FILED
Jul 17, 2023, 8:30 am
OFFICE OF FAIR HEARINGS

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

[redacted],

PETITIONER, **AHCA Case No.: 23-FH0911**

vs.

AGENCY FOR HEALTH CARE ADMINISTRATION,

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, Hearing Officer Joseph Mabry convened a telephonic Fair Hearing on the instant case on June 8, 2023, at 9:02 a.m. Eastern Standard Time ("EST").

APPEARANCES

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

For the Respondent: Doris Rivera
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 applied behavior analysis ("ABA" or "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. Myron Scott ("Ms. Scott"), BCBA and lead analyst, attended as a witness for Petitioner.

Doris Rivera, Medical Health Care Program Analyst for the Agency for Health Care Administration ("Agency" or "AHCA"), appeared on behalf of Respondent. Dr. Joseph Darling ("Dr. Darling"), Board Certified Behavior Analyst ("BCBA") at the doctoral level and Second Level Reviewer at eQHealth Solutions, Inc. ("eQHealth"), attended as a witness for Respondent.

Prior to the hearing, Respondent sent to the Office of Fair Hearings and Petitioner a ninety-one (91)-page evidence packet. The packet appears in the Office of Fair Hearings' case management system as "[redacted] FH 06.08.2023." Absent an objection from the Petitioner, the undersigned admitted the evidence packet into evidence as Respondent's Composite Exhibit 1 ("RCE 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-FH0911- Agency policy 49 pgs." Absent an objection from the Petitioner, the undersigned admitted the 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 (QIO) contracted by the agency to review prior authorization requests for services. *See* page 2 of RCE 2.

2. Petitioner is [redacted] old. *See* page 16 of RCE 1. Petitioner is diagnosed with [redacted]. *Id.*

3. The Behavior Support Plan ("treatment plan"), shows that Petitioner is engaging in the following maladaptive behaviors: [redacted] *Id.* at 80. Petitioner is learning the following replacement behaviors: [redacted] *Id.* at 82.

4. Petitioner requested the continuation of the following BA services: 416 units of code 97155; 2,080 units of code 97153; and 104 units of code 97156. In a Notice of Outcome ("NOO"), dated March 23, 2023, Respondent terminated Petitioner's BA services. *See* RCE 1 pages 23 - 25. 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:

> PR Clinical Rationale – Denial: According to the Florida Medicaid State Plan (Appendix 9.3.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. The recommendations for procedural modifications include additions/changes to treatment plan to impact behaviors targeted for reduction. Procedural modification should include one or more of the following: antecedent manipulation modifications, modifications of prompting procedures used in acquisition, modifications in consequence-based strategies—ones that either reduce maladaptive behavior or reinforce replacements behavior (e.g., manipulation of reinforcement schedules, switch to a different decelerative procedure), or if lack of progress was due to therapist error (e.g, poor data collection or poor training on intervention methods), how you will address human error. The provider has not addressed the lack of progress during the last observation period and did not amend the treatment plan in relation to the lack of progress. The provider was requested to submit additional information on

> treatment modifications to determine the medical necessity of this request and the provider has either failed to submit this information or the information submitted does not meet standards of care within the field of behavior analysis or the information submitted is insufficient to address the lack of progress indicated. The request for BA services is denied.
> . . .

Pages 23 – 24 of RCE 1.

5. Petitioner requested reconsideration of the Respondent's decision. In a Notice of Reconsideration Determination ("NRD"), dated April 26, 2023, the Respondent upheld its decision. *Id.* at 35 - 38. The NRD stated as follows:

> PR Recon Determination: At reconsideration all documents were carefully reviewed. According to the Florida Medicaid State Plan (Appendix 9.3.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. The recommendations for procedural modifications include: additions/changes to treatment plan to impact behaviors targeted for reduction. Procedural modifications should include one or more of the following: antecedent manipulation modifications, modifications of prompting procedures us in acquisition, modification in consequence-based strategies—ones that either reduce maladaptive behavior or reinforce replacement behavior (e.g., manipulation of reinforcement schedules, switch to a different decelerative procedure), or if lack of progress was due to therapist error (e.g., poor data collection or poor training on intervention methods), how the provider will address human error. The recommendations are insufficient to support continued care. This reconsideration request has been reviewed, reconsidered and the denial is upheld.
> . . .

Page 36 of RCE 1.

6. Dr. Darling is a BCBA at the doctoral level and a Second Level Reviewer at eQHealth. Dr. Darling testified to the following:

a. eQHealth's reviews behavior analysis cases to see if 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

original and revised treatment plans submitted in this case to ensure that all five (5) conditions of medical necessity policy are met. Petitioner's request for continuation of service was denied because the treatment plan is not consistent with generally accepted professional medical standards as determined by the Medicaid program.

b. The original treatment plan did not include the requisite standards of ABA therapy necessary to demonstrate a need for continued treatment. *Id.* at 18. Without demonstration of previously collected data regarding the recipient's treatment during the previously approved care period, the treatment plan did not meet the requirements to demonstrate a need for continued care.

c. The provider had an opportunity to submit additional data from the previously approved care period to demonstrate a need for continued care. The provider submitted additional information regarding the treatment plan and requested reconsideration. However, the additional treatment information submitted by the provider failed to include procedural modifications to address the lack of treatment progress as evidenced by the previously submitted data. Dr. Darling pointed out that the reviewer on reconsideration found that the procedural modifications that were included were "[i]nsufficient to support continued care." *Id.* at 19.

d. Dr. Darling testified that the behavior plan that was submitted by the provider did not sufficiently comply with the practice guidelines for the field of Behavioral Analysis services. The treatment plans submitted by the practitioner did not

indicate that previous ABA treatment had any positive impact on the recipient's maladaptive behaviors. *Id.* at 82.

e. Dr. Darling explained that maladaptive behaviors are the behaviors that are intended to be reduced and that replacement behaviors are intended to be increased. The efficacy of treatment is done primarily by the visual interpretation of graphs. Here, the graphs of the replacement behaviors do not show any change during the course of treatment. *Id.* at 81. There is a slight increase of the replacement behaviors – but there's no indication that is the result of therapy or rather the maturation of the Petitioner. *Id.* at 82.

f. Dr. Darling concluded that in sum the information submitted by the provider failed to show that sufficient progress had been made during the previous period of ABA therapy to justify the continuation of that care.

7. [redacted] provided the following information during [redacted] testimony at the hearing:

a. Petitioner needs behavior analysis services because [redacted] is unable to recognize the concept of safety for [redacted] and those around him. The petitioner and [redacted] family are seeking behavior analysis services to discover treatment options that work best for the petitioner's needs.

b. [redacted] shared that the petitioner has been diagnosed [redacted] and [redacted] that have impacted [redacted] ability to function normally in a school environment. The petitioner has transferred schools as a result of [redacted] behaviors in the past. As a result of [redacted] behaviors, [redacted]

c. [redacted] testified that the petitioner has experienced negative reactions to treatment in the past and expressed a desire to find treatment safe and effective treatment for the petitioner in the future. Further, [redacted] shared that the petitioner seemed to be making behavioral progress at home.

8. Ms. Scott provided the following information during her testimony at the hearing:

a. Ms. Scott testified that temporal inconsistencies with the petitioner's baseline data were a result of lack of treatment because of a previous denial of treatment. Further, she clarified her methods of demonstrating analysis data. Ms. Scott's methods of displaying analysis data involve grouping types of behavior together.

b. Further, Ms. Scott affirmed [redacted] opinion that the Petitioner has made significant progress as a result of [redacted] treatment.

CONCLUSIONS OF LAW

9. 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).

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

11. Because Respondent terminated 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.).

12. 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 no 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.

13. 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 than 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

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 age 21, and therefore EPSDT applies to the 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 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.

17. 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.

18. In the instant case, Respondent terminated Petitioner's ABA services. *See* ¶ 4. In the NOO dated March 23, 2023, Respondent explained that continuing services with the current provider

was not medically necessary, specifically, that it did not meet the requirements that services must be "consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigation." *Id.* Respondent further explained that "[t]he information submitted does not meet standards of care within the field of behavior analysis or the information submitted is insufficient to address the lack of progress indicated." *Id.*

19. 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, Petitioner's submitted treatment plan shows no improvement regarding the reduction of maladaptive behaviors and little improvement in increasing Petitioner's replacement behaviors. *See* ¶ 6. Dr. Darling explained that the lack of progress shows that the provider's treatment does not conform to the standards of care within the field of ABA. In all, based on Dr. Darlings's credible testimony and the lack of progress in the treatment, Respondent demonstrated that the provider's treatment is not ""consistent with generally accepted professional medical standards as determined by the Medicaid program".

20. 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* ¶ 17. As discussed, supra ¶ 20, the current treatment plan is ineffective. Here, Petitioner's lack of improvement is well documented.

21. 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 is **AFFIRMED**. Petitioner's appeal based on Respondent's termination is **DENIED**.

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

Joseph Mabry
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JOSEPH MABRY, 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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