



**FILED**

Jul 25, 2023, 1:38 pm  
OFFICE OF FAIR HEARINGS

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

[REDACTED]

**PETITIONER,**

**AHCA Case No.: 23-FH0940**

**vs.**

**AGENCY FOR HEALTH CARE  
ADMINISTRATION,**

**RESPONDENT.**

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**FINAL ORDER**

Pursuant to notice, the undersigned convened a telephonic Fair Hearing on the instant case on **June 20, 2023**, at **1:00** p.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 Behavior Analysis (“BA” or “ABA”) services was correct.

**PRELIMINARY STATEMENT**

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

Doris Rivera ("Ms. Rivera") Medical/Health Care Program Analyst for the Agency for Health Care Administration ("Agency" or "AHCA"), appeared on behalf of Respondent. David Bicard ("Dr. Bicard"), Director of Clinical Operations for eQHealth Solutions Inc. ("eQHealth") appeared as a witness for Respondent.

Prior to the hearing, Respondent sent to the Office of Fair Hearings and Petitioner a two hundred and forty-six (246)-page evidence packet and a forty-nine (49)-page evidence packet. The two hundred and forty-six (246) page packet appears in the Office of Fair Hearings' document management system as the file title "[REDACTED] FH 06.30.23 1-143.pdf" and "[REDACTED] FH 06.30.23 144-246.pdf." The forty-nine (49)-page evidence packet appears in the Office of Fair Hearings' document management system as the file title "23-FH0940 -Agency BA pg 49.pdf". Absent an objection from the Petitioner, the undersigned admitted the two hundred forty-six (246)-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] old. *See* page 16 of RCE 1. Petitioner is diagnosed with the following: [REDACTED]. *Id.* According to the ABA Support Plan, dated [REDACTED] ("Treatment Plan"),

Petitioner engages in the following maladaptive behaviors that interfere with the Petitioner's daily functioning: [REDACTED].

*Id.* at 221.

3. The Treatment Plan data graphs for maladaptive behaviors show the following: instances of [REDACTED] decreased from [REDACTED] to [REDACTED] per month; incidents of [REDACTED] increased from [REDACTED] to [REDACTED] per month; incidents of [REDACTED] decreased from [REDACTED] to [REDACTED] per month; incidents of [REDACTED] decreased from [REDACTED] to [REDACTED] per month. *Id.* at 226-227.

4. Petitioner requested continuation of BA services; specifically, 2,080 units of code 97153; 104 units of code 97155; and 312 units of code 97156. In a Notice of Outcome ("NOO"), dated April 18, 2023, Respondent terminated Petitioner's ABA services. The NOO explained the basis for the reduction/termination 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 or injury under treatment, and not in excess of the patient's needs.

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

The NOO further provided:

PR Principal Reason – Denial:

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

PR Clinical Rationale – Denial: According to 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 the treatment plan to impact behaviors targeted for reduction. Procedural modification should include one or

more of the following: antecedent manipulation modifications, modifications prompting procedures used in acquisition, modifications of consequence-based strategies ones that either reduce maladaptive behavior or reinforce replacement behavior (e.g. manipulation of reinforcement schedules, switch to a different declarative procedure), or if lack of progress was due to therapist error (e.g. 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. And did not amend the treatment plan in relation to the lack of progress. The information submitted does not meet standards of care within the field of behavior analysis. This request is denied.

...

Pages 28-30 of RCE 1.

5. Petitioner requested reconsideration of the Respondent's decision. In a Notice of Reconsideration Determination ("NRD"), dated April 27, 2023, Respondent upheld its decision.

*Id.* at 40 – 41. The NRD explained the basis for the decision as follows:

The reason for the denial is that the services are not medically necessary as defined in 59G-1.010, Florida Administrative Code. Specifically[,] the services must be:

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

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 in 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 come on modifications of prompting procedures used in acquisition, modifications in consequence- based strategies ones that either reduce maladaptive behavior or reinforce replacement behavior (e.g., manipulation of reinforcement schedules, switch to a different declarative 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.

...

Pages 40 – 41 of RCE 1.

6. On April 26, 2023, Petitioner requested a Fair Hearing to challenge the termination of ABA services. On May 12, 2023, the undersigned issued an Order Scheduling Fair Hearing and Prehearing Instructions, setting the hearing for June 20, 2023, at 1:00 p.m. EST.

7. Dr. Bicard is a Board-Certified Behavior Analyst at the doctoral level. Dr. Bicard testified to the following:

- a. The data reviewed reflects Petitioner is receiving sub-standard care.
- b. Petitioner has been receiving BA services for over [REDACTED]
- c. Petitioner is not making progress on [REDACTED] goals.
- d. On page 226 of RCE 1, the graphs show no improvement in maladaptive behaviors of [REDACTED].
- e. Provider is only collecting data monthly and the data do not match the graphs. Consistent with standards of care in ABA, new procedures would be implemented within a month to address a lack of progress and that did not happen here.
- f. The treatment plan lacks sufficient information and clarity; for instance, the data graphs do not show that the provider has made appropriate interventions to address Petitioner's lack of progress.
- g. Dr. Bicard asserted that the Petitioner meets the criteria for discontinuation of services on page 46 of RCE 2. Dr. Bicard believes Petitioner needs BA services, but the information provided does not show progress or that the Treatment Plan is effective.

8. [REDACTED] Petitioner's [REDACTED] testified to the following:

- a. [REDACTED] child has a [REDACTED].
- b. [REDACTED] [REDACTED] recently died from [REDACTED].
- c. [REDACTED] [REDACTED] recently started a new school and [REDACTED] behavior therapists are complaining about [REDACTED] [REDACTED] 's behaviors.
- d. Petitioner has had changes in [REDACTED] life because [REDACTED] prior behavioral therapist left.
- e. [REDACTED] agrees that problems with [REDACTED] [REDACTED] and [REDACTED] are not being addressed.
- f. [REDACTED] believes [REDACTED] [REDACTED] has [REDACTED] and need needs [REDACTED]

#### **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 reduced/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.)

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 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.

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 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

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 ■■■ 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, in the NOO and NRD, Respondent terminated Petitioner's ABA services. See ¶ 4-5. Respondent explained that the services did not meet the following medical necessary criteria: "individualized, specific and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patients' needs" and "consistent

with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational.” The NOO and NRD stated that the data must show evidence that the frequency of the maladaptive behaviors has decreased since the last review and if not that there is a modification of the behavior plan. *Id.*

19. As provided in the BA Policy and EPSDT requirements, the Recipient must meet the medical necessity criteria as outlined in Florida Administrative Code R. 59 G- 1.010. See ¶13. Dr. Bicard provided credible and persuasive testimony that the Treatment Plan does not meet standards of care in the field of ABA. As Dr. Bicard testified, the data and plan received from provider shows no improvement in maladaptive behaviors without any corresponding modifications to counteract the lack of improvement. See ¶ 3, 4-6.

20. Dr. Bicard further testified that the Treatment Plan did not meet standards of care in ABA because the data was difficult to read the data as it did not match with the graphs provided. See ¶ 6.

21. In this case, Petitioner has received BA services for the past [REDACTED]. The Treatment Plan shows no improvement and no intervention to address the lack of progress in maladaptive behaviors to include [REDACTED]. As Dr. Bicard testified, the Treatment Plan is not effective. Accordingly, Petitioner would not gain any additional benefit from continuing under the Treatment Plan.

22. In this case, Petitioner’s provider recommended the continuation of BA services. See ¶ 4. 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 ¶ 16.

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 requested ABA services are not medically 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 reduction 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 25th day of July, 2023, in Tallahassee, Leon County, Florida.



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**LYNNE RINGERS, Hearing Officer**  
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**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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