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

FILED
Jan 10, 2024, 12:07 pm
OFFICE OF FAIR HEARINGS

[redacted],

PETITIONER, **AHCA Case No.: 23-FH2340**

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 21, 2023, at 9:00 EST.

APPEARANCES

For the Petitioner: [redacted]
Petitioner's Authorized Representative

For the Respondent: Marielisa Amador
Medical Health Care Program Analyst
Agency for Health Care Administration

STATEMENT OF ISSUE

The issue is whether 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 for the scheduled Fair Hearing telephonically. [redacted] ("[redacted]"), Petitioner's Authorized Representative and [redacted], appeared for the Fair Hearing on behalf of Petitioner and provided testimony.

Marielisa Amador, 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") for eQHealth Solutions, appeared for the Fair Hearing as a witness for Respondent.

Interpreters Adilene, ID no. 361179, and Jose, ID no. 379441, with Language Line Solutions, provided translation services for Petitioner.

Petitioner did not introduce any exhibits at the Fair Hearing. Prior to the Fair Hearing, Respondent filed with the Office of Fair Hearings and sent to Petitioner a one hundred and sixty-four (164)-page evidence packet. The evidence packet appears in the Office of Fair Hearings' case management system as "[redacted] FH 11.21.2023.pdf." Without objection, the evidence packet was admitted into evidence as Respondent's Composite Exhibit 1.

Prior to the Fair Hearing, Respondent filed with the Office of Fair Hearings and sent to Petitioner a forty-nine (49)-page evidence packet. The evidence packet appears in the Office of Fair Hearings' case management system as "23-FH2340 AHCA Evidence (Pages 1-49 of 49).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 from the Agency. *See* Respondent's Composite Exhibit 1 at page 22. 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]. *See* Respondent's Composite Exhibit 1 at page 21. Petitioner is diagnosed with [redacted]. *Id*. at 51. The Behavior Analysis Assessment and Treatment Plan ("Treatment "Plan") at issue identified the following maladaptive behaviors: [redacted], [redacted], [redacted], [redacted], [redacted], [redacted], [redacted], [redacted], [redacted]. *Id*. at 60-62.

3. Petitioner requested the continuation of the following BA services: 3,120 units of code 17153, 104 units of code 97156, 104 units of code 97156 HN, 104 units of code 97155, and 312 units of code 97155 HN for the certification period of September 7, 2023, through March 4, 2024. *Id*. at 24-25.

4. On September 13, 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:

> Submitted information does not support the medical necessity for requested frequency and\or duration.
> Requested services are denied because documentation is neither showing improvement nor support for maintenance.
>
> PR Clinical Rationale – Denial: The definitions of behaviors under treatment must be written according to generally accepted practice within the field of ABA and according to AHCA standards of care (the Florida Behavior Analysis Services Coverage Policy, page 6, 9.2.i). The behavioral definitions must be clear, complete, objective and free of unobservable intentional states ([redacted] – deficit, not maladaptive). The behaviors should have clear boundaries, definite

on-sets and off-sets, should not overlap with other target behaviors, and not be a listing of behaviors that the recipient is engaging in. The behavioral definitions in the treatment plan do not conform to generally accepted standards of care within the field of applied behavior analysis.

Provider, the date show limited to no progress with duplicate continuous data paths across all behaviors/goals. The data appear fabricated. 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 of progress was due to therapist error (e.g., poor data collection or poor training on intervention methods), how the provider 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 sufficiently in relation to the lack of progress. The information submitted does not meet standards of care within the field of behavior analysis. The request is denied.

Id. at 28-29.

5. On September 20, 2023, Petitioner requested reconsideration of the Respondent's decision. *Id*. at 39. On September 26, 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:

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.

. . .
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 the provider will address human error. The recommendations are insufficient to support continued care.

Id. at 41.

6. On September 15, 2023, [redacted] requested a Fair Hearing on behalf of Petitioner based on the termination of BA services. *Id*. at 8. On October 30, 2023, the undersigned Hearing Officer issued a notice to the parties of record scheduling the Fair Hearing for November 21, 2023, at 9:00 a.m. EST. *Id*. at 8. Administrative approval was granted for continued care pending the outcome of the Fair Hearing. *Id*. at 25.

7. Dr. Bicard testified that eQHealth reviews behavior analysis cases to ensure that 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"). eQHealth reviewed the Treatment Plan submitted in this case to determine whether all five (5) conditions of medical necessity are met. Dr. Bicard asserted that Petitioner's services were terminated because the Treatment Plan does not meet two 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. Bicard established that an effective treatment plan is built around maladaptive behaviors (which decrease in frequency) and skills to be acquired (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 the field of BA require an immediate intervention or modification of a treatment plan every time there is no progress after approximately 3 graph points or approximately 3-6 weeks of treatment. An intervention is shown by a vertical line on the data graph marking its start point so that a recipient's progress can be evaluated. Standards of care dictate that BA services must be effective or immediately modified to address a lack of progress.

9. Dr. Bicard established that Petitioner has been in BA therapy for 30 hours per week for over one year with the current provider. As Dr. Bicard testified, all of the graphs for Petitioner's maladaptive behaviors look identical and the only difference in the graphs is in the scale of the data (shown on the "y" axis). In Dr. Bicard's experience, he has never seen essential identical data for each maladaptive behavior and it calls into question the credibility of the data. Moreover, the data graphs do not show progress over the course of treatment. For example, the data graph for [redacted] shows that Petitioner engages in the maladaptive behavior [redacted] times per week. *Id*. at 84. However, there were no modifications to the Treatment Plan to address the lack of progress on this or any other maladaptive behaviors. [redacted], in Dr. Bicard's opinion, is relatively easy to treat and should show progress. For replacement behaviors, Dr. Bicard similarly testified that all of the data graphs for Petitioner's replacement behaviors looks identical, which is impossible when tracking each of these behaviors over the last observation period. Dr. Bicard concluded that the data graphs do not appear to provide "real" data and are not credible.

Moreover, all of the replacement behaviors are at less than 50%, and some are lower than [redacted] This means that 50% of the time or more, Petitioner is not doing what they are working on, and this is far below standards of care in the filed of behavior analysis. Dr. Bicard established that treatment has been ineffective for more than one year and Petitioner would not gain any additional benefit from continuing under the Treatment Plan at issue.

10. [redacted] asserted that Petitioner suffers from multiple medical conditions but has made significant improvement with the current BA provider even if the progress does not appear in the data graphs. One example is that Petitioner is now able to [redacted] Further, [redacted] asserted that Petitioner has met some short term objectives in the Treatment Plan.

CONCLUSIONS OF LAW

11. 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).

12. This hearing was held as a *de novo* proceeding pursuant to Rule 59G-1.100(17)(b), Florida Administrative Code ("F.A.C.").

13. Because Respondent terminated a previously approved service, Rule 59-1.100(17)(g), F.A.C. 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.).

14. 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).

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

17. 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.

18. 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.

19. The Behavior Analysis Services Coverage Policy (October 2017) ("BA Policy"), incorporated by reference in Rule 59G-4.125, F.A.C., 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, 42.

20. 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 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.

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

. . .

5. Criteria for Discharge from Behavior Analysis Services - ONE or **MORE** of the following **MUST**
be satisfied:

a. The <u>critical elements</u> are **no longer met.**

b. The data provided shows that the frequency and severity of maladaptive behavior(s) has declined to the point that they no longer pose a barrier to the child's ability to function in his/her environment.
c. The data provided shows the recipient has made no progress toward any goals in the last 12 consecutive months.
d. The level of functional impairment as expressed through behaviors no longer justifies continued BA services.
e. Parent/guardian withdraws consent for treatment.

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

21. The Florida Medicaid Authorization Requirements Policy ("Authorization Requirements Policy") (June 2016), incorporated by reference in Rule 59G-1.053, F.A.C., 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.

22. 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 medical necessity criteria as the Treatment Plan was not "[c]onsistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational" and "[i]ndividualized, specific, and consistent with symptoms or confirmed diagnosis of the illness under treatment, and not in excess of the patient's needs." *See* supra ¶ 4-5.

23. As provided in the BA policy (Appendix 9.0, section (a)), and the EPSDT requirements, the recipient must meet the meet the medical necessity criteria as outlined in Fla. Admin. Code R. 59G-1.010. A component of medical necessity is that services must be "consistent with generally accepted professional medical standards" and "[i]ndividualized, specific, and consistent with the confirmed diagnosis of the illness under treatment." As outlined above, Dr. Bicard provided credible and persuasive testimony identifying several instances where the revised Treatment Plan did not follow generally accepted standards of BA. For example, after more than one year year of BA treatment with the provider, the Treatment Plan does not show evidence that the frequency of Petitioner's maladaptive behaviors has decreased and does not show that there was a modification or intervention to address Petitioner's lack of progress. *See* supra ¶ 8-9. As Dr. Bicard testified, the data graphs for Petitioner's replacement behaviors show that behaviors targeted for improvement also do not show improvement, and no intervention was made to change Petitioner's lack progress. *See* supra ¶ 8-9. Further, the data graphs for maladaptive behaviors are virtually identical, as well as the data graphs for replacement behaviors, and this calls into question the credibility of the data graphs. Accordingly, the submitted information does not support the medical necessity for the BA services at issue. Finally, Dr. Bicard established that

no progress was made on the majority of replacement behaviors which remain at or below 50% or chance level after more than one years of BA treatment. Thus, Respondent demonstrated that, based on the information in the record, the requested BA services are not "consistent with generally accepted professional medical standards" and are not "individualized, specific, and consistent with the illness under treatment." Accordingly, the critical element of medical necessity is not met and, as Dr. Bicard testified, Petitioner will not gain any additional benefit by continuing services under the Treatment Plan at issue. *See* supra ¶ 9.

24. 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 ¶ 18.

25. Accordingly, Respondent met their burden of proof to show that the requested BA services no longer meet medical 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.

26. 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 10th day of January 2024, in Tallahassee, Leon County, Florida.

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:

[redacted]

AHCA Medicaid Hearing Unit
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