

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



**FILED**  
Oct 02, 2023, 9:04 am  
OFFICE OF FAIR HEARINGS

██████████,

PETITIONER,

AHCA Case No.: 23-FH1458

vs.

AGENCY FOR HEALTH CARE  
ADMINISTRATION,

RESPONDENT.

\_\_\_\_\_ /

**FINAL ORDER**

Pursuant to notice, the undersigned Hearing Officer convened a telephonic Fair Hearing in the instant case on August 9, 2023, at 1:00 p.m. Eastern Standard Time ("EST").

**APPEARANCES**

For the Petitioner:

██████████

Petitioner's Authorized Representative

For the Respondent:

Suzanne Chillari  
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 denial of Behavior Analysis ("BA") services was correct.

**PRELIMINARY STATEMENT**

All parties and witnesses appeared for the scheduled Fair Hearing telephonically. ██████████

██████████ ("██████████"), Petitioner's Authorized Representative and ██████████ appeared for the Fair Hearing on behalf of Petitioner, provided testimony, and did not call any witnesses.

Suzanne Chillari, Medical Health Care Program Analyst for the Agency for Health Care Administration (“Agency” or “AHCA”), appeared for the Fair Hearing as the representative for Respondent. Dr. David Bicard (“Dr. Bicard”), a Board-Certified Behavior Analyst at the doctoral level (“BCBA-D”) and Director of Clinical Operations for eQHealth Solutions, appeared for the Fair Hearing as a witness for Respondent.

Prior to the Fair Hearing, Petitioner filed with the Office of Fair Hearings a twenty-eight (28)-page evidence packet. The evidence packet appears in the Office of Fair Hearings’ case management system as “23-FH1458 Supporting documents.pdf.” Without objection, the evidence was admitted into evidence as Petitioner’s Composite Exhibit 1.

Prior to the Fair Hearing, Respondent sent to the Office of Fair Hearings and Petitioner a one hundred and twenty-four (124)-page evidence packet. The evidence packet appears in the Office of Fair Hearings’ case management system as “[REDACTED] FH 08.09.2023.pdf.” Without objection, the evidence was admitted into evidence as Respondent’s Composite Exhibit 1.

Prior to the Fair 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’ case management system as “Agency Evidence Legal Authorities 23-FH1458.pdf.” Without objection, the evidence packet was admitted into evidence as Respondent’s Composite Exhibit 2.

### **FINDINGS OF FACT**

1. Petitioner receives Medicaid services on a fee-for-service basis through the Agency. See Respondent’s Composite Exhibit 1, page 21. eQHealth is a Quality Improvement Organization contracted by the Agency to review prior authorization requests for Medicaid services, including

Behavior Analysis services, to ensure that the request meets medical necessity. See Respondent's Composite Exhibit 2 at page 2.

2. As of the date of the Fair Hearing, Petitioner is [REDACTED] ([REDACTED] [REDACTED] old and diagnosed with [REDACTED]. See Respondent's Composite Exhibit 1 at page 16. The Behavior Analysis service provider in this case is [REDACTED]. *Id.* According to the Comprehensive Initial Interview and Initial ABA Therapy Care Plan ("Treatment Plan") at issue, Petitioner engages in the following behaviors: [REDACTED]

[REDACTED] *Id.* at 47.

3. On February 24, 2023, Petitioner requested the BA services at issue. *Id.* at 45. On March 3, 2023, Respondent requested additional information from the provider. *Id.* The requested information included baseline data for all behaviors and caregiver training goals. *Id.*

4. On March 10, 2023, Respondent issued a Notice of Outcome – Denial ("NOO") denying Petitioner's request for BA services. *Id.* at 23-24. The NOO states the following, in pertinent part:

Code:	97153
Description:	Intervention without protocol modification, per 15 minutes, lead analyst, BCaBA, or RBT
Total Units:	Denied – 2,600

Code:	97155
Description:	Intervention with protocol modification, per 15 minutes
Total Units:	Denied – 520

Code:	97156
Description:	Family training, per 15 minutes
Total Units:	Denied – 52

The request for services is denied in whole or in part because they are not medically necessary as defined in 59G-1.010, Florida Administrative Code. Specifically, the requested services are not medically necessary under the following standard(s):

Individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs.

The rationale for our decision is as follows:

PR Principal Reason - Denial:

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

PR Clinical Rationale - Denial: According to the Behavior Analysis Services Coverage Policy (9.2.b) all treatment plan submitted for modification of care must include updated data for all behaviors under treatment as well as changes to the treatment plan, if necessary. The provider was requested to submit baseline data and graphs for all behaviors under treatment. The provider has not submitted all the data or graphs. Provider, baseline data must be graphed data for behaviors directly observed by the analyst during the assessment. The request for services is denied.

*Id.*

5. On March 16, 2023, Respondent issued a Notice of Reconsideration Determination ("NRD") upholding the denial of Behavior Analysis services. *Id.* at 34-35. The NRD also states the following:

PR Recon Determination: At reconsideration all documents were carefully reviewed. The supporting documentation does not meet generally accepted practices within the filed of applied behavior analysis and standards set for the in the Florida Behavior Analysis Services Coverage Policy (Pages 6-7). The provider was approved to complete an assessment[.] The provider has not submitted all graphed data for skill acquisition goals and maladaptive behaviors that were to be completed during the assessment. The provider was requested to produce those graphed data to initiate behavior analysis services. The provider did not make the needed changes to the treatment plan. This denial is upheld.

*Id.*

6. On June 13, 2023, Petitioner requested a Fair Hearing to challenge the denial of BA services. *Id.* at 8. On July 6, 2023, the undersigned Hearing Officer issued a notice to the parties of record scheduling the Fair Hearing for August 9, 2023, at 1:00 p.m. EST. *Id.* at 8-19.

7. [REDACTED] asserted that BA services should be authorized because Petitioner is diagnosed with [REDACTED]

8. Dr. Bicard established the standard of care in the field of BA require a behavior assessment authored by a lead analyst. The assessment contains baseline data gathered by the provider, identifies maladaptive behaviors, and provides baseline data.

9. Dr. Bicard established that the request for BA services went through a peer review process at eQHealth. The first level reviewer was a BCBA who did not approve the request. The second level reviewed was a BCAB-D who requested additional information from the provider to include: baseline data for all maladaptive behaviors and replacement behaviors. Further, the provider failed to identify any caregiver training goals in the Treatment Plan. On reconsideration, the provider submitted data collected by the caregiver rather than the BA provider. No data was provided for replacement behaviors. It appeared that, although previously authorized, the lead analyst had not conducted a behavior assessment on Petitioner identifying maladaptive behaviors, baseline data, and caregiver goals.

#### **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 (2022). 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 Rule 59G-1.100(17)(b), Florida Administrative Code (F.A.C.), which states "[e]ach fair hearing shall be a *de novo*, evidentiary proceeding, and shall be conducted in a manner that meets the requirements of this rule."

12. Because Petitioner is requesting a new service, Rule 59G-1.100(17)(g), F.A.C., 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 Policy (October 2017) (“BA Policy”), incorporated by reference in Rule 59G-4.125, F.A.C., establishes the provision of Behavior Analysis services to Medicaid recipients under the age of 21 years. See Respondent’s Composite Exhibit 2 at pages 38-47. The BA Policy provides as follows, in pertinent part:

**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
- 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 be 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 year 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.

Respondent’s Composite Exhibit 2 at pages 40-42.

14. Appendix 9.0 of the BA Policy provides the Review Criteria for Behavior Analysis Services.

*Id.* at pages 45-47. The Review Criteria state as follows, in pertinent part:

**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)
  - ii. Baseline and/or updated treatment data (if reassessment)
  - iii. Progress toward identified goals (if a reassessment)
  - iv. Identification of the events, times, and situations that appear to be associated to the occurrence of the maladaptive behaviors

...

- 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.

...

**4. Criteria to Assess the Intensity of Behavior Analysis Services:** Providers may request up to 40 hours of BA services per week, per recipient, based upon the following:

As a rule, higher number of maladaptive behaviors, higher severity and frequency of behaviors, as well as the multiplicity of settings where the behaviors occur, would usually justify a higher number of services hours. The greater the number of goals targeted to reduce maladaptive behaviors, the more the likelihood that a higher number of services hours could also be warranted.

Providers **MUST** ensure that proper justification for the requested hours of services is adequately documented in the behavior plan. Based on the information provided in the assessment, behavior plan, and any other supporting documentation, 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

*Id.* at 45-46.

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 the age of 21 years, and therefore EPSDT applies to [REDACTED] 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 (August 2017) (“Definitions Policy”), incorporated by reference in Rule 59G-1.010, F.A.C., defines medically necessary or medical necessity as follows:

**2.83 “Medically Necessary” or “Medical Necessity”**

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.

*Id.* at 18.

18. The Florida Medicaid Authorization Requirements Policy (June 2016) (“Authorization Requirements Policy”), incorporated by Rule 59G-1.053, F.A.C., provides general requirements for providers to obtain authorization to render Florida Medicaid services. *Id.* at 30-33. The Authorization Requirements Policy states the following, in pertinent part:

**1.2 Definitions**

The following definitions are applicable to this policy. For additional definitions that are applicable to all sections of Rule Division 59G, F.A.C., please refer to the Florida Medicaid definitions policy.

...

**1.3.1 Authorization**

The process of obtaining approval for reimbursement of a service based on medical necessity.

...

**1.3.6 Provider**

The term used to describe any entity, facility, person, or group that has been approved for enrollment or registered with Florida Medicaid.

**1.3.7 Quality Improvement Organization**

Entity designated to perform utilization review, quality assurance, and quality improvement activities for Florida Medicaid-covered services rendered by fee-for-service providers (also known as the QIO).

...

**2.0 Authorization Requirements**

...

**2.4.2 Requests for Additional Information**

The QIO may request additional information, as necessary, to determine medical necessity.

...

**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.

*Id.* at 32-33.

19. In the instant case, Petitioner is under the age of 21 and therefore EPSDT applies to [REDACTED] request for Behavior Analysis services. Specifically, Petitioner's Behavior Analysis provider requested 2,600 units of code 97153, 520 units of code 97155, and 52 units of code 97156. *See supra* ¶ 4. 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* ¶ 17.

20. Based on the NOO, NRD, and Dr. Bicard's testimony, Respondent denied Petitioner's request based on a failure to meet the following medical necessary criteria: consistent 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 or injury under treatment, and not in excess of the patient's needs. *See supra* ¶ 4, 5, 9.

21. Pursuant to the Behavior Analysis Coverage Policy, the critical elements necessary for any type of BA service are: (a) eligibility – the recipient must meet all criteria for Behavior Analysis 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 in Rule 59G-1.010, F.A.C; (c) the recipient currently engages in maladaptive behaviors; and (d) these maladaptive behaviors interfere with the recipient’s daily functioning. *See supra* ¶ 14-16. Moreover, the Treatment Plan is the “cornerstone of the delivery of behavior analysis services and it is based on the information obtained in the assessment.” *See supra* ¶ 14. Pursuant to section 2.83 of the Florida Medicaid Definitions Policy, all five (5) conditions of Medical Necessity must be met for “medical . . . services furnished or ordered” to be determined medically necessary. *See supra* ¶ 17. The QIO may deny a request if it cannot substantiate medical necessity based on the information submitted. *See supra* ¶ 18.

22. In this case the record does not reflect that the requested BA services meet all 5 medical necessity criteria. Dr. Bicard provided credible and persuasive testimony that the treatment plan did not meet standards of care in ABA. *See supra* ¶ 8, 9. In this case, the Respondent requested additional information from the provider to include: baseline data for all maladaptive behaviors and replacement behaviors and that the provider identify the caregiver training goals underlying its request for caregiver training services in the Treatment Plan. On reconsideration, the provider submitted incomplete data collected by the caregiver rather than the BA provider. No data was provided for replacement behaviors. It appeared that, although previously authorized, the lead analyst had not conducted a behavior assessment on Petitioner identifying maladaptive behaviors, baseline data, and caregiver goals. Further, because the baseline data was either not

provided or deficient and no caregiver goals were identified, the record demonstrates that the requested services were not shown to be individualized and specific to Petitioner.

23. Accordingly, for the foregoing reasons, Petitioner has not met their burden of proof to show that the requested Behavior Analysis services meet all medical necessity criteria. Looking at all the evidence relevant to the particular needs of Petitioner, the requested Behavior Analysis services at issue are not necessary to correct or ameliorate a defect or a physical and mental illness or condition.

24. Therefore, in light of both parties' testimony, Petitioner's Composite Exhibit 1, Respondent's Composite Exhibit 1, Respondent's Composite Exhibit 2, and the applicable laws and policies, the undersigned Hearing Officer finds that Petitioner has not proven by a preponderance of the evidence that Respondent's denial of Behavior Analysis services was incorrect.

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

Respondent's denial of Petitioner's request for Behavior Analysis services is hereby **AFFIRMED**. Petitioner's request for relief is **DENIED**.

**DONE AND ORDERED** this 2<sup>nd</sup> day of October 2023, in Tallahassee, Leon County, Florida.

Laura Gallagher

23-FH1458

2023.10.02



~~05:38:48 -04'00'~~  
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**