



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

**FILED**

Nov 21, 2023, 3:02 pm  
OFFICE OF FAIR HEARINGS

[REDACTED]

PETITIONER,

AHCA Case No.: 23-FH2058

vs.

AGENCY FOR HEALTH CARE  
ADMINISTRATION,

RESPONDENT.

\_\_\_\_\_ /

**FINAL ORDER**

Pursuant to notice, the undersigned convened a telephonic Fair Hearing on the instant case on October 6, 2023, at 10:32 a.m. Eastern Standard Time ("EST").

**APPEARANCES**

For the Petitioner:

[REDACTED]

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 decision to reduce Petitioner's Behavior Analysis ("BA" or "ABA") services was correct.

**PRELIMINARY STATEMENT**

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

Suzanne Chillari (“Ms. Chillari”), Medical Health Care Program Analyst for the Agency for Health Care Administration (“Agency” or “AHCA”), appeared on behalf of Respondent. Dr. David Bicard (“Dr. Bicard”), Board Certified Behavior Analyst and Director of Clinical Operations for eQHealth Solutions Inc. (“eQHealth”), appeared as a witness for Respondent.

Petitioner did not introduce any exhibits at the hearing. Prior to the hearing, Respondent sent to the Office of Fair Hearings and Petitioner a one-hundred and sixty-eight (168)-page evidence packet and a forty-nine (49)-page evidence packet. The one-hundred and sixty-eight (168)-page evidence packet appears in the Office of Fair Hearings’ document management system as the file titles “[REDACTED] FH 10.06.2023 1-137.pdf” and “[REDACTED] FH 10.06.2023 138-168.pdf”. The forty-nine (49)-page evidence packet appears in the Office of Fair Hearings’ document management system as the file title “Agency Evidence Legal Authorities 23-FH2058.pdf”. Absent an objection from the Petitioner, the undersigned admitted the one-hundred and sixty-eight (168)-page evidence packet into evidence as Respondent’s Composite Exhibit 1 (“RCE 1”) and the forty-nine (49)-page evidence packet into evidence as Respondent’s Composite Exhibit 2 (“RCE 2”).

#### **FINDINGS OF FACT**

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

2. On the date of the Fair Hearing, Petitioner was [REDACTED] See RCE 1 at page 16. Petitioner is diagnosed with [REDACTED] and [REDACTED].  
[REDACTED]. *Id.*

3. Petitioner requested continuation of BA services; specifically, 3,120 units of code 97153; 416 units of code 97155; and 208 units of code 97156. *Id.* at pages 23-24. In a Notice of Outcome (“NOO”), dated June 20, 2023, Respondent approved 2,496 units of code 97153; 416 units of code 97155; and 156 units of 97156, but denied the remaining units. The NOO explained the basis for the reduction as follows, in pertinent part:

The request for services is denied in whole or in part because they are not medically necessary as defined in Rule 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 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 requests for services must be based on the medical necessity of the recipient’s maladaptive behaviors and skill deficits. The recipient is engaging in problem behaviors that threaten access to typical environments and negatively affects activities of daily living. However, the frequency, intensity, or severity of the recipients’ maladaptive behaviors does not justify the requested units of services. The requested units of BA services are in excess of medical necessity.

*Id.* at pages 23 – 24.

4. Petitioner requested reconsideration of the Respondent’s decision. In a Notice of Reconsideration Determination (“NRD”), dated August 31, 2023, Respondent upheld its decision.

*Id.* at pages 35-36. The NRD explained the basis for the decision as follows. in pertinent part:

The reason for the denial is that the services are not medically necessary as defined in 59G-1.010, Florida Administrative Code. 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.

PR Recon Determination: At reconsideration all documents were carefully reviewed. The provider did not submit any new documentation that supports the medical necessity of this request. According to The Behavior Analysis Services Coverage Policy, (page 6, 9.0 c-d) the recipient of ABA therapy services must engage in maladaptive behavior that interferes with the recipient's daily functioning. Although the recipient is engaging in topographies of maladaptive behaviors, the frequency and intensity of the maladaptive do not support the request for services. This reconsideration request has been reviewed, reconsidered and the partial denial is upheld.

*Id.* at pages 35-36

5. On August 24, 2023, Petitioner requested a Fair Hearing to challenge the reduction of behavior analysis services. On September 12, 2023, the undersigned issued an Order Scheduling Fair Hearing by Telephone and Prehearing Instructions, setting the hearing for October 6, 2023, at 10:30 a.m. EST.

6. Dr. Bicard is a Board-Certified Behavior Analyst at the doctoral level. Dr. Bicard testified to the following at the Fair Hearing:

- a. Petitioner has participated in behavior analysis services since [REDACTED], and has been with the current provider since [REDACTED].
- b. A review of the treatment plan revealed that Petitioner has made significant improvements regarding maladaptive behavior and skill acquisition goals. Using medical necessity criteria, standards of care within the field of behavior analysis, and the Behavior Analysis Services Coverage Policy, it was determined that the provider's request was in excess of the patient's needs.
- c. The Behavior Analysis Services Coverage Policy requires providers to ensure that proper justification for the requested hours of services is adequately documented

in the behavior plan. See RCE 2 at page 47. The provider did not submit a fading schedule in the behavior plan, and there is no criteria nor justification for the hours requested. Petitioner previously received about thirty (30)-hours per week of therapy. In this request, twenty-five (25)-hours were approved. Services were approved at a relatively high level.

- d. Overall, there was a [REDACTED] decrease in Petitioner's maladaptive behaviors during the last authorization period. Behaviors range from [REDACTED] decrease, for [REDACTED], to a low of [REDACTED] decrease, for [REDACTED]. Petitioner's [REDACTED] show marked improvement across all skills. According to the treatment plan, the provider has identified that Petitioner can [REDACTED] and [REDACTED]. Petitioner's [REDACTED] was taken into consideration. See RCE 1 at pages 65-68.
- e. All maladaptive behaviors are decreasing, and Petitioner is responding well to treatment. [REDACTED] and [REDACTED] have decreased by [REDACTED], [REDACTED] has decreased by [REDACTED] and [REDACTED] has decreased by [REDACTED]. See RCE 1 at pages 65-69. Standards of care within the field of behavior analysis dictate that services should be decreased as the recipient meets goals and continues to progress. Petitioner is progressing adequately across replacement skills. *Id.* at page 89.
- f. The provider requested two (2)-hours per week of parent training, and one and a half hours were approved. The caregiver is progressing well in parent training

goals. *Id.* at page 97. Based on the number of goals, the requested hours were in excess of medical necessity.

- g. At reconsideration, the provider did not change the treatment plan to account for a fading of services or provide a justification of number of hours requested.
- h. Based on the information submitted by the provider in relation to standards of care within the field of behavior analysis and the criteria for determining intensity of services, the reviewers determined that the requested services were in excess of Petitioner's needs.

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

- a. Petitioner has trouble at home and at school. Petitioner [REDACTED] when [REDACTED] does not get [REDACTED] way. Petitioner does not [REDACTED] well. [REDACTED] stated [REDACTED] needs the thirty (30)-hours. [REDACTED] stated [REDACTED] does not see where Petitioner has improved.

**CONCLUSIONS OF LAW**

8. 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).

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

10. Because Respondent reduced a previously approved service, Fla. Admin. Code R. 59G-1.100(17)(g) assigns the burden of proof to the Respondent. The standard of proof in an

administrative hearing is a preponderance of the evidence. The preponderance of the evidence standard requires proof by “the greater weight of the evidence” (Black’s Law Dictionary at 1201, 7th Ed.)

11. 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.

See RCE 2 at pages 40, 42.

12. 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

*Id.* at pages 45-46.

13. 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.

*Id.* at pages 4-5.

14. Petitioner is under age 21, and therefore EPSDT applies to ■■■ request for services. However, a state may place medical necessity limitations on EPSDT services. *See* 42 C.F.R. §§ 440.230(a), (b), (d). Fla. Stat. § 409.905(2) limits EPSDT services with a medical necessity standard:

The [Agency] shall pay for early and periodic screening and diagnosis of a recipient under age 21 to ascertain physical and mental problems and conditions and all services determined by the agency to be medically necessary for the treatment, correction, or amelioration of these problems and conditions, including personal care, private duty nursing, durable medical equipment, physical therapy, occupational therapy, speech therapy, respiratory therapy, and immunizations.

*Id.* at page 6.

15. The Definitions Policy, incorporated by reference in Fla. Admin. Code R. 59G-1.010, defines “Medically Necessary” or “Medical Necessity” as follows:

The medical or allied care, goods, or services furnished or ordered must meet the following conditions:

- Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate pain
- Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient’s needs
- Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational
- Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available statewide
- Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient’s caretaker, or the provider

The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services does not, in itself, make such care, goods or services medically necessary or a medical necessity or a covered service.

*Id.* at page 23.

16. 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.

*Id.* at page 34.

17. In the instant case, Respondent reduced Petitioner’s ABA services. *See* ¶ 3. In the NOO dated June 20, 2023, Respondent explained that continuing services at the prior level was not medically necessary, specifically, that it did not meet the requirement that services must be “individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness under treatment, and not in excess of the patient’s needs.” *Id.* Respondent further explained that “the requested units of BA services are in excess of medical necessity.” *Id.*

18. 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 “individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness under treatment, and not in excess of the patient’s needs.” *See* ¶ 15.

19. As shown by the record, each of Petitioner’s maladaptive behaviors is decreasing in frequency, with there being an overall [REDACTED] decrease in Petitioner’s maladaptive behaviors during the last authorization period. *See* ¶ 6, RCE 1 at pages 65-68. Dr. Bicard testified that Petitioner’s [REDACTED] and [REDACTED] have decreased by [REDACTED], [REDACTED] has decreased by [REDACTED] and [REDACTED] has decreased by [REDACTED]. *Id.* Dr. Bicard testified that Petitioner is progressing well, as Petitioner’s [REDACTED] show marked improvement across all skills. *Id.*

Although [REDACTED] testified that [REDACTED] has not seen progress, the evidence submitted by the provider indicates that significant progress has been made. See ¶ 6, RCE 1 at pages 89-94. As Petitioner has made substantial improvements, the record shows that Petitioner's previously approved level of treatment is "in excess of" Petitioner's need.

20. As QIO for the Agency, eQHealth is authorized to reduce services when it is determined that "there is documented improvement in the recipient's medical condition." See ¶ 16. As discussed, *supra* ¶ 19, Petitioner has made progress in reducing [REDACTED] maladaptive behaviors and improving [REDACTED] replacement behaviors. Here, Petitioner's improvement is well documented and supported by Respondent's evidence. Although Petitioner's BA provider recommended the continuation of services at the current level, 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 ¶ 15.

21. Upon consideration of the testimony provided, evidence submitted, and applicable polices, the undersigned concludes that Respondent proved by a preponderance of the evidence that the previously approved level of BA services no longer meet medical necessity criteria. Looking at all the evidence relevant to the particular needs of Petitioner, Respondent has demonstrated that the previously authorized services, based on the treatment plan at issue in this case, are not necessary to correct or ameliorate a defect or a physical and mental illness or condition. Accordingly, Respondent proved by a preponderance of the evidence that Respondent's reduction of ABA services was correct.

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

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

**DONE** and **ORDERED** this 21st day of November, 2023, in Tallahassee, Leon County, Florida.



Lynne Ringers  
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**LYNNE RINGERS, 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**  
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