

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



FILED

Jul 10, 2023, 10:48 am
OFFICE OF FAIR HEARINGS

[REDACTED],

PETITIONER,

AHCA Case No.: 23-FH0805

vs.

AGENCY FOR HEALTH CARE ADMINISTRATION,

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned Hearing Officer convened a telephonic Fair Hearing in the instant case on June 13, 2023, at 12:00 p.m. EST Eastern Standard Time ("EST") and July 6, 2023, at 1:00 p.m. EST.

APPEARANCES

For the Petitioner:

[REDACTED]

Authorized Representative

For the Respondent:

Suzanne Chillari
Medical Health Care Program Analyst
Agency for Health Care Administration

Linda Latson
Registered Nurse Specialist
Agency for Health Care Administration

STATEMENT OF ISSUE

The issue is whether Petitioner proved by a preponderance of the evidence that Respondent's denial of Behavior Analysis services was incorrect.

PRELIMINARY STATEMENT

All parties and witnesses appeared for the scheduled Fair Hearings telephonically. [REDACTED] (“[REDACTED]”), Petitioner’s Authorized Representative and [REDACTED] appeared for the Fair Hearing on behalf of Petitioner and provided testimony. Hervey Penate (“Mr. Penate”), a Board-Certified Behavior Analyst (“BCBA”), appeared for the scheduled Fair Hearings as a witness for Petitioner.

Suzanne Chillari, a Medical Health Care Program Analyst and Fair Hearing Liaison for the Agency for Health Care Administration (“Agency” or “AHCA”), appeared for the June 13, 2023, Fair Hearing as representative for Respondent. Linda Latson, a Registered Nurse Specialist and Fair Hearing Liaison for the Agency for Health Care Administration (“Agency” or “AHCA”), appeared for the July 6, 2023, Fair Hearing as representative for Respondent. Dr. David Bicard (“Dr. Bicard”), a Board-Certified Behavior Analyst-Doctorate (“BCBA-D”) and the Director of Clinical Operations for eQHealth Solutions, appeared for the Fair Hearing on both dates as a witness for Respondent.

Interpreter Robin, a Spanish Interpreter, appeared for the June 13, 2023, Fair Hearing to provide language translation services on behalf of Petitioner. Interpreter Diego, a Spanish Interpreter, appeared for the July 6, 2023, Fair Hearing to provide language translation services on behalf of Petitioner.

Prior to the Fair Hearing, Petitioner filed with the Office of Fair Hearings (“Office”) an 11-page evidence packet, which was admitted into the record as Petitioner’s Composite Exhibit 1. Petitioner’s Composite Exhibit 1 includes the following documents: an email; and the Florida Medicaid Behavior Analysis Services Coverage Policy (“Behavior Analysis Policy”) (Draft rule).

Prior to the Fair Hearing, Respondent filed with the Office a 183-page evidence packet, which was admitted into the record as Respondent's Composite Exhibit 1. Respondent's Composite Exhibit 1 includes the following documents: a Table of Sections; Fair Hearing Physician Call-in Instructions; an Order Scheduling Fair Hearing by Telephone and Prehearing Instructions ("Scheduling Order") (dated May 4, 2023) – English and Spanish; Outpatient Review History; a Notice of Outcome – Denial ("Notice") (dated March 22, 2023); a Notice of Reconsideration Determination ("Reconsideration Determination") (dated April 7, 2023); a Request for Additional Information (dated March 13, 2023); a Psychological Evaluation; a Domain-Level Parent/Caregiver Form Report; two copies of a Behavior Analysis Assessment; a Prescription for Behavior Analysis services; a letter from [REDACTED]; a letter from Hervey Penate, BCBA; a Request for Reconsideration; and an Acronym/Abbreviation index.

Prior to the Fair Hearing, Respondent filed with the Office a 49-page evidence packet, which was admitted into the record as Respondent's Composite Exhibit 2. Respondent's Composite Exhibit 2 includes the following documents: a Table of Contents; Memorandum – Fair Hearings Process Authorization for Quality Improvement Organization in Medical Necessity Determinations (dated October 19, 2021); Memorandum – Medical Necessity as a Limitation on Medicaid Services, Including EPSDT (dated August 5, 2014); Florida Statutes ("Fla. Stat.") § 409.905 (excerpt); Florida Administrative Code Rule ("Fla. Admin. Code R.") 59G-1.001; Fla. Admin. Code R. 59G-1.010; the Florida Medicaid Definitions Policy ("Definitions Policy") (August 2017); Fla. Admin. Code R. 59G-1.035; Fla. Admin. Code R. 59G-1.053; the Florida Medicaid Authorization Requirements Policy ("Authorization Requirements Policy") (June 2016); Fla. Admin. Code R. 59G-4.125; the Florida Medicaid Behavior Analysis Services Coverage Policy

("Behavior Analysis Policy") (October 2017); and the Behavior Analysis Services Fee Schedule (2021 Promulgated, 2022 Updated).

FINDINGS OF FACT

1. Petitioner receives Medicaid services on a fee-for-service basis through the Agency. See Respondent's Composite Exhibit 1, pages 16. eQHealth is a Quality Improvement Organization contracted by the Agency to review prior authorization requests for Medicaid services, including Behavior Analysis services, to ensure that the request meets medical necessity. See Respondent's Composite Exhibit 2, page 2.

2. As of the date of the Fair Hearing, Petitioner is [REDACTED] old and diagnosed with [REDACTED]. See Respondent's Composite Exhibit 1, pages 21, 52, 120. Petitioner's Behavior Analysis provider is [REDACTED]. *Id.* at 21. Petitioner submitted a Behavior Analysis Assessment and a Psychological Evaluation. *Id.* at 52-118, 122-182. According to [REDACTED], the assessment was conducted in the home and lasted four hours over the span of two days. Petitioner's pediatrician, [REDACTED], signed a prescription for Behavior Analysis services. *Id.* at 119. Petitioner exhibits the following maladaptive behaviors:

[REDACTED]

[REDACTED]. *Id.* at 156-157, 178-179. The Agency's Outpatient Review History states the following, in pertinent part:

1ST LEV DECISION/CRITERIA: 3/8/2023

Mandatory BA Documents Present and Reviewed: Yes

Initial Continued Stay: Treatment Plan

Criteria/Guidelines applied: Medicaid Handbook and Clinical Judgement

Recommendation: Referral to SLR

Rationale: [REDACTED]-old [REDACTED] diagnosed with [REDACTED]. The provider is requesting 34 hours per week to be used in the home and community. Maladaptive behaviors meet medical necessity criteria; however, SLR should

determine if all submitted baseline graphs are sufficient. SLR to determine the appropriateness and hours of the current request based on the information provided.

Documentation does not meet the following medical necessity guidelines:

b. 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.

Respondent's Composite Exhibit 1, page 23. (Emphasis added).

3. The Behavior Analysis provider requests the following Behavior Analysis services: 2 hours per week of Family Training by Lead Analyst; 2 hours per week of Behavior Treatment with Protocol Modification; and 30 hours per week of Behavior treatment by Protocol. *Id.* at 182. ■

■ generally states that Behavior Analysis services are medically necessary but does not specify the quantity or intensity of BA services needed. *Id.* at 119-120.

4. On March 22, 2023, Respondent issued a Notice denying Petitioner's request for Behavior Analysis services based on medical necessity. *Id.* at 28-30. The Notice states the following, in pertinent part:

Code: 97153
Description: Intervention without protocol modification, per 15 minutes, Lead Analyst, BCaBA, or RBT
From: 3/6/23
Thru: 9/1/23
Total Units: Denied – 3,120

Code: 97156
Description: Family training, per 15 minutes, Lead Analyst
From: 3/6/23
Thru: 9/1/23
Total Units: Denied – 208

Code: 97155
Description: In
tervention without protocol modification, per 15
minutes,

From: 3/6/23
Thru: 9/1/23
Total Units: Denied – 208

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):

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

The rationale for our decision is as follows:

PR Principal Reason - Denial:

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

PR Clinical Rationale - Denial:

Provider, you must report baseline data graphs collected during the assessment process. This request cannot be reviewed until baseline data are submitted based on the results of your assessment for maladaptive behaviors, replacement/acquisition skills. The request was pended for baseline data graphs of maladaptive behaviors, replacement behaviors, acquisition skills, and parent data goals. The pend response does not contain baseline data graphs for all behaviors indicated. The request is denied.

Respondent's Composite Exhibit 1, pages 28-30. (Emphasis added).

5. On July 4, 2023, Petitioner's Behavior Analysis provider requested a reconsideration review. *Id.* at 39. On April 7, 2023, Respondent issued a Reconsideration Determination upholding the denial of Behavior Analysis services. *Id.* at 39-41. The Reconsideration Determination states the following, in pertinent part:

The rationale for our decision is as follows:

PR Recon Determination: At reconsideration, all documents were carefully reviewed. The provider submitted 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. The current request is in excess of medically necessary BA services, but BA services are approved at a lower level than requested.**

Respondent's Composite Exhibit 1, pages 39-41. (Emphasis added).

6. On April 11, 2023, [REDACTED] requested a Fair Hearing on behalf Petitioner to dispute Respondent's denial of Behavior Analysis services. See Respondent's Composite Exhibit 1, page 24. On May 4, 2023, the undersigned Hearing Officer issued a Scheduling Order to all parties of record scheduling the Fair Hearing to be conducted by telephone on June 13, 2023, at 12:00 p.m. EST. *Id.* at 8-19. On June 16, 2023, the undersigned Hearing Officer issued a continuance based on good cause (e.g., technical problems with the conference call device). On June 19, 2023, the undersigned Hearing Officer issued a Scheduling Order to all parties of record rescheduling the Fair Hearing to be conducted by telephone on July 6, 2023, at 1:00 p.m. EST.

7. Mr. Penate testified that he evaluated the Petitioner in the Behavior Analysis Assessment, identified maladaptive behaviors the Petitioner possesses, and recommends Behavior Analysis services to treat these maladaptive behaviors. Mr. Penate argued that the Agency has sufficient information to approve Petitioner's request for services. Mr. Penate does not dispute that [REDACTED] [REDACTED] collected data and the data was included in Petitioner's assessment, but he argues that the data is accurate and the requested intensity of services is appropriate.

8. Based on Dr. Bicard's testimony presented at the Fair Hearing, Medical Necessity determinations are based on Florida law, Florida Medicaid policies, and generally accepted professional standards. The Agency approved Mr. Penate to conduct an initial assessment to determine if Behavior Analysis services are necessary, and if so, the intensity of treatment

needed. However, Mr. Penate and the provider did not submit the requisite baseline graphical data that Mr. Penate personally observed, which does not meet standards of care in the field of BA services. *Id.* at 151. Dr. Bicard pointed out that [REDACTED] is not trained in the field of Behavior Analysis to be proficient in data collection, and the Agency does not believe [REDACTED] data collection is an accurate representation of Petitioner's conditions. Dr. Bicard classifies the baseline data as "made up." *Id.* at 169-170. Dr. Bicard does not question that Petitioner engages in maladaptive behaviors *or* that Behavior Analysis services are medically necessary. However, Dr. Bicard's position is that without accurate, reliable baseline data neither the Agency nor the Behavior Analysis provider can determine the appropriate treatment intensity ("hours per week") that the Petitioner requires.

CONCLUSIONS OF LAW

9. The Agency's Office has jurisdiction over the subject matter of this proceeding and the parties pursuant to section 409.285(2) of the Florida Statutes ("Fla. Stat." or "F.S") (2022). This order is the final administrative decision of AHCA under Fla. Stat. § 409.285(2)(a).

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

11. Because Petitioner requested a new service, Fla. Admin. Code R. 59G-1.100(17)(g) assigns the burden of proof to 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.).

12. The Florida Medicaid Behavior Analysis Policy, incorporated by reference in Fla. Admin. Code R. 59G-4.125, establishes the provision for Behavior Analysis services available to Medicaid

recipients under the age of 21 years. See Respondent's Composite Exhibit 2, pages 38-47. The

Florida Medicaid Behavior Analysis Policy provides as follows, in pertinent part:

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.

Respondent's Composite Exhibit 2, pages 38-47.

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

See Respondent's Composite Exhibit 2, pages 45-47. The 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)
- ii. Baseline and/or updated treatment data (if reassessment)
- iii. Progress toward identified goals (if a reassessment)
- iv. Identification of the events, times, and situations that appear to be associated to the occurrence of the maladaptive behaviors

...

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.

...

4. Criteria to Assess the Intensity of Behavior Analysis Services: Providers may request up to 40 hours of BA services per week, per recipient, based upon the following:

As a rule, higher number of maladaptive behaviors, higher severity and frequency of behaviors, as well as the multiplicity of settings where the behaviors occur, would usually justify a higher number of services hours. The greater the number of goals targeted to reduce maladaptive behaviors, the more the likelihood that a higher number of services hours could also be warranted.

Providers **MUST** ensure that proper justification for the requested hours of services is adequately documented in the behavior plan. Based on the information provided in the assessment, behavior plan, and any other supporting documentation, 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

Respondent’s Composite Exhibit 2, pages 45-47. (Emphasis added).

14. States must provide Early and Periodic Screening, Diagnostic, and Treatment (“EPSDT”) services to Medicaid-eligible children under age 21 when requested under the Medicaid state plan. See 42 U.S.C. § 1396a(a)(43); 42 U.S.C. § 1396d(a)(4). 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.

15. Petitioner is under the age of 21 years, 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.

16. The Florida Medicaid Definitions Policy, incorporated by reference in Fla. Admin. Code R. 59G-1.010, provides definitions of commonly used terms that are applicable to all sections of Rule Division 59G, Florida Administrative Code (F.A.C.), unless specifically stated otherwise in a service-specific coverage policy or rule. See Respondent's Composite Exhibit 2, pages 16-27. The Definitions Policy states as follows, in pertinent part:

2.83 "Medically Necessary" or "Medical Necessity"

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, page 23. (Emphasis added).

17. The Authorization Requirements Policy, incorporated by Fla. Admin. Code R. 59G-1.053, provides general requirements for providers to obtain authorization to render Florida Medicaid

services. See Respondent's Composite Exhibit 2, pages 30-37. The Authorization Requirements Policy states the following:

1.2 Definitions

The following definitions are applicable to this policy. For additional definitions that are applicable to all sections of Rule Division 59G, F.A.C., please refer to the Florida Medicaid definitions policy.

...

1.3.1 Authorization

The process of obtaining approval for reimbursement of a service based on medical necessity.

...

1.3.6 Provider

The term used to describe any entity, facility, person, or group that has been approved for enrollment or registered with Florida Medicaid.

1.3.7 Quality Improvement Organization

Entity designated to perform utilization review, quality assurance, and quality improvement activities for Florida Medicaid-covered services rendered by fee-for-service providers (also known as the QIO).

...

2.0 Authorization Requirements

...

2.4.2 Requests for Additional Information

The QIO may request additional information, as necessary, to determine medical necessity.

...

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, pages 30-36.

18. In the instant case, Petitioner is under the age of 21 and therefore EPSDT applies to [REDACTED] request for the initial authorization of Behavior Analysis services. Specifically, Petitioner's Behavior Analysis provider is requesting 34 hours per week of Behavior Analysis services. See supra ¶ 3. Petitioner's Behavior Analysis provider submitted an initial Behavior Analysis Assessment to eQHealth, which was reviewed and the primary source of the medical necessity determination. See supra ¶ 2, 7-8. Respondent denied Petitioner's request as not medically necessary because the Behavior Analysis Assessment was not, "[c]onsistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational." See supra ¶ 4. In their explanation, Respondent stated "[s]ubmitted information does not support the medical necessity for requested frequency and/or duration," and "the frequency and intensity of the maladaptive do not support the request for services." See supra ¶ 4-5.

19. Pursuant to the Behavior Analysis Coverage Policy, the critical elements necessary for any type of BA service are: (a) eligibility – the recipient must meet all criteria for Behavior Analysis 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 in Rule 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* ¶ 12-13. As a rule, higher number of maladaptive behaviors, higher severity and frequency of behaviors, as well as the multiplicity of settings where the behaviors occur, would usually justify a higher number of service hours. *See supra* ¶ 12-13. Dr. Bicard, on behalf of eQHealth, testified that Behavior Analysis services may be medically necessary as the Petitioner possesses maladaptive behaviors, but it cannot be determined what the appropriate intensity/frequency of Behavior Analysis services is because of the faulty data collection. *See supra* ¶ 8. The faulty data stems from Mr. Penate including the Petitioner's [REDACTED] data collection in his assessment. *See supra* ¶ 7-8. Petitioner's [REDACTED] is not a Behavior Analysis professional and is not skilled in Behavior Analysis data collection. *See supra* ¶ 6-8.

20. Pursuant to section 2.83 of the Florida Medicaid Definitions Policy, the five (5) conditions of Medical Necessity must be met for "medical . . . services furnished or ordered" to be determined medically necessary. *See supra* ¶ 16. Accordingly, all five (5) of the conditions must be met for eQHealth to approve requested Behavior Analysis services. In this case, Respondent determined that the requested intensity of Behavior Analysis services is in excess of Petitioner's needs and not consistent with generally accepted professional standards based on the Behavior Analysis Policy's criteria in relation to the Behavior Analysis Reassessment. *See supra* ¶ 2-8. Petitioner's Behavior Analysis provider, Mr. Penate, asserted that the Behavior Analysis Assessment is an accurate representation of Petitioner's condition, and the Hearing Officer should apply significant weight to the assessment, and recommendation of the Behavior Analysis provider. *See supra* ¶ 7. Petitioner's pediatrician, [REDACTED], also signed a prescription for Behavior Analysis services and signed a letter of medical necessity, but did not discuss the

appropriate treatment intensity. *See supra* ¶ 2. Florida law mandates, “[t]he fact that a provider . . . recommended . . . services does not, in itself, make such . . . services medically necessary.” *See supra* ¶ 16. Simply, just because the Behavior Analysis provider recommends a specific number of hours per week of a service does not mean that services are automatically approved without peer review. The provider *must prove* that the services are medically necessary beyond relying on their credentials as the treating provider and their professional recommendation. Nonetheless, the undersigned Hearing Officer took into consideration the recommendation of Mr. Penate on behalf of the Behavior Analysis provider.

21. Respondent and the Behavior Analyst provider agree that the Petitioner currently engages in maladaptive behaviors, these maladaptive behaviors interfere with the recipient’s daily functioning, and Behavior Analysis services are medically necessary for the Petitioner. *See supra* ¶ 2-5, 7-8. Respondent and the Behavior Analyst provider also agree that [REDACTED] data collection was included in the Behavior Analysis Assessment along with Mr. Penate’s, [REDACTED] [REDACTED] is not a Behavior Analysis professional, [REDACTED] is not skilled in Behavior Analysis data collection, and Behavior Analysis data collection is necessary to determine the appropriate level of care a Behavior Analysis recipient requires. *See supra* ¶ 7-8. At the Fair Hearing, it should be noted that Mr. Penate did not address why a layperson’s data collection was included in a Behavior Analysis Assessment that was completed by a Florida-licensed BCBA. Based on the record, Respondent determined that the Behavior Analysis Assessment did not meet the following medical necessity standard: consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational. *See supra* ¶ 8. This medical necessity standards are expressly outlined in § 2.83 of the Definitions

Policy and a critical element for Behavior Analysis services reassessments. *See supra* ¶ 16. The Behavior Analysis Policy mandates that the behavior plan (e.g., Behavior Analysis Assessment) must be detailed enough to warrant the requested intensity of Behavior Analysis services and include mechanisms to monitor and evaluate its effectiveness. *See supra* ¶ 12-13.

22. Dr. Bicard, a Board-Certified Behavior Analyst at the Doctoral level (“BCBA-D”), provided credible testimony that basing an initial assessment of the data collection of an unskilled person (e.g., ██████████) is not consistent with the standards established by the Florida Medicaid program. *See supra* ¶ 8. The Behavior Analysis Assessment should be based solely on the data collection of the Behavior Analysis professional (e.g., Mr. Penate, Florida-licensed BCBA). *See supra* ¶ 8. The evidence does not indicate that ██████████ was properly trained in Behavior Analysis data collection, or why only including Mr. Penate’s data collection was not sufficient for the assessment. When given the opportunity, Mr. Penate’s testimony only included declaratory statements that the information is accurate and that there is sufficient evidence to approve the request. Mr. Penate provided no substance to his testimony that would address the points of contention brought by Dr. Bicard. The undersigned Hearing Officer finds Dr. Bicard’s testimony to be more credible and reliable than the recommendations of ██████████ and Mr. Penate as Dr. Bicard thoroughly addressed the standards in the field of Behavior Analysis, the errors in the Behavior Analysis Assessment, and how the appropriate level of care cannot be determined when the data is faulty. ██████████ and Mr. Penate provided no testimony directly addressing the accuracy and reliability of the data collected. *See supra* ¶ 6-7. Outside of Mr. Penate’s and ██████████’s professional recommendations, there was no evidence presented that the treatment intensity meets the following medical necessity criteria for Behavior Analysis services: consistent

with generally accepted medical standards. Therefore, Petitioner was unable to establish the requested 34 hours per week of Behavior Analysis services is the appropriate intensity of treatment that the Petitioner requires.

23. Accordingly, though Petitioner may need Behavior Analysis services, Petitioner has not met their burden of proof to show that the requested intensity of Behavior Analysis services is medically necessary. Looking at all the evidence relevant to the particular needs of Petitioner, the requested intensity of Behavior Analysis services at issue is not necessary to correct or ameliorate a defect or a physical and mental illness or condition.

24. Therefore, in light of both parties' testimony, both parties' admitted evidence, and the applicable laws and policies, the undersigned Hearing Officer finds that Petitioner has not proven by a preponderance of the evidence that Respondent's denial of Behavior Analysis services was incorrect.

IT IS HEREBY ORDERED AND ADJUDGED THAT:

Respondent's denial of Behavior Analysis services is hereby **AFFIRMED**. Petitioner's request for relief is **DENIED**.


DONE AND ORDERED this 10th day of July, 2023, in Tallahassee, Leon County, Florida.

Laura Gallagher

23-FH0805

2023.07.10

08:25:54 -04'00'



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:



AHCA Medicaid Hearing Unit
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