



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

FILED

Sep 20, 2023, 9:45 am

OFFICE OF FAIR HEARINGS

[REDACTED]

PETITIONER,

AHCA Case No.: 23-FH1338

vs.

AGENCY FOR HEALTH CARE
ADMINISTRATION,

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic Fair Hearing on the instant case on August 1, 2023, at 1:00 p.m. Eastern Standard Time (“EST”).

APPEARANCES

For the Petitioner:

[REDACTED]

Petitioner’s Authorized Representative

For the Respondent:

Marielisa Amador
Medical Health Care Program Analyst
Agency for Health Care Administration

STATEMENT OF ISSUE

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

PRELIMINARY STATEMENT

All parties and witnesses appeared telephonically. [REDACTED] (“[REDACTED]”),
Petitioner’s Authorized Representative and Board Certified Behavior Analyst (“BCBA”), appeared

on behalf of Petitioner. [REDACTED], Petitioner's [REDACTED], appeared as a witness for Petitioner.

Marielisa Amador, Medical Health Care Program Analyst for the Agency for Health Care Administration ("Agency" or "AHCA"), appeared on behalf of Respondent. Dr. Joseph Darling ("Dr. Darling"), BCBA 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 Fair Hearing. Prior to the hearing, Respondent sent to the Office of Fair Hearings and Petitioner a one hundred and sixty-six (166)-page evidence packet. The evidence packet appears in the Office of Fair Hearings' document management system as "[REDACTED] FH 08.01.2023 1-129.pdf" and "[REDACTED] FH 08.01.2023 130-166.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 evidence packet appears in the Office of Fair Hearings document management system as the file title "23-FH1338 AHCA Evidence (Pages 1-49 or 49).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 contracted by the Agency to review prior authorization requests for services. See Respondent's Composite Exhibit 2 at page 2.

2. Petitioner is [REDACTED]. See Respondent's Composite Exhibit 1 at page 16. Petitioner is diagnosed with [REDACTED]. *Id.*

3. As provided in the Behavior Analysis Services Plan ("Treatment Plan"), Petitioner is engaging in the following maladaptive behaviors: [REDACTED], [REDACTED], [REDACTED], [REDACTED], [REDACTED], [REDACTED], and [REDACTED]. *Id.* at 132-133.

4. Petitioner requested continuation of BA services, specifically, 1,030 units of code 97156 (Family training, per 15 minutes, Lead Analyst). In a Request for Additional Information letter sent to the provider, dated May 9, 2023, eQHealth requested "data showing that the frequency of the maladaptive behavior(s) has decreased since the last review and, if not, that there is a modification to the behavior plan" and clarification regarding direct treatment goals. *Id.* at 46.

5. In a Notice of Outcome ("NOO"), dated May 22, 2023, Respondent denied Petitioner's request. The NOO explained the basis for the determination 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.
Individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness under treatment, and not in excess of the patient's needs.

The NOO further provided:

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

PR Clinical Rationale – Denial: 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 the request and the provider has [not.] According to the Florida Medicaid State Plan

(appendix 9.3.b), the data provided must show evidence that the frequency of the maladaptive behaviors(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 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 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.

Additionally, there appear to be inconsistencies in the Plan as the requested units are for code 97156 only, yet the Feb. 2023 Clinical Summary indicates that recipient has demonstrated a need for ABA to be conducted in all settings.

This request for BA services is denied.

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Id. at 23-24.

6. Petitioner requested reconsideration of the Respondent's decision. In a Notice of Reconsideration Determination ("NRD"), dated May 30, 2023, Respondent upheld its decision.

Id. at 35 - 36. The NRD explained the basis for the decision as follows:

PR Recon Determination: At reconsideration all documents were carefully reviewed. Based on the information submitted for review at reconsideration, additional units of services are approved, However, the current requested is in excess of medically necessary for BA services. Although the recipient is engaging in topographies of maladaptive behaviors, the frequency and intensity of the maladaptive do not support the request for services.

Id. at 35-36.

7. On June 2, 2023, Petitioner requested a Fair Hearing to challenge the termination of BA services. On July 6, 2023, the undersigned issued an Order Scheduling Fair Hearing and Prehearing Instructions, setting the hearing for August 1, 2023, at 1:00 p.m. EST.

8. Dr. Darling is a BCBA at the doctoral level. Dr. Darling testified to the following:

- a. The request was in excess of Petitioner's needs. The provider requested approximately ten (10) hours per week of BA services and four (4) hours per week of family training were authorized based on the Treatment Plan goals submitted.
- b. eQHealth uses a peer review process. The first level reviewer in this case is an experienced BCBA who determined that the requested units were excessive based on the Treatment Plan submitted. The second level reviewer is a BCBA at the doctoral level who pended the Treatment Plan, made recommendations, and requested information showing that maladaptive behaviors have decreased and showing that modifications to the Treatment Plan to address lack of progress. In the absence of a response from the provider, a BCBA at the doctoral level denied the request on reconsideration. Dr. Darling reviewed all documentation submitted and agrees with the previous eQHealth reviewers that the requested services are in excess of need.
- c. When looking at the data graphs of maladaptive behaviors, the data should trend downward if progress is being made in treatment. When looking at the data graphs of replacement behaviors, the data should trend upward if progress is being made in treatment. If progress is not made, there must be modifications to the Treatment Plan to increase the effectiveness of the Treatment Plan.
- d. In this case the data graphs do not meet standards of care in the field of BA. The data graphs do not show progress nor do they show that modifications were made to address the lack of progress. *Id.* at 163 – 165. There is only one data point per month on the data graphs maladaptive behaviors, replacement behaviors, and

parent monitoring. *Id.* at 163 – 165. Therefore, trends in behavior cannot be determined. Data graphs for maladaptive behaviors of [REDACTED] and [REDACTED] are covered over by the data graph for [REDACTED]. *Id.* at 163 - 164.

9. [REDACTED] testified that every time there is a pause in BA services, Petitioner regresses and is a danger to [REDACTED] family.

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 denied a requested service, Fla. Admin. Code R. 59G-1.100(17)(g) assigns the burden of proof to 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.

...

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.

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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). 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.

17. 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.

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.

...

Page 3 of Authorization Policy.

19. In the instant case, Respondent denied Petitioner's request for additional BA services. See ¶ 5, 6. In the NOO dated May 22, 2023, Respondent explained that the submitted information does not support the medical necessity for requested frequency and/or duration. Respondent

determined that the request does not meet medical necessity criteria because the requested services are not “[c]onsistent with generally accepted professional medical standards as determined by the Medicaid program,” are not “[i]ndividualized, specific, and consistent with symptoms or confirmed diagnosis of the illness under treatment,” and are “in excess of the patient’s needs.” *See supra* ¶ 5, 6.

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.” *See supra* ¶ 17. Here Dr. Darling provided credible and persuasive testimony that the Treatment Plan is in excess of Petitioner’s needs based on his review of all documentation and agreement with three previous BCBA reviewers at eQHealth. *See supra* ¶ 8. Further, data graphs are inconsistent with standards of care in ABA because: the data graphs do not show progress nor were modifications made to address the lack of progress; there is only one data point per month on the data graphs maladaptive behaviors, replacement behaviors, and parent monitoring, which prevent trends in behavior from being determined; and graphs for maladaptive behaviors of [REDACTED] and [REDACTED] are covered over by the data graph for [REDACTED]. *See supra* ¶ 8.


21. Upon consideration of the testimony provided, evidence submitted, and applicable polices, the Petitioner did not prove by a preponderance of the evidence that the additional BA services at issue are medically necessary. Looking at all the evidence relevant to the particular needs of Petitioner, Petitioner has not demonstrated that the requested additional services,

based on the treatment plan at issue in this case, 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 additional BA services was incorrect.

IT IS HEREBY ORDERED AND ADJUDGED THAT:

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

DONE and **ORDERED** this 20th day of September 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:




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