

attended as witnesses for Petitioner: Danitza Rodriguez, Board Certified Behavior Analyst (“BCBA”) for Petitioner; Yahumara Gener, BCBA for Petitioner; and Segundo Gonzalez, for

[REDACTED].

Diana Hearod, Medical/Health Care Program Analyst for the Agency for Health Care Administration (“Agency” or “AHCA”), appeared on behalf of Respondent. The following attended as witnesses for Respondent: Allissa Conway, BCBA at the doctoral level and Second Level Reviewer for eQHealth Solutions Inc. (“eQHealth”); and Marielisa Amador, Medical/Health Care Program Analyst for the Agency.

George, interpreter number 68005930 of Global Interpreting Network, appeared to offer translation services for the Petitioner.

Prior to the hearing, Respondent sent to the Office of Fair Hearings and Petitioner an x-page evidence packet and a forty-nine (49)-page evidence packet. The 170-page packet appears in the Office of Fair Hearings document management system as the file title “[REDACTED] FH 06.15.2023.pdf”. The forty-nine (49)-page evidence packet appears in the Office of Fair Hearings document management system as the file title “23-FH0999 AHCA Evidence (Pages 1 – 49 of 49).pdf”. Absent an objection from the Petitioner, the undersigned admitted 170-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] old. See page 21 of RCE 1. Petitioner is diagnosed with [REDACTED]. *Id.*

3. Petitioner requested the following ABA services; specifically, 3,120 units of code 97153; 208 units of code 97155; and 208 units of code 97156. *Id.* at 27 – 29. In response to the request, eQHealth issued a Request for Additional Information (“RAI”), dated March 17, 2023, that stated as follows:

The supporting documentation does not meet generally accepted practices within the field of applied behavior analysis and standards set forth in the Florida Behavior Analysis Services Coverage Policy (Pages 6-7). According to the Florida Medicaid State Plan (Appendix 9.2.c), assessment and used to develop replacement skills. Also, please submit a rationale for this request for services units. The justification submitted with this treatment plan is insufficient given the requested units and the recipient’s maladaptive behaviors and skill deficits addressed in this treatment plan. Thank you.

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Page 50 of RCE 1.

4. In a Notice of Outcome (“NOO”), dated March 28, 2023, Respondent denied Petitioner’s request. The NOO explained the basis for its decision 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 Clinical Rationale – Denial: The supporting documentation does not meet generally accepted practices within the field of applied behavior analysis and standards set forth in the Florida Behavior Analysis Services Coverage Policy (Pages 6 -7). The provider was approved to complete an assessment and the provider has not submitted skill assessment outcomes as informed in the assessment and used to develop replacement skills that were to be completed during the assessment. The provider was requested to produce those data to

initiate behavior analysis services. The provider did not make the needed changes to the treatment plan. This request for services is denied.

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Pages 27 – 28 of RCE 1.

5. Petitioner requested reconsideration of the Respondent’s decision. In a Notice of Reconsideration Determination (“NRD”), dated May 1, 2023, Respondent upheld its decision. *Id.* at 38 - 40. 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. The supporting documentation does not meet generally accepted practices within the field of applied behavior analysis and standards set forth in the Florida Behavior Analysis Services Coverage Policy (Pages 6 – 7). The provider was approved to complete an assessment, [t]he provider has not submitted all observed graphed data for skill acquisition goals and maladaptive behaviors that were to be complete during the assessment. The provider was requested to produce those graphed data to initiate behavior analysis services. The provider has submitted graphed data that do not reflect information in their treatment plan. The data appear fabricated. This denial is upheld.

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Pages 40 – 41 of RCE 1.

6. On May 2, 2023, Petitioner requested a Fair Hearing to challenge the denial of ABA services. On May 16, 2023, the undersigned issued an Order Scheduling Fair Hearing and Prehearing Instructions, setting the hearing for June 15, 2023, at 9:00 a.m. EST.

7. [REDACTED] is Petitioner’s [REDACTED] [REDACTED] testified to the following:

- a. Petitioner is diagnosed with [REDACTED].
- b. Petitioner exhibits [REDACTED] at school.

- c. The provider did the assessment over two (2) days, spending three (3) hours each day on the assessment.
 - d. The provider observed Petitioner during the assessment.
 - e. The provider spoke with the Petitioner directly and asked [REDACTED] a “lot of different questions”.
8. Ms. Gener is a BCBA. Ms. Gener testified to the following:
- a. The provider conducted a direct observation of the client, interviewed the caregiver, and used a test to create an initial assessment. Using the Functional Analysis Screen Tool, Motivation Assessment Scale, Vineland, and the Assessment of Basic Language and Learning Skills (“ABLLS”), the provider identified seven (7) maladaptive behaviors.
 - b. Petitioner engages in [REDACTED]
[REDACTED]
 - c. The provider conducted a Vanderbilt test at Petitioner’s school. It was reported that Petitioner has [REDACTED]
[REDACTED]
 - d. The direct observations were done in the home. The data in the graphs come from direct observation by the provider and the caregiver.
9. Dr. Conway is a BCBA at the doctoral level. Dr. Conway testified to the following:
- a. Petitioner was approved for a six (6) hour ABA assessment. The treatment plan indicates that the analyst completed direct observations, but there is no Antecedent Behavior Consequence Data from this observation.

- b. There are only indirect or interview style assessments that the provider discussed in her testimony, that do not require direct observation of the client.
- c. The essential practice elements include: an objective assessment and analysis of the client's condition by observing how the environment affects the client's behavior as evidence by appropriate data collection; and consistent, on-going objective assessment of data analysis to inform clinical decision making. Behaviors should be directly observed in a variety of relevant and naturally occurring settings and structured interactions. Baseline data is necessary to target maladaptive behaviors and replacement behaviors.
- d. The treatment plan provides that three (3) hours of observation were performed on [REDACTED], and one (1) hour on [REDACTED]. See page 145 of RCE 1. However, the graphs in the treatment plan do not match this information. For example, some graphs show data from [REDACTED], which is not listed as a date an analyst was present. See page 137 of RCE 1.
- e. The graph for [REDACTED] shows extremely high levels. See page 129 of RCE. This level would approximate to more than [REDACTED] instances per hour for [REDACTED] hour observations; [REDACTED] would indicate [REDACTED] per hours for a [REDACTED] hour observation. *Id.* at 129 and 132. Data graphed should be from direct observation by the analyst – assumptions cannot be made about maladaptive behaviors or replacement behaviors without direct testing and observation. The assessment is crucial for building the foundation of ABA. That data included do not appear to be from direct observation.

- f. The provider was given the opportunity to adjust the graphs and submit data from direct observation but did not do so.

CONCLUSIONS OF LAW

10. 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).

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

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

13. 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.

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1.4.5 Medically Necessary/Medical Necessity

As defined in Rule 59G-1.010, F.A.C.

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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)

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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.

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Pages 1 – 3 of BA Policy.

14. 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

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Pages 6 – 8 of BA Policy.

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

16. 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.

17. 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.

18. In the instant case, Petitioner requested the following ABA services: 3,120 units of code 97153; 208 units of code 97155; and 208 units of code 97156. See ¶ 3. In the NRD, dated May 1, 2023, Respondent explained that the request for services did not meet the following criteria: “[c]onsistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational.” See ¶ 5. Respondent further explained that “[t]he provider has not submitted all observed graphed data . . . that were to be complete during the assessment”. *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 “[c]onsistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational.” At the Fair Hearing, Dr. Conway testified that an essential element of ABA services is an objective assessment of the client's behavior that is directly observed by the analyst. See ¶ 9. Here, the treatment plan shows that data was used in the assessment that was not directly observed by the analyst. *Id.* Moreover, this was confirmed by


Ms. Gener, who explained that some of the data came from the caregiver's observations. See ¶ 8. As such, the Petitioner did not show that the submitted treatment plan was "consistent with generally accepted professional medical standards."

20. Upon consideration of the testimony provided, evidence submitted, and applicable polices, the undersigned concludes that Petitioner did not prove by a preponderance of the evidence that the denied units of ABA services were necessary. Looking at all the evidence relevant to the particular needs of Petitioner, Petitioner has not demonstrated that the services based on this treatment plan, are necessary to correct or ameliorate a defect or a physical and mental illness or condition. Accordingly, Petitioner did not prove by a preponderance of the evidence that Respondent's denial of ABA services was incorrect.

IT IS HEREBY ORDERED AND ADJUDGED THAT:

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

DONE and ORDERED this 28th 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:



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