



**FILED**

Aug 24, 2023, 8:36 am  
OFFICE OF FAIR HEARINGS

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

[REDACTED]

**PETITIONER,**

**AHCA Case No.: 23-FH1198**

**vs.**

**AGENCY FOR HEALTH CARE  
ADMINISTRATION,**

**RESPONDENT.**

\_\_\_\_\_ /

**FINAL ORDER**

Pursuant to notice, the undersigned convened a telephonic Fair Hearing on the instant case on July 21, 2023, at 9:00 a.m. Eastern Standard Time (“EST”).

**APPEARANCES**

For the Petitioner:

[REDACTED]

Petitioner’s Authorized Representative

For the Respondent:

Lee Ann Williams  
Medical/Health Care Program Analyst  
Agency for Health Care Administration

**STATEMENT OF ISSUE**

The issue is whether Respondent proved by a preponderance of the evidence that Respondent’s decision to terminate Petitioner’s Behavior Analysis (“BA” or “ABA”) services was correct.

**PRELIMINARY STATEMENT**

All parties and witnesses appeared telephonically. Petitioner’s Authorized Representative and [REDACTED], [REDACTED] (“[REDACTED]”), appeared on behalf of Petitioner.

Lee Ann Williams (“Ms. Williams”), Medical/Health Care Program Analyst and Fair Hearing Liaison for the Agency for Health Care Administration (“Agency” or “AHCA”), appeared on behalf of Respondent. Dr. Joseph Darling (“Dr. Darling”), Board Certified Behavior Analyst at the doctoral level and Second Level Reviewer for eQHealth Solutions Inc. (“eQHealth”), appeared as a witness for Respondent.

Petitioner did not introduce any exhibits at the hearing. Prior to the hearing, Respondent sent to the Office of Fair Hearings and Petitioner a two-hundred and twenty (220)-page evidence packet and a forty-nine (49)-page evidence packet. The two-hundred and twenty (220)-page evidence packet appears in the Office of Fair Hearings’ document management system as the file titles “[REDACTED] FH 07.03.2023 1-68.pdf”, “[REDACTED] FH 07.03.2023 69-104.pdf”, “[REDACTED] FH 07.03.2023 105-139.pdf”, “[REDACTED] FH 07.03.2023 140-172.pdf”, “[REDACTED] FH 07.03.2023 173-208.pdf”, and “[REDACTED] FH 07.03.2023 209-220.pdf”. The forty-nine (49)-page evidence packet appears in the Office of Fair Hearings’ document management system as the file title “23-FH1198 AHCA Evidence packet 49 pages.pdf”. Absent an objection from the Petitioner, the undersigned admitted the two-hundred and twenty (220)-page evidence packet into evidence as Respondent’s Composite Exhibit 1 (“RCE 1”) and the forty-nine (49)-page evidence packet into evidence as Respondent’s Composite Exhibit 2 (“RCE 2”).

#### **FINDINGS OF FACT**

1. Petitioner receives Medicaid services on a fee-for-service basis from the Agency. eQHealth is a Quality Improvement Organization contracted by the Agency to review prior authorization requests for services. See page 2 of RCE 2.

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

3. As provided in the Behavior Analysis Reassessment (“Treatment Plan”), Petitioner is engaging in the following maladaptive behaviors: [REDACTED] ([REDACTED], [REDACTED] and [REDACTED]); [REDACTED] ([REDACTED], [REDACTED]); [REDACTED]; [REDACTED] ([REDACTED]); [REDACTED]; [REDACTED]; [REDACTED]; [REDACTED]; and [REDACTED]. *Id.* at 53, 55-56.

4. Petitioner successfully engages in [REDACTED] replacement behaviors, for the period of September 17, 2022, to February 25, 2023, at the following rates: for [REDACTED], Petitioner’s incidents increased from [REDACTED] per week; for [REDACTED], Petitioner’s incidents increased from [REDACTED] per week; for [REDACTED], Petitioner’s incidents increased from [REDACTED] per week; for [REDACTED], Petitioner’s incidents increased from [REDACTED] per week; for [REDACTED], Petitioner’s incidents increased from [REDACTED] per week; for [REDACTED], Petitioner’s incidents increased from [REDACTED] per week; for [REDACTED], Petitioner’s incidents increased from [REDACTED] per week; for [REDACTED], Petitioner’s incidents increased from [REDACTED] per week; for [REDACTED], Petitioner’s incidents increased from [REDACTED] per week; for [REDACTED], Petitioner’s incidents increased from [REDACTED] per week; and for [REDACTED], Petitioner’s incidents increased from [REDACTED] per week. *Id.* at 112-121.

5. Petitioner requested continuation of BA services; specifically, 3,120 units of code 97153; 416 units of code 97155; and 104 units of code 97156. In a Notice of Outcome (“NOO”), dated April 12, 2023, Respondent terminated Petitioner’s ABA services. 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:

All submitted records were reviewed. There are two maladaptive behaviors that indicate minimal progress for the previous authorization period.

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 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 decelerative procedure), or if the 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.

This request for BA services is denied.

...

Pages 22 – 23 of RCE 1.

6. Petitioner requested reconsideration of the Respondent’s decision. In an Untimely

Request for Reconsideration Review, dated May 12, 2023, Respondent explained as follows:

We sent a letter saying that the care above had been denied.

We received a request to look at your case again. We are sorry to tell you that the deadline for doing so has passed.

...

7. On May 16, 2023, Petitioner requested a Fair Hearing to challenge the termination of ABA services. *Id.* at 8. On June 6, 2023, the undersigned issued an Order Scheduling Fair Hearing by Telephone and Prehearing Instructions (“Scheduling Order”), scheduling the hearing for July 3, 2023, at 1:00 p.m. EST. *Id.* On June 29, 2023, the undersigned issued a second Scheduling Order, scheduling the hearing for July 21, 2023, at 9:00 a.m. EST.

8. Dr. Darling is a Board Certified Behavior Analyst at the doctoral level. Dr. Darling testified to the following at the Fair Hearing:

- a. The treatment plan did not meet the medical necessity criteria that services must be consistent with generally accepted professional medical standards and not in excess of the patient’s needs. The data indicate minimal progress and ineffective treatment.
- b. Behavior Analysis involves graphing of behaviors – behaviors that need to be reduced (maladaptive behaviors), and behaviors that are intended to replace those behaviors. The goal is to replace problem behaviors with acceptable and functional behaviors (replacement behaviors). Effective treatment will show, through graphs, less maladaptive behaviors over time and more replacement behaviors. The visual interpretation of graphs is the main way effective treatment is demonstrated.
- c. The baseline for “ [REDACTED] – [REDACTED] ” has a baseline of [REDACTED], and over approximately [REDACTED], did not show a significant decrease. Over [REDACTED] of treatment it reduced from approximately [REDACTED]. See page 57 of RCE

1. Essentially, this is a flat and needs an intervention to make the behavior reduce more quickly.

- d. The remaining maladaptive behaviors largely show the same thing – flat data with little improvement. When data are flat, standards of care for active treatment within the field of behavior analysis require a change in procedure to more rapidly decrease the maladaptive behavior. The provider did not make changes, when the behavior was not decreasing, in a timely manner.
- e. Petitioner’s replacement behavior data represent ineffective treatment. The provider’s goal for Petitioner’s replacement behaviors to improve by 5% every eight (8)-weeks is not supported by research within the field of applied behavior analysis. Treatment should move more quickly given Petitioner’s age. Targets should be met every three (3) to five (5) days.

9. [REDACTED] is the [REDACTED] of the Petitioner. [REDACTED] testified to the following at the Fair Hearing:

- a. Services were not continued as they should have been pending the outcome of the Fair Hearing. Petitioner has not had therapy in [REDACTED]. Without therapy, Petitioner’s maladaptive behaviors have increased.
- b. In [REDACTED], Petitioner began treatment with a new therapist.
- c. Petitioner’s graphs are stable and not increasing, which is a great improvement.

**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 Respondent terminated a previously approved service, Fla. Admin. Code R. 59G-1.100(17)(g) assigns the burden of proof to the Respondent. The standard of proof in an administrative hearing is a preponderance of the evidence. The preponderance of the evidence standard requires proof by “the greater weight of the evidence” (Black’s Law Dictionary at 1201, 7th Ed.)

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.

...

**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.

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

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 ■ 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. 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.

19. In the instant case, Respondent terminated Petitioner’s ABA services. *See* ¶ 5. In the NOO dated April 12, 2023, Respondent explained that continuing services at the prior level was not medically necessary, specifically, that it did not meet the requirement that services must be “consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational.” *Id.* Respondent further explained that “the 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.” *Id.*

20. 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 maladaptive behavior and replacement behavior graphs exhibit minimal progress. *See* ¶¶ 4, 8. Dr. Darling described the treatment being rendered as “ineffective” due to the lack of intervention to address the flat data

depicting Petitioner’s maladaptive behaviors. *See* ¶ 8. Dr. Darling also described the rate of progress outlined for Petitioner’s replacement behaviors as being too slow, and therefore inconsistent with standards of care within the field of behavior analysis. *Id.* Dr. Darling also asserted that the provider’s treatment plan does not meet medical necessity criteria. *Id.* As Petitioner has not made substantial improvements, the record shows that Petitioner will not gain any additional benefit by continuing services at the current level.

21. 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* ¶ 18. As discussed, *supra* ¶ 20, Petitioner has not made progress in reducing ■ maladaptive behaviors, nor in improving ■ replacement behaviors. Here, Petitioner’s lack of improvement is well documented.

22. Upon consideration of the testimony provided, evidence submitted, and applicable polices, the undersigned concludes that Respondent proved by a preponderance of the evidence that the termination of ABA services was necessary. Looking at all the evidence relevant to the particular needs of Petitioner, Respondent has demonstrated that the previously authorized services, based on the treatment plan at issue in this case, are not necessary to correct or ameliorate a defect or a physical and mental illness or condition. Accordingly, Respondent proved by a preponderance of the evidence that Respondent’s termination of ABA services was correct.

**IT IS HEREBY ORDERED AND ADJUDGED THAT:**

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

**DONE** and **ORDERED** this 24th day of August, 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]  
[REDACTED]  
[REDACTED]  
[REDACTED]

**AHCA Medicaid Hearing Unit**  
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