



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

FILED

Feb 02, 2024, 1:10 pm

OFFICE OF FAIR HEARINGS
AHCA Case No.: 23-FH2554

[REDACTED]

PETITIONER,

vs.

AGENCY FOR HEALTH CARE
ADMINISTRATION,

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic Fair Hearing on the instant case on December 7, 2023, at 9:05 a.m. Eastern Standard Time ("EST").

APPEARANCES

For the Petitioner:

[REDACTED]

Petitioner's Authorized Representative

For the Respondent:

Diana Hearod
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 Applied Behavior Analysis ("ABA" or "BA") services was correct.

PRELIMINARY STATEMENT

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

Diana Hearod (“Ms. Harris”), Medical Health Care Program Analyst for the Agency for Health Care Administration (“Agency” or “AHCA”), appeared on behalf of Respondent. Dr. Alissa Conway (“Dr. Conway”), Board Certified Behavior Analyst at the doctoral level (“BCBA-D”) and second level reviewer of 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 an eighty-four (84)-page evidence packet and a forty-nine (49)-page evidence packet. The eighty-four (84) page evidence packet appears in the Office of Fair Hearings’ Case Management System as file “[REDACTED] FH 12.07.2023.pdf”. The forty-nine (49) page evidence packet appears in the Office of Fair Hearings’ Case Management System as file “23-FH2554 BA AHCA Evidence 49 PGS [Petitioner Name].pdf.” Absent an objection from the Petitioner, the undersigned admitted the eighty-four (84)-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. Petitioner is [REDACTED]. *See* RCE 1 at page 21. Petitioner is diagnosed with [REDACTED] [REDACTED] *Id.*

3. As provided in the Behavior Analysis Service Plan (“treatment plan” or “behavior plan”), Petitioner is engaging in the following maladaptive behaviors: [REDACTED]; [REDACTED]; [REDACTED]; [REDACTED]; [REDACTED]; [REDACTED]; and [REDACTED]. *Id.* at 56. During the period of February 25, 2023, through July 29, 2023, Petitioner’s maladaptive behaviors showed the following: for [REDACTED], Petitioner reduced [REDACTED] incidents from approximately [REDACTED]; for [REDACTED], Petitioner reduced [REDACTED] incidents from approximately [REDACTED]; for [REDACTED], Petitioner reduced [REDACTED] incidents from approximately [REDACTED]; for [REDACTED], Petitioner reduced [REDACTED] incidents from approximately [REDACTED]; for [REDACTED], Petitioner reduced [REDACTED] incidents from approximately [REDACTED]; for [REDACTED], Petitioner reduced [REDACTED] incidents from approximately [REDACTED]; for [REDACTED], Petitioner reduced [REDACTED] incidents from approximately [REDACTED]; and for [REDACTED], Petitioner reduced [REDACTED] incidents from approximately [REDACTED]. *Id.* at 61 – 66.

4. Petitioner requested continuation of BA services; specifically, 3,120 units of code 97153; 208 units of code 97155 HN; 208 units of code 97156 HN; 104 units of code 97155; and 104 units of 97156 *Id.* at 25, 26. The request for services covered the period of August 23, 2023, through February 18, 2024. In a Notice of Outcome (“NOO”), dated September 8, 2023, Respondent terminated Petitioner’s BA services. 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.

Requested services are denied because documentation is neither showing improvement nor support for maintenance.

The NOO further provided:

PR Clinical Rationale – Denial: According to the Florida Medicaid State Plan (Appendix 9.3.b), the data provided must show evidence that the frequency of the maladaptive behavior(s) has decreased since the last review and, if not, that there is a modification of the behavior plan. The recommendations for procedural modifications include: additions/changes to treatment plan to impact behaviors targeted for reduction. Procedural modifications should include one or more of the following: antecedent manipulation modifications, modifications of prompting procedures used in acquisition, modifications in consequence-based strategies—ones that either reduce maladaptive behavior or reinforce replacement behavior (e.g., manipulation of reinforcement schedules, switch to a different decelerative procedure), or if lack of progress was due to therapist error (e.g., poor data collection or poor training on intervention methods), how you will address human error. The provider has not addressed the lack of progress during the last observation period and did not *sufficiently* amend the treatment plan in relation to the lack of Progress. This request is denied.

...

RCE 1 at Pages 29 – 30.

5. Petitioner requested reconsideration of the Respondent’s decision. In a Notice of Reconsideration Determination (“NRD”), dated October 12, 2023, Respondent upheld its decision. *Id.* at 42. The NRD explained the basis for the decision as follows:

PR Recon Determination: At reconsideration all documents were carefully reviewed. The provider was previously authorized to implement BA services for this recipient. The services were denied due to a lack of progress and held up at reconsideration. This denial is upheld.

...

RCE 1 at Page 42.

6. On October 5, 2023, Petitioner requested a Fair Hearing to challenge the termination of BA services. On November 14, 2023, the undersigned issued an Order Scheduling Fair Hearing by Telephone and Prehearing Instructions, setting the hearing for December 7, 2023, at 9:00 a.m. EST.

7. Dr. Conway is a BCBA-D and second level reviewer for eQHealth. Dr. Conway testified to the following at the Fair Hearing:

- a. eQHealth is contracted by Florida Medicaid to review requests for services and to determine if the requests are medically necessary or a medical necessity. In this case, Dr. Conway testified that the recipient of the services has made no significant improvement during the six-month treatment period and the provider has submitted the same treatment plan with no modifications during the second level review of the treatment plan nor during the reconsideration of the denial of the services.
- b. Dr. Conway's testimony included a review of the charted behaviors found in the treatment plan during the six-month period from February of 2023 through July of 2023. In addition to reviewing each chart, Dr. Conway testified to the fact that each charted behavior had virtually the same track, which Dr. Conway found highly unlikely and questioned the data collection. Dr. Conway testified that her review of these graphs demonstrated "very limited progress" and the patterns of the charted behavior are not typical of human behavior and a new behavior developed during the treatment.
- c. Dr. Conway also testified as to the replacement behavior graphs contained in RCE 1 beginning on page 67. Dr. Conway found that the graphs as displayed were inappropriate in that they did not reflect a scale of 100% and that by limiting the vertical scale to 20%, it created a false impression of greater improvement. The replacement behaviors graphs include the following: [REDACTED], at page 67, [REDACTED] at

page 68, [REDACTED] found at page 68, [REDACTED] at page 69, [REDACTED] found at page 69, [REDACTED] at page 70, [REDACTED] found at page 70, [REDACTED] found at page 71, and [REDACTED] found at page 71. Dr. Conway addressed each of these graphs and testified that each graph started with a base at [REDACTED] and each graph ended with minimal improvement at [REDACTED]. Dr. Conway took exception to the graph for daily living skills ([REDACTED]) at page 73. Dr. Conway testified that with the age of this individual, the provider should have taken additional action to increase progress in a quicker fashion. The graph reflects that the charted progress is below [REDACTED]. Dr. Conway also testified to the charted behavior of [REDACTED] at page 73. This chart established a baseline of [REDACTED] and after 6 months of treatment was charted at [REDACTED].

- d. Dr. Conway testified that the provider attempted to introduce new interventions and antecedent manipulations. These additions included [REDACTED]
[REDACTED]
[REDACTED] RCE 1 pages 76 and 77. After her review, Dr. Conway found that the proposed interventions were not true modifications to the treatment plan in that these modifications and interventions overlapped with previously stated procedures within the existing plan.
- e. Dr. Conway summarized her review of the items moved into evidence to find that Petitioner had failed to make any significant improvement or progress under the treatment plan submitted by the provider during the six-month treatment period.

Further, that, the data charted in the various graphs submitted all contain the same data path or track which is highly unusual for human behavior.

f. Dr. Conway believes that the recipient was qualified to receive behavior analysis services, however those services should be from a different provider.

8. [REDACTED] is the [REDACTED] of the Petitioner. [REDACTED] testified to the following at the Fair

Hearing:

a. [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED].

CONCLUSIONS OF LAW

9. 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).

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

11. Because Respondent terminated 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.)

12. 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.

13. 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

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). 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.

15. Petitioner is under age 21, 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). 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.

16. 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.

17. 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.

18. In the instant case, Respondent terminated Petitioner’s ABA services. See ¶ 4. In the NOO dated September 8, 2023, Respondent explained that continuing services at the prior level was not medically necessary, specifically, that it did not meet the requirements that services must be “consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational”. Respondent further explained that the “requested services are denied because documentation is neither showing improvement nor support for maintenance.” Additionally, the Respondent found that “the provider had not addressed the lack of progress during the last observation period and did not *sufficiently* amend the treatment plan in relation to the lack of progress.”

19. 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, medically necessary or medical necessity are that services must be “consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational”. As shown by the record and specifically the testimony of Dr. Conway as to the graphs and charts submitted into evidence, there is a significant lack of improvement by the Petitioner under the current treatment plan. See ¶¶ 3, 7. The provider proposed to introduce [REDACTED]. However, as testified to by Dr. Conway, these new modifications were not true modifications as these modifications in the treatment plan simply overlapped previously contained procedures of the treatment plan. *Id.* at 7. Dr. Conway testified that with the significant lack of improvement under the current treatment plan and the lack of any meaningful modification to the treatment plan, the Petitioner will not gain any additional benefit

by continuing services at the current level. As Dr. Conway is a BCBA-D, her testimony is credible. Here, the record shows that the services rendered by the provider were not “consistent with generally accepted professional medical standards as determined by the Medicaid program”. As such, continuing services with this provider is not medically necessary for Petitioner.

20. As QIO for the Agency, eQHealth is authorized to terminate services when “the reviewing physician determines the recipient will not gain any additional benefit by continuing services at the current level.” See ¶ 17. As discussed, *supra* ¶ 19, and according to an expert in the field of behavior analysis, the treatment plan in this case does not meet medical necessity criteria, nor does it satisfy specifications in the Behavior Analysis Services Coverage Policy.

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 BA services at issue do not 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 termination of ABA services was correct.

IT IS HEREBY ORDERED AND ADJUDGED THAT:

Respondent’s termination of BA services is **AFFIRMED**. Petitioner’s appeal based on Respondent’s termination is **DENIED**.

DONE and **ORDERED** this 2nd day of February 2024, in Tallahassee, Leon County, Florida.



Joseph Mabry

23-FH2554

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JOSEPH MABRY, 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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