), dated February 1, 2023, Respondent upheld its decision. *Id.* at 35 – 36. The NRD explained the basis for the decision as follows:

PR Recon Determination: At reconsideration all documents were carefully reviewed. The provider did not submit any new documentation that supports the medical necessity of this request. According to The Behavior Analysis Services Coverage Policy, (page 6, 9.0 c-d) the recipient of ABA therapy services must engage in maladaptive behavior that interferes with the recipient’s daily functioning. Although the recipient is engaging in topographies of maladaptive behaviors, the frequency and intensity of the maladaptive do not support the request for services. This reconsideration request has been reviewed, reconsidered and the partial denial is upheld.

...

Id.

8. On January 31, 2023, Petitioner requested a Fair Hearing to challenge the termination of ABA services. *Id.* at 8. On February 23, 2023, the undersigned issued an Order Scheduling Fair Hearing and Prehearing Instructions (“Scheduling Order”), setting the hearing for March 17, 2023, at 9:00 a.m. EST. *Id.* On March 20, 2023, the undersigned issued an Order Granting Continuance and another Scheduling Order, setting the hearing for April 7, 2023, at 9:00 a.m. Petitioner did not appear for the Fair Hearing. On April 20, 2023, the undersigned issued another Scheduling Order, setting the hearing for May 12, 2023, at 10:00 a.m. EST.

9. Dr. Darling established the following at the Fair Hearing:

- a. The provider was asked to submit an updated Treatment Plan that conformed to the standards of care in behavior analysis and a rationale for the requested service units. See ¶ 5. Two phone calls were attempted to contact the provider and request that they make the necessary corrections. *Id.* at 21. Subsequently, eQHealth’s reviewers determined that Petitioner’s maladaptive behaviors did not warrant the hours requested by the provider and the services were denied because medical necessity was not met, as components of the treatment plan were considered experimental or investigational. *Id.* at 19.
- b. While it is medically necessary for Petitioner to receive BA services, the provider did not appropriately correct the Treatment Plan to meet ABA standards of care. Dr. Darling takes as an example, within the Treatment Plan, a statement asserting that “[p]rotocol below was taken from "Flexible and Focused, Teaching Executive Function Skills to Individuals with [REDACTED] and [REDACTED]" by Adel Nadjowski” is not cited or established in literature within the fields of behavior analysis. *Id.* at 79. As another example, Dr. Darling asserts that the provider’s procedures for teaching emotional regulation, such as meditative deep breathing, close eyes and imagine, progressive muscle relaxation, and write down/draw a picture of how you feel, are not supported by scientific research. *Id.* at 80 – 81. Moreover, Dr. Darling contends that the provider had multiple opportunities to correct the Treatment Plan, such as removing the tracking of emotional regulation and its corresponding visual representations, as these procedures did not support medical necessity within the standards of ABA. *Id.* at 77 – 81, 195.

- c. Services should have continued pending the outcome of the Fair Hearing.
10. ██████ testified to the following at the Fair Hearing:
- a. Petitioner has engaged in several severe maladaptive behaviors, and ██████ behavior has significantly worsened since the termination of behavioral services. ██████ believes the termination of services was a disservice to Petitioner as ██████ progress has been lost and ██████ cannot be in a social setting.

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. 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.)
14. 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.

15. 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

16. 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.

17. 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.

18. 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.

19. 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.

20. In the instant case, Respondent terminated Petitioner’s ABA services. See ¶ 6. In the NOO dated December 5, 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 “consistent with generally accepted professional medical standards as determined by the

Medicaid program, and not experimental or investigational.” *Id.* Respondent further explained that the “required modifications to [the treatment] plan [were] not submitted as requested.” *Id.*

21. 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 “consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational.” As shown by the record, the provider’s Treatment Plan did not conform to standards of care within the field of behavior analysis. *See* ¶ 8. Dr. Darling testified that the Treatment Plan contained procedures and methods that were experimental or investigational. *Id.* According to Dr. Darling’s testimony, the provider’s procedures for teaching emotional regulation, such as meditative deep breathing, close eyes and imagine, progressive muscle relaxation, and write down/draw a picture of how you feel, are not supported by scientific research. *Id.* Moreover, the provider failed to remove the tracking of emotional regulation and its corresponding visual representations as procedures that do not support medical necessity within the standards of ABA. *Id.* Thus, the provider never completely corrected the Treatment Plan to remove all experimental or investigational components. *Id.* Therefore, the requested services were denied because components of the Treatment Plan were not supported by scientific literature within the field of behavior analysis. *Id.*

22. As QIO for the Agency, eQHealth is authorized to terminate services when “the reviewing physician determines the recipient will not gain any additional benefit by continuing services at the current level.” *See* ¶ 19. According to [REDACTED] testimony, Petitioner’s behavior has significantly worsened since the termination of behavioral services. *See* ¶ 10. As discussed, *supra*


¶ 21, the provider did not submit a treatment plan that sufficiently demonstrated effectiveness of treatment and conformed to standards of care within the field of behavior analysis.

23. 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 termination 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 termination of ABA services was correct.

IT IS HEREBY ORDERED AND ADJUDGED THAT:

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

DONE and **ORDERED** this 27th day of June, 2023, in Tallahassee, Leon County, Florida.


Kimberly Roche
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KIMBERLY ROCHE, 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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