



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

FILED

Dec 05, 2023, 10:52 am

OFFICE OF FAIR HEARINGS

[REDACTED],

PETITIONER,

AHCA Case No.: 23-FH2218

vs.

AGENCY FOR HEALTH CARE
ADMINISTRATION,

RESPONDENT.

FINAL ORDER

Pursuant to notice, the undersigned Hearing Officer convened a telephonic Fair Hearing on the instant case on November 8, 2023, at 10:00 a.m. EST.

APPEARANCES

For the Petitioner:

[REDACTED]
Petitioner's Authorized Representative

For the Respondent:

Chrissie Simmons
Agency for Health Care Administration

STATEMENT OF ISSUE

The issue in this matter is whether the Petitioner has proved by a preponderance of the evidence that Respondent's decision to deny behavior analysis services for the Petitioner was incorrect.

PRELIMINARY STATEMENT

All parties and witnesses appeared telephonically. Petitioner's Authorized Representative [REDACTED], (" [REDACTED] ") appeared on behalf of the Petitioner. Tenesha West ("Ms. West"), Board Certified Behavior Analyst ("BCBA") of [REDACTED]

appeared as a witness for the Petitioner. Chrissie Simmons, (“Ms. Simmons”) Medical Healthcare Program Analyst and Fair Hearing Liaison for Health Care Administration (“Agency” or “AHCA”), appeared on behalf of Respondent. Dr. Joseph Darling (“Dr. Darling”), a Board Certified Behavior Analyst (“BCBA”) at the Doctorate level and second level reviewer (“Dr. Darling”), for eQHealth Solutions appeared as a witness for Respondent.

Prior to the Hearing, the Respondent sent the Office of Fair Hearings and Petitioner a one hundred and ninety-two (192)-page proposed evidence package and a forty-nine (49)-page evidence package that were admitted into evidence without objection. The one hundred and ninety-two (192)-page package is identified as “Respondent’s Composite Exhibit 1” and is maintained in the Office of Fair Hearings’ case management system as “[REDACTED] FH 11.08.2023 1-131.pdf” and “[REDACTED] FH 11.08.2023 132-192.pdf”. The forty-nine (49)-page exhibit is identified herein as “Respondent’s Composite Exhibit 2” and appears in the Office of Fair Hearings’ case management system as “23-FH2218 Behavior Analysis ACHA Evidence.pdf”.

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 Behavioral Analysis (“ABA”) services. See Respondent’s Composite Exhibit 2, page 2.
2. The Petitioner is a [REDACTED] old [REDACTED] and has been diagnosed with [REDACTED]. See Respondent’s Composite Exhibit 1, page 16.
3. On or about [REDACTED] [REDACTED], and Teneshia West, BCBA, submitted a proposed initial Functional Behavioral Assessment Report and Treatment Plan (“Treatment

Plan”) to provide initial BA services to the Petitioner. See Petitioner’s Composite Exhibit 1, pages 49-73. In the initial BA Treatment Plan and all the subsequent Treatment Plans submitted in this matter, the Petitioner requested the following BA services: 2,600 units of code 97153, 234 units of Code 97155, 416 units of code 97155, and 208 units of code 97156 for the certification period of July 25, 2023, through January 20, 2024. See Respondent’s Composite Exhibit 1, page 22.

4. On July 28, 2023, the Respondent sent [REDACTED], a letter requesting additional information regarding the proposed initial Treatment Plan, requesting the inclusion of baseline graphs of directly observed behavior of the Petitioner in order for the maladaptive behaviors to be assessed and measured. See Respondent’s Composite Exhibit 1, pages 47-48. In addition, the letter requested a confirmation of the signatures appearing on the proposed treatment plan. *Id.*

5. On or about July 31, 2023, [REDACTED], submitted an amended proposed initial treatment plan that included baseline graphs of the Petitioner’s “new acquisition skills” and a confirmation of electronic signatures but not any graphs for the Petitioner’s maladaptive behaviors. See Respondent’s Composite Exhibit 1, pages 74-97.

6. On August 2, 2023, the Respondent sent [REDACTED], another letter requesting additional information regarding the proposed initial Treatment Plan, requesting the inclusion of baseline graphs of directly observed behavior of the Petitioner in order for the maladaptive behaviors to be assessed and measured. See Respondent’s Composite Exhibit 1, pages 46. In addition, the letter again requested a confirmation of the signatures appearing on the proposed treatment plan. *Id.*

7. [REDACTED], submitted a third amended proposed initial treatment plan in response to the Respondent's August 2, 2023, letter requesting additional information. See Respondent's Composite Exhibit 1, pages 98-124. On August 24, 2023, the Respondent sent another letter requesting additional information to the Petitioner. See Respondent's Composite Exhibit 1, page 45. The August 14, 2023, letter requested additional information and more specifically as follows:

Provider, the justification for this request for services is not clear. eQHealth Solutions reviewers requires more information on stress ball, exercise, drawing, deep breathing interventions listed in the treatment plan. Please note that these methods may not conform to stands of care within the field of applied behavior analysis. Please explain all procedures in detail. Also, please submit a rationale for this request for services units. The justification submitted with this treatment is insufficient given the requested units and the recipient's maladaptive behaviors and skill deficits addressed in this treatment plan. Thank you.

Id.

8. The Respondent submitted a fourth (4th) amended Treatment Plan to the Respondent in response to the August 14, 2024, letter requesting additional information. See Respondent's Composite Exhibit 1, pages 125-167. On August 23, 2023, the Respondent issued a Notice of Outcome ("NOO"), denying the initial Treatment Plan for 2,600 units of code 97153, 234 units of Code 97155, 416 units of code 97155, and 208 units of code 97156 for the certification period of July 25, 2023, through January 20, 2024. See Respondent's Composite Exhibit 1, pages 22-25. The NOO explained the basis for the denial as follows:

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.

Id. The NOO further provided:

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: Self-regulation strategies/deep breathing are not an empirically supported procedures within the conceptual system of behavior analysis for treating the functions of maladaptive behavior. According to Behavior Analysis Services Coverage Policy (page-6-7), treatment that does not meet generally accepted standards of care within the field of applied behavior analysis are not covered under the behavior analysis service coverage policy. This request for ABA services is denied.

...

See Respondent's Composite Exhibit 1, pages 22-25.

9. The Petitioner submitted a fifth amended Treatment Plan to the Respondent and requested a reconsideration of the Respondent's decision to deny the requested 2,600 units of code 97153, 234 units of Code 97155, 416 units of code 97155, and 208 units of code 97156 for the certification period of July 25, 2023, through January 20, 2024. See Respondent's Composite Exhibit 1, pages 168-191. On September 5, 2023, the Respondent issue its' Notice of Reconsideration Determination ("NRD") upholding the denial of 2,600 units of code 97153, 234 units of Code 97155, 416 units of code 97155, and 208 units of code 97156 for the certification period of July 25, 2023, through January 20, 2024. See Respondent's Composite Exhibit , pages 33-36. The NRD explained the basis for the denial as follows:

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:

Consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational.

The rationale for our decision is as follows:

PR Recon Determination: At reconsideration all documents were carefully reviewed. Calming strategies/coping strategies, expressing emotions in self using words or alternatives, alternative strategies are not an empirically supported procedures within the conceptual system of behavior analysis for treating the functions of maladaptive behavior of children with [REDACTED]. According to Behavior Analysis Services Coverage Policy (page-6-7), treatment that does not meet generally accepted standards of care within the field of applied behavior analysis are not covered under the behavior analysis service coverage policy. This reconsideration request has been reviewed, reconsidered and the denial is upheld.

Id.

10. The fourth and fifth Treatment Plans which were the basis of the NOO and the NRD identified the following maladaptive behaviors for the Petitioner: [REDACTED]
[REDACTED] See Petitioner's Composite Exhibit 1, pages 178-179.

11. The fourth and fifth Treatment Plan replacement behaviors, which were the basis of the NOO and the NRD, are designed to reduce and/or replace the maladaptive behaviors and include the following nine (9) behavior skills: [REDACTED]
[REDACTED]
[REDACTED]. See Respondent's Composite Exhibit 1, pages 146 and 180.

12. Dr. Darling testified on behalf of the Respondent that it is medically necessary for the Petitioner to receive applied behavior analysis services and testified that the following [REDACTED] adaptive skills/replacement behavior goals of the [REDACTED] in the fourth Treatment Plan did not

meet the accepted professional medical standards of applied behavior analysis services for the treatment of maladaptive behaviors of children diagnosed with [REDACTED]:

- a. [REDACTED]

See also Respondent's Composite Exhibit 1, page 146 and pages 22-25.

13. The first and second replacement behaviors that formed the basis of the denial in the Respondent's NOO were amended in the fifth (5th) Treatment Plan and are reflected as follows:

- a. [REDACTED]

Dr. Darling testified that the above changes to the replacement behaviors now met the accepted professional medical standards of applied behavior analysis services for the treatment of maladaptive behaviors of children diagnosed with [REDACTED]. However, Dr. Darling further testified that the remaining replacement behavior towards increasing verbal expression by [REDACTED] [REDACTED] was unchanged from the fourth (4th) initial Treatment Plan, did not meet the accepted professional medical standards of applied behavior analysis services for the treatment of maladaptive behaviors of children diagnosed with [REDACTED], and was the basis of the

denial in the Respondent's NRD. *See also* Respondent's Composite Exhibit 1, page 180 and pages 33-36.

14. The Petitioner's Authorized Representative testified that the Petitioner is [REDACTED] due to his [REDACTED] and that [REDACTED] can't control [REDACTED] behaviors. The Authorized Representative expressed [REDACTED] frustration in that [REDACTED] has done everything that was asked from [REDACTED] but that [REDACTED] [REDACTED] can't get the applied behavior analysis services [REDACTED] desperately needs because of simple language in the Treatment Plan.

15. Ms. West testified that the reinforcement behaviors in the Treatment Plan complies with the seven (7) dimensions of applied behavior analysis and that the behaviors are within the evidence-based practices of applied behavior analysis. Ms. West further testified that taking a deep breath is a differential reinforcement and that this matter is more of a difference in interpretation of functional communication training.

CONCLUSIONS OF LAW

16. 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).

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

18. The burden of proof in this proceeding is governed by Florida Administrative Code, Rule. 59G-1.100(17)(g), which provides as follows:

The burden of proof is on the party asserting the affirmative of an issue, except as otherwise required by statute. The burden of proof is on the Agency or plan, whichever is applicable, when the issue presented is the suspension, reduction, or termination of a previously authorized service. The burden of proof is on the

recipient or enrollee when the issue presented is the denial or a limited authorization of a service. The party with the burden of proof shall establish its position to the satisfaction of the Hearing Officer by a preponderance of the evidence.

19. Because the Respondent limited the authorization of a newly requested service, Fla. Admin. Code R. 59-1.100(17)(g) assigns the burden of proof to the Petitioner to establish by a preponderance of the evidence that the decision by the Respondent to deny the requested hours of BA therapy services in the fourth (4th) and fifteen (5th) initial Treatment Plan was incorrect. The preponderance of the evidence standard requires proof by “the greater weight of the evidence” (Black’s Law Dictionary at 1201, 7th Ed.).

20. 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).

21. 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.

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

23. 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.

24. The Florida Medicaid 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.

25. The 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 no duplicate another
- Meet the criteria as specified in this policy

Respondent's Composite Exhibit 2 at page 40 and 42.

26. 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:

- 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.
- Medical necessity – The recipient must meet medical necessity criteria as outlined in Rule 59G-1.010, F.A.C.
- The recipient currently engages in maladaptive behaviors
- These maladaptive behaviors interfere with the recipient's daily functioning

1. Criteria for Initial Behavior Analysis Assessment – BOTH of the following **MUST** be satisfied:

- ALL** critical elements are met
- Provider 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:

- ALL** critical elements are met
- 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 than 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.

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See Respondent's Composite Exhibit 2 at pages 45-46.

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

The Authorization Requirements Policy states, in pertinent part:

3.0 Determination Process

3.1 Review Criteria

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

3.2 Review Process

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

Respondent's Composite Exhibit 2 at page 33.

28. In this case, Respondent denied the services requested in the Petitioner's fourth (4th) and fifth (5th) initial Treatment Plan for BA services. The NOO and NRD explained that Petitioner's request for applied behavior analysis services did not meet medical necessity because the treatment plan was not individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness under treatment, and did not meet generally accepted professional medical standards as determined by the Medicaid program. See supra ¶¶ 8 and 9.

29. As provided in the BA policy (Appendix 9.0, section (a)), and the EPSDT requirements, the recipient must meet the medical necessity criteria as outlined in Fla. Admin. Code R. 59G-1.010. Two of the five components of medical necessity are that 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," and "be consistent with generally accepted professional medical standards as determined by the Medicaid program" See supra ¶¶ 23, 24, and 25. As outlined above, Dr. Darling provided credible and persuasive testimony identifying several instances where the Treatment Plan did not follow generally accepted medical standards of BA, is not individualized, specific, and consistent with symptoms or confirmed diagnosis, and

reflective of the level of service that can be safely furnished. Those aspects of the Petitioner's Treatment Plan that are related to [REDACTED] and more specifically [REDACTED] [REDACTED] are not recognized by the established Florida practice guidelines within the accepted professional medical standards of applied behavior analysis for the treatment of a child diagnosed with [REDACTED]. See supra ¶¶ 24, 25, and 26.

30. Thus, Respondent demonstrated by a preponderance of the evidence that, based on the information in the record, the requested BA services are not "consistent with generally accepted professional medical standards as determined by the Medicaid program", and not "individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness under treatment" for a child with diagnosed [REDACTED]. See supra ¶ 12 and 13.

31. Accordingly, the Petitioner has not demonstrated by a preponderance of the evidence that the requested 2,600 units of code 97153, 234 units of Code 97155, 416 units of code 97155, and 208 units of code 97156 for the certification period of July 25, 2023, through January 20, 2024 in the initial Treatment Plan by [REDACTED] are consistent with generally accepted professional medical standards as determined by the Medicaid program for the treatment of [REDACTED] and are individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness under treatment for a child with diagnosed [REDACTED].

32. Upon consideration of the testimony provided, evidence submitted, and applicable policies, the undersigned concludes that Petitioner has not proved by a preponderance of the evidence that the denied 2,600 units of code 97153, 234 units of Code 97155, 416 units of code 97155, and 208 units of code 97156 for the certification period of July 25, 2023, through January

20, 2024, are medically necessary. Looking at all the evidence relevant to the particular needs of Petitioner, Respondent has demonstrated that the 2,600 units of code 97153, 234 units of Code 97155, 416 units of code 97155, and 208 units of code 97156 included in the initial Treatment Plan by [REDACTED], are not necessary to correct or ameliorate the Petitioner's defect or a physical and mental illness or condition, namely the diagnosed [REDACTED]. Accordingly, Petitioner did not prove by a preponderance of the evidence that Respondent's denial of ABA services was incorrect.

DECISION

Respondent's denial of behavior analysis services is **AFFIRMED**. Petitioner's appeal based on Respondent's denial of behavior analysis services is **DENIED**.

DONE and **ORDERED** this 5th day of December 2023, in Tallahassee, Leon County, Florida.

Alan J. Leifer
23-FH2218
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ALAN LEIFER, 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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