

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



FILED

Oct 30, 2023, 8:55 am  
OFFICE OF FAIR HEARINGS

[REDACTED],

PETITIONER,

AHCA Case No.: 23-FH1442

vs.

AGENCY FOR HEALTH CARE  
ADMINISTRATION,

RESPONDENT.  
\_\_\_\_\_ /

**FINAL ORDER**

Pursuant to notice, a Hearing Officer with the Office of Fair Hearings convened a telephonic Fair Hearing on the instant case on October 6, 2023, at 9:03 a.m. EST.

**APPEARANCES**

For the Petitioner:

[REDACTED]

Petitioner's Authorized Representative

For the Respondent:

Doris Rivera  
Medical Health Care Program Analyst  
Agency for Health Care Administration

**STATEMENT OF ISSUE**

The issue is whether Respondent proved by a preponderance of the evidence that Respondent's decision to terminate Petitioner's behavior analysis ("BA") services was correct.

**PRELIMINARY STATEMENT**

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

Doris Rivera, 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 (“BCBA-D”) and second level reviewer for eQHealth Solutions, Inc. (“eQHealth”), attended 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 two hundred and twenty-seven (227)-page evidence packet. The packet appears in the Office of Fair Hearings’ case management system as “[REDACTED] FH 08.245.2023 1-161.pdf” and “[REDACTED] FH 08.245.2023 162-227.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-FH1442\_Behavior Analysis\_AHCA Evidence.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. As of the date of the Fair Hearing, Petitioner is [REDACTED] ([REDACTED]-[REDACTED]) old. See Respondent's Composite Exhibit 1 at page 21. Dr. Darling established that Petitioner has received BA services from the current provider, [REDACTED], for approximately [REDACTED] of continuous services. *Id.* at 24. The Behavior Analysis Reassessment, dated [REDACTED] ("Treatment "Plan"), identified the following maladaptive behaviors: [REDACTED]

[REDACTED]  
[REDACTED]. *Id.* at 172.

3. Petitioner requested the continuation of the following BA services: 2,912 units of code 97153; 104 units of code 97156 HN, 312 units of code 97155 HN, and 48 units of code 97155 for the certification period of May 14, 2023, through November 9, 2023. *Id.* at 28.

4. As Dr. Darling testified, the Treatment Plan data graphs for maladaptive behaviors show the following (after [REDACTED] of BA treatment): the frequency of [REDACTED] incidents has not improved and there was no modification of procedures to address the lack of progress; incidents of [REDACTED] have not improved and there was no modification of procedures to address the lack of progress; incidents of [REDACTED] are occurring about [REDACTED] ([REDACTED]) times per week with no modification of procedures to address the lack of progress; and the frequency of incidents of [REDACTED] [REDACTED] have not improved and there is no modification of procedures to address the lack of progress. *Id.* at 186 – 194. As Dr. Darling further testified, the Treatment Plan data graphs for replacement behaviors show no improvement over the course of six (6) months of BA treatment and that no changes in procedures were proposed by the provider to address the lack of progress. *Id.* at 194 - 215.

5. On May 26, 2023, Respondent issued a Notice of Outcome (“NOO”), terminating Petitioner’s BA services. *Id.* at 28-30. 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. 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:

Requested services are denied because documentation is neither showing [i]mprovement nor support for maintenance.

PR Clinical Rationale – Denial: The recipient has neem in services with this provider since [REDACTED]. The recipient is still engaging in high levels of maladaptive behaviors with minimal progress throughout this authorization. Additionally, the majority of skill acquisition/replacement goals are at 50% independence or below after over [REDACTED].

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 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 information submitted does not meet standards of care within the field of behavior analysis. This request is denied.

*Id.* at 28-29.

6. Petitioner requested reconsideration of the Respondent’s decision. On June 16, 2023, Respondent issued a Notice of Reconsideration Determination (“NRD”) upholding its decision. *Id.* at 40-41. The NRD states, in pertinent part as follows:

Specifically the services must be:

Individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness 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.

...

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 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 or reinforcement schedules, switch to a different decelerative procedure), or if lack or progress was due to therapist error (e.g., poor data collection or poor training on intervention methods), how human error will be addressed. The recommendations are insufficient to support continued care. This reconsideration request has been reviewed, reconsidered and the denial is upheld.

*Id.*

7. Dr. Darling established that eQHealth uses a peer review process to review behavior analysis cases and ensure that BA providers are giving quality care consistent with the standards enumerated in the BA Policy as well as professional medical standards of applied behavior analysis (“ABA”). Three independent BCBA’s at eQHealth reviewed the Treatment Plan submitted, and modifications, in this case to determine whether all five (5) conditions of medical

necessity are met. Dr. Darling asserted that Petitioner's services were terminated because the Treatment Plan does not meet the following medical necessity criteria: "consistent with generally accepted professional medical standards as determined by the Medicaid program"; and "individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness under treatment, and not in excess of the patient's needs."

8. Dr. Darling asserted that the third Treatment Plan that was submitted to eQHealth does not show evidence that the frequency of Petitioner's maladaptive behaviors has decreased and does not show that there were effective modifications or interventions to address Petitioner's lack of progress. Dr. Darling asserted that the data graphs show that there has been no improvement for over a year on maladaptive behaviors and replacement behaviors and no interventions to address the lack of progress. Therefore, according to Dr. Darling, the Treatment Plan does not meet standards of care in ABA and is not effective.

9. Dr. Darling established that an effective treatment plan is built around maladaptive behaviors (which decrease in frequency) and skills to be acquired or replacement behaviors (which increase in frequency) over the course of treatment. The effectiveness of a treatment plan is determined by reference to data, which is visually depicted in graphs showing a recipient's progress through treatment. Further, standards of care in ABA require an intervention or modification of the treatment plan if there is no progress after a few weeks of treatment. An intervention is shown by a vertical line on the data graph marking its start point so that progress can be evaluated.

10. Referring to the data graphs in Petitioner's Treatment Plan, Dr. Darling established that Petitioner's maladaptive behaviors and replacement behaviors have not improved over the

course of treatment, and the provider has not proposed or implemented effective interventions to address the lack of progress. Based on the documentation provided, Dr. Darling opined that Petitioner would not gain any additional benefit from continuing treatment under the Treatment Plan at issue.

11. [REDACTED] testified that Petitioner continues to need BA services, has shown improvement, and that Petitioner's behavior and grades have improved as a result of receiving BA services. [REDACTED] stated that Petitioner is [REDACTED] without a BA therapist.

### CONCLUSIONS OF LAW

12. 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).

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

14. 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.).

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).

16. 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.

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

18. 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.

19. The Florida Medicaid Definitions Policy (August 2017) (“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.

Respondent’s Composite Exhibit 2 at page 23.

20. 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.

...

**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

Respondent’s Composite Exhibit 2 at page 40, 42.

21. 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

Respondent's Composite Exhibit 2 at pages 45-47.

22. The Florida Medicaid Authorization Requirements Policy (June 2016) ("Authorization Requirements Policy"), 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.

23. 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 the following two medical necessity criteria: "[c]onsistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational" and "individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness under treatment, and not in excess of the patient's needs." See supra ¶¶ 5-6, 7.

24. As provided in the BA policy (Appendix 9.0, section (a)), and the EPSDT requirements, the recipient must meet the meet all five (5) of the medical necessity criteria as outlined in Fla. Admin. Code R. 59G-1.010. As outlined above, Dr. Darling provided credible and persuasive testimony identifying instances where the revised Treatment Plan did not follow generally accepted standards of BA. For example, an effective treatment plan is built around maladaptive

behaviors (which decrease in frequency) and skills to be acquired or replacement behaviors (which increase in frequency) over the course of treatment. The effectiveness of a treatment plan is determined by reference to data graphs. Further, standards of care in ABA require an intervention or modification of the treatment plan if there is no progress after a few weeks of treatment. In this case, the data graphs in the Treatment Plan do not show evidence that the frequency of Petitioner's maladaptive behaviors have decreased and does not show that there was a modification or intervention to address Petitioner's lack of progress. *See supra* ¶¶ 4 – 6, 9. Similarly, the data graphs for replacement behaviors show no improvement over the course of six (6) months of BA treatment and that no changes in procedures were proposed by the provider to address the lack of progress. *See supra* ¶¶ 4 – 6, 9.

25. As shown above, Dr. Darling also showed that the Treatment Plan was not individualized and specific to Petitioner. Here Petitioner has been receiving continuous BA services from the same provider for approximately [REDACTED]. Despite the fact that the data graphs for the past six (6) months were showing no progress on maladaptive behaviors and replacement behaviors, the BA provider did not make any modifications to Petitioner's treatment to address the lack of progress. *See supra* ¶¶ 4 – 6, 9. Therefore, the BA services were not specific and individualized to the Petitioner's needs over the course of treatment. As Dr. Darling concluded, the data graphs show that Petitioner would not gain any additional benefit from continuing under the Treatment Plan at issue.

26. 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 ¶ 20.


27. Accordingly, Respondent met their burden of proof to show that the requested BA services no longer meet medically necessity criteria. 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.

28. Upon consideration of the testimony provided, Respondent's Composite Exhibit 1, Respondent's Composite Exhibit 2, and the applicable law and policies, the undersigned finds that Respondent proved by a preponderance of the evidence that Respondent's termination of BA services was correct.

#### **DECISION**

Respondent's termination of Behavior Analysis services is **AFFIRMED**. Petitioner's appeal based on Respondent's termination of Behavior Analysis services is **DENIED**.

**DONE** and **ORDERED** this 30th day of October 2023, in Tallahassee, Leon County, Florida.

Laura Gallagher  
23-FH1442  
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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**