

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



FILED

Aug 16, 2023, 10:49 am

OFFICE OF FAIR HEARINGS

[REDACTED]

PETITIONER,

AHCA Case No.: 23-FH1205

vs.

AGENCY FOR HEALTH CARE  
ADMINISTRATION,

RESPONDENT.

\_\_\_\_\_ /

**FINAL ORDER**

Pursuant to notice, the undersigned Hearing Officer convened a telephonic Fair Hearing on the instant case on June 22, 2023, at 1:00 p.m. EST.

**APPEARANCES**

For the Petitioner:

[REDACTED]

Petitioner's Authorized Representative

For the Respondent:

Diana Hearod  
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") services was correct.

**PRELIMINARY STATEMENT**

All parties and witnesses appeared telephonically. Petitioner's Authorized Representative and [REDACTED], [REDACTED] ("[REDACTED]"), appeared on behalf of the Petitioner. Dr. Adrienne Ellers ("Dr. Ellers"), Board Certified Behavior Analyst, attended as a witness for the Petitioner. Dr. Cheryl Alvies ("Dr. Alvies"), Board Certified Behavior Analyst at the Doctoral level and Clinical Director overseeing the Petitioner's care, also attended as a witness for the Petitioner.

Diana Hearod, Medical Health Care Program Analyst for the Agency for Health Care Administration ("Agency" or "AHCA"), appeared on behalf of Respondent. Doris Rivera, Medical Health Care Program Analyst for AHCA appeared as an observer. Dr. David Bicard ("Dr. Bicard"), Board Certified Behavior Analyst and Director of Clinical Operations at eQHealth Solutions, Inc. ("eQHealth"), attended as a witness for Respondent.

Prior to the hearing, Petitioner sent to the Office of Fair Hearings and Respondent a fifty-four (54)-page evidence packet. The packet appears in the Office of Fair Hearings' case management system as "23-FH1205 Supporting Documents.pdf." Absent an objection from the Respondent, the undersigned admitted the evidence packet into evidence as Petitioner's Composite Exhibit 1.

Prior to the hearing, Petitioner sent to the Office of Fair Hearings and Respondent a twenty (20)-page evidence packet. The packet appears in the Office of Fair Hearings' case management system as "23-FH1205 Petitioner Faxed Evidence.pdf." Absent an objection from the Respondent, the undersigned admitted the evidence packet into evidence as Petitioner's Composite Exhibit 2.

Prior to the hearing, Respondent sent to the Office of Fair Hearings and Petitioner a one hundred seventy-four (174)-page evidence packet. The packet appears in the Office of Fair

Hearings' case management system as "[REDACTED] FH 06.22.2023.pdf." Absent an objection from the Petitioner, the undersigned admitted the evidence packet into evidence as Respondent's Composite Exhibit 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-FH1205 -Agency Evidence BA 49pgs.pdf." Absent an objection from the Petitioner, the undersigned admitted the evidence packet into evidence as Respondent's Composite Exhibit 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.

2. As of the date of the hearing, Petitioner is [REDACTED]. See Respondent's Composite Exhibit 1 at page 16.

3. Petitioner requested the continuation of the following BA services: 3,360 units of code 97153, 144 units of code 97155, and 52 units of code 97156. *Id.* at 20-21. In an Notice of Outcome ("NOO") dated April 10, 2023, Respondent terminated Petitioner's BA services. *Id.* at 24-25. 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 NOA further provided:

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

PR Clinical Rationale – Denial: The maladaptive behavior or physical aggression has increased from baseline. Additionally, despite the Pend, Provider is graphing data on a monthly basis only. 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 reductions . . . The provide 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 medical necessity of this request and the provider has either failed to submit this information of 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.

*Id.*

4. Petitioner requested reconsideration of the Respondent’s decision. In an Notice of Reconsideration Determination (“NRD”), dated May 20, 2023, the Respondent upheld its decision. *Id.* at 36 - 38. The NRD provides 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 are insufficient to support continued care. This reconsideration request has been reviewed, reconsidered and the denial is upheld.

*Id.*

5. Dr. Bicard is a Board Certified Behavior Analyst and the Director of Clinical Operations at eQHealth. At the hearing, Dr. Bicard established that eQHealth 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 services was denied because the treatment plan is not consistent with generally accepted professional medical standards as determined by the Medicaid program.

6. Specifically in this case, Dr. Bicard explained that the services requested by the Petitioner were terminated because the Petitioner has not made demonstrated progress on the maladaptive behaviors identified by the treatment plan submitted by the provider.

7. The data submitted by the provider depicted six points of data collected at monthly intervals. Dr. Bicard stated that not only is data collected at monthly intervals inconsistent with standards of care in behavior analysis, but it is difficult to interpret the data to determine whether real progress had been made over the course of treatment. Dr. Bicard asserted that none of the documentation submitted by the provider suggests that the provider worked with the Petitioner on any replacement skills identified in the treatment plan. For these reasons, the treatment was denied because the treatment plan did not meet standards of care within the behavioral analysis field.

8. The original treatment plan submitted by the provider was recommended to a second level reviewer at eQHealth. A second level reviewer requested additional graphs from the provider to supplement the originally submitted plan. The provider submitted additional "treatment results" from the last authorization period. *Id.* at 19. After reviewing the additional data, the second level reviewer denied the treatment based on a lack of progress made by the Petitioner and because the data failed to sufficiently demonstrate that the Petitioner's treatment plan addressed targeted behaviors. *Id.* Upon request for reconsideration, the provider had the

opportunity to submit additional information for review but did not exercise the opportunity to do so. The treatment was denied upon reconsideration. Dr. Bicard stated that by the end of the reconsideration process, three separate board-certified behavior analysts had reviewed the data submitted by the provider and agreed that it did not meet standards of care for the field of behavioral analysis or the BA service coverage policy. After reviewing the data, Dr. Bicard agreed with the conclusions of the previous reviewers.

9. As Dr. Bicard established, the treatment plan states that behavioral data will be collected from working with the recipient daily. *Id.* at 172. The data provided however, details only monthly data points. *Id.* 149-150. Further, the data provided does not reflect that the Petitioner's maladaptive behaviors have improved. *Id.* Standards of care within the BA field dictate that a recipient's behavior is continuously documented and when the recipient does not respond to treatment, an intervention must be made by the Behavioral Analyst. An intervention is a change in the treatment that is meant to address why there is a lack of response to treatment. The treatment plan does not provide any example of interventions planned or given. Therefore, the treatment plan does not meet standards of care within the BA field.

10. Dr. Bicard concluded [REDACTED] testimony by stating that the data provided by the provider is unclear. *Id.* 150. The initial request for treatment provided very little detail about the treatment given to the Petitioner. The provider was asked to submit additional information detailing the treatment delivered and did not do so. The request for treatment was then denied.

11. Dr. Adrienne Ellers is the primary provider of therapy for the Petitioner and the individual that provided the information to eQHealth upon request. She testified that, at the start of therapy, Petitioner demonstrated a significant problem with [REDACTED]. She explained that

any [REDACTED]. This made taking an initial skills assessment highly difficult, so a substitute assessment was used.

12. Dr. Ellers testified the treatment plan resulted in skill gains. She recognized that the documented maladaptive behaviors had not decreased to the extent desired; however, she asserted that the Petitioner demonstrated positive skills gains that supported the conclusion that the treatment was working. Dr. Ellers noted that ABA therapy alone would likely not be sufficient and that medication may be used to supplement behavior analysis therapy.

13. Dr. Alvies testified to her personal work with the Petitioner and described [REDACTED] need for BA services. She stated that work with the Petitioner has been extensive, and due to the nature of the Petitioner's behavior, documentation of behavior on a daily basis would be unreadable on a graph. Dr. Alvies noted that the Petitioner has improved, but in order to document this improvement [REDACTED] behavior needed to be shown on a percentage-based graph to be intelligible. Dr. Alvies asserted that the nature of the Petitioner's behavior was difficult to document in a manner that demonstrates Petitioner's progress.

#### **CONCLUSIONS OF LAW**

14. 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).

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

16. 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.).

17. 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).

18. 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.

19. A state may place medical necessity limitations on EPSDT services. *See* 42 C.F.R. §§ 440.230(a), (b), (d).

20. Section 409.905(2), Florida Statutes, 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.

21. The Florida Medicaid Definitions Policy (“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.

Definitions Policy at page 7.

22. The Behavior Analysis Services Coverage Policy (“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.

...

**4.0 Coverage Information**

**4.1 General Criteria**

Florida Medicaid covers services that meet all of the following:

- Are determined medically necessary
- Do not duplicate another
- Meet the criteria as specified in this policy

23. 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

...

**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:
- 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 treatment 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 Self-stimulating, abnormal, inflexible, or intense preoccupations Self-care - difficulty recognizing risks or danger, grooming, eating, or toileting
  - iii. Other- behaviors not identified above

24. The Florida Medicaid Authorization Requirements Policy (“Authorization Requirements Policy”) (June 2016), incorporated by reference in Fla. Admin. Code R. 59G-1.053, provides general requirements for providers to obtain authorization to render Florida Medicaid services.

The Authorization Requirements Policy states, in pertinent part:

### **3.0 Determination Process**

#### **3.1 Review Criteria**

The QIO may use a national standardized set of criteria, or other set of criteria, approved by AHCA, as a guide for authorizations performed at the first review level. If services cannot be approved at the first level review, the QIO’s physician peer reviewer will determine medical necessity using his or her clinical judgment, acceptable standards of care, state and federal laws, and AHCA’s medical necessity definition.

#### **3.2 Review Process**

The QIO will review each authorization request and will approve, deny, or request additional information. The QIO may deny a portion of the requested units of service if it cannot substantiate medical necessity based upon the information submitted.

##### **3.2.1 Continued Authorization Requests**

The QIO shall not deny or reduce the amount, frequency, or duration of a service that is already being provided, unless:

- The reduction is to correct for factual errors or omissions in prior certifications.
- There is a documented improvement in the recipient’s medical condition.
- There is a documented change in the recipient’s circumstances.
- The reviewing physician determines the recipient will not gain any additional benefit by continuing services at the current level.

Respondent’s Composite Exhibit 2 at pages 32-34.

25. In this case, Respondent terminated Petitioner’s BA services. The NOO and NRD explained that Petitioner’s request for continuation of services did not meet medical necessity as the treatment plan was not “[c]onsistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational.” *See supra* ¶ 3. Further, the submitted information does not support the medical necessity for requested frequency and/or duration. *See supra* ¶ 3.

26. As provided in the BA policy (Appendix 9.0, section (a)), and the EPSDT requirements, the recipient must meet the meet the medical necessity criteria as outlined in Fla. Admin. Code R. 59G-1.010. A component of medical necessity is that services must be “consistent with generally accepted professional medical standards.” As outlined above, Dr. Bicard provided credible and persuasive testimony that the revised treatment plan did not follow generally accepted standards of BA. *See supra* ¶ 6-10. The provider resubmitted a treatment plan for the Petitioner but did not show that Petitioner has made progress on maladaptive behaviors and include procedural modifications to address the lack of progress to the treatment plan and tailor the plan to meet the Petitioner’s specific needs. *See supra* ¶ 6. Thus, Respondent demonstrated that, based on the information in the record, the requested services were not shown to be “consistent with generally accepted professional medical standards.” Because the services are not consistent with generally accepted professional medical standards, the critical element of medical necessity is not met and, as Dr. Bicard testified, the recipient will not gain any additional benefit by continuing services at the current level. *See supra* ¶ 6-10.

27. In this case, Petitioner’s provider recommended the continuation of BA services. 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* ¶ 21.

28. Accordingly, Respondent met their burden of proof to show that the requested BA services are no longer medically necessary. Looking at all the evidence relevant to the particular needs of Petitioner, the BA services at issue are not necessary to correct or ameliorate a defect or a physical and mental illness or condition.

29. Therefore, upon consideration of the testimony provided, evidence submitted, and applicable policies, the undersigned finds that Respondent proved by a preponderance of the evidence that Respondent's termination of BA 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 16th day of August 2023, in Tallahassee, Leon County, Florida.

Laura Gallagher

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**LAURA GALLAGHER, Hearing Officer**  
**Agency for Health Care Administration**  
**Office of Fair Hearings**  
**2727 Mahan Drive, Mail Stop # 11**  
**Tallahassee, FL 32308-5407**

**NOTICE OF A RIGHT TO JUDICIAL REVIEW**

A PARTY WHO IS ADVERSELY AFFECTED BY THIS FINAL ORDER IS ENTITLED TO JUDICIAL REVIEW, WHICH SHALL BE INSTITUTED BY FILING THE ORIGINAL NOTICE OF APPEAL WITH THE AGENCY CLERK OF AHCA, AND A COPY, ALONG WITH THE FILING FEE PRESCRIBED BY LAW, WITH THE DISTRICT COURT OF APPEAL IN THE APPELLATE DISTRICT WHERE THE AGENCY MAINTAINS ITS HEADQUARTERS OR WHERE A PARTY RESIDES. REVIEW PROCEEDINGS SHALL BE CONDUCTED IN ACCORDANCE WITH THE FLORIDA APPELLATE RULES. THE NOTICE OF APPEAL MUST BE FILED WITHIN 30 DAYS OF THE RENDITION OF THE ORDER TO BE REVIEWED.

**Copies Furnished To:**


**AHCA Medicaid Hearing Unit**  
**MedicaidHearingUnit@ahca.myflorida.com**