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

FILED

Jan 18, 2024, 3:14 pm

OFFICE OF FAIR HEARINGS

[redacted],

PETITIONER, **AHCA Case No.: 23-FH2589**

vs.

AGENCY FOR HEALTH CARE ADMINISTRATION,

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic Fair Hearing on the instant case on November 20, 2023, at 10:03 a.m. Eastern Standard Time ("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 Petitioner proved by a preponderance of the evidence that Respondent's denial of Petitioner's behavior analysis ("BA" or "ABA") services was incorrect.

PRELIMINARY STATEMENT

All parties and witnesses appeared telephonically. [redacted] ("[redacted]"), Petitioner's Authorized Representative and [redacted], appeared for the Fair Hearing on behalf of Petitioner. [redacted], Board Certified Behavior Analyst ("BCBA") for [redacted]

Inc., appeared for the Fair Hearing as a witness for Petitioner. [redacted], BCBA for [redacted] Inc., appeared for the Fair Hearing as a witness for Petitioner.

Marielisa Amador, Medical/Health Care Program Analyst for the Agency for Health Care Administration ("Agency" or "AHCA"), appeared for the Fair Hearing as representative for Respondent. Dr. David Bicard ("Dr. Bicard"), BCBA and Director of Clinical Operations for eQHealth Solutions Florida ("eQHealth"), appeared for the Fair Hearing as a witness for Respondent.

Petitioner did not introduce any exhibits at the hearing.

Prior to the hearing, the Office of Fair Hearings received a seventy-eight (78)-page evidence packet and a forty-nine (49)-page evidence packet from Respondent. The seventy-eight (78)-page packet appears in the Office of Fair Hearings document management system as the file title "[redacted] FH 11.20.2023.pdf". The forty-nine (49)-page evidence packet appears in the Office of Fair Hearings document management system as the file title "23-FH2589 AHCA evidence (Pages 1 - 49 of 49).pdf." Absent an objection from the Petitioner, the undersigned admitted the seventy-eight (78)-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 ("QIO") 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 16. Petitioner is diagnosed with [redacted]. *Id.*

3. As provided in the Medicaid Initial Assessment and Treatment Plan ("Treatment Plan") submitted by [redacted] Inc., Petitioner is engaging in the following maladaptive behaviors: [redacted], [redacted], [redacted], and [redacted]. *Id*. at 69-70.

4. Petitioner requested ABA services for the certification period of July 5, 2023, to December 31, 2023; specifically, 2,600 units of code 97153; 1144 units of code 97155; and 104 units of code 97156. *Id*. at 20, 24. On July 9, 2023, Respondent issued a request for information ("PEND") to Petitioner's provider requesting as follows:

> This review was submitted untimely, all services must be submitted with a start date of either the date of receipt or after 7/5/2023. Please respond to this pend with future dates of service, otherwise, this review will need to be cancelled.
>
> Please submit graphs of directly observed behavior data gathered during the assessment. The presence or absence of maladaptive behaviors and replacement skills directly assessed and measured according to standards of care within the field of behavior analysis and the behavior analysis services coverage policy.
> You may supplement observed data with anecdotal reports from the recipient's caregiver on historical instances of problem behaviors and replacement skills. That information may be reported in the provider's treatment plan within the indirect functional assessment or background information section.
>
> All medical necessity determinations are made on the totality of the treatment plan information submitted for each of the following:
> - Maladaptive behaviors,
> - Replacement behaviors/skill acquisition behaviors, and
> - Parent training skills

Id. at 18-19, 48.

5. On July 18, 2023, during the second level review, Respondent issued another PEND to Petitioner's provider, requesting as follows:

> Provider,
>
> The definitions do not conform to the Florida Behavior Analysis Services Coverage Policy. According to (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. The behaviors should have clear boundaries, definite on-sets and off-sets, should not overlap with other target behaviors definitions, and not be a listing of behaviors that the recipient does not engaging in. The definitions for [redacted] creates multiple overlaps with other behavioral definitions and requires your review. Further, there are discrepancies in the goals listed and maladaptive behaviors reported (pg. 5). The plan lists goals for [redacted] that are not mentioned elsewhere in the plan. Additionally, according to the Florida Medicaid State Plan (Appendix 9.2.c), assessment results must be present in the plan. You were authorized units to complete an individualized assessment and collect baseline data. Please submit observed and measured baseline data and individual graphs for maladaptive behavior and skill acquisition goals that were directly observed and measured (not parent report, indirect interview, or an estimate) during the assessment. Finally, According to The Behavior Analysis Services Coverage Policy (9.2.b.iv and v) and standards of care within the field of behavior analysis proposed strategies of antecedent and consequent strategies of the maladaptive behavior(s) must be present in the plan.
>
> The plan lacks identification of antecedent and consequence strategies for each behavior or function.

Id. at 19, 47.

6. In a Notice of Outcome ("NOO"), dated July 28, 2023, Respondent denied Petitioner's requested ABA services. *Id.* at 24-26. The NOO explained the basis for the denial as follows:

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

The NOO further provided:

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

> PR Clinical Rationale - Denial: According to (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. The behaviors should have clear boundaries, definite on-sets and off-sets, should not overlap with other target behaviors definitions, and not be a listing of behaviors that the recipient does not engag[e] in. The behavior definitions for [redacted] creates overlap in this treatment plan do not conform to generally accepted standards of care within the field of applied behavior analysis. The provider was requested to review and amend the definitions and the provider did not satisfy the request. Further, According to The Behavior Analysis Services Coverage Policy (9.2.b.iv and v) and standards of care within the field of behavior analysis proposed strategies of antecedent and consequent strategies of the maladaptive behavior(s) must be present in the plan. The plan lacks identification of antecedent and consequence strategies for each behavior or function. Additionally, according to the Behavior Analysis Services Coverage Policy (9.2.b) all treatment plans submitted for modification of care must include updated data for all behaviors under treatment as well as changes to the treatment plan, if necessary. The provider was requested to submit updated graphs for all behaviors under treatment. The provider has not submitted all the graphs. This request is denied.

Id.

7. Petitioner requested reconsideration of the Respondent's decision. In a Notice of Reconsideration Determination ("NRD"), dated October 17, 2023, Respondent upheld its decision. *Id.* at 36-37. The NRD explained the basis for the decision as follows:

> PR Recon Determination: At reconsideration all documents were carefully reviewed. The supporting documentation does not meet generally accepted practices within the field of applied behavior analysis and standards set forth in the Florida Behavior Analysis Services Coverage Policy (Pages 8, 6.2.3). The provider was approved to complete an assessment, The provider has not submitted all graphed baseline data for skill acquisition goals and maladaptive behaviors that were to be completed during the assessment. Additionally, the provider has not data from the functional assessment/analysis completed during this assessment. This request for ABA treatment does not meet medical necessity criteria as the information submitted by the provider does not meet standards of care within the field of behavior analysis nor specifications from the Behavior Analysis Services Coverage Policy. The request for 97155 code (protocol modification by the lead analyst) does not meet standards of care within the field of behavior analysis and is in excess of medical necessity. This denial is upheld.

Id. at 37.

8. On October 19, 2023, Petitioner requested a Fair Hearing to challenge the denial of ABA services. On October 24, 2023, the undersigned issued an Order Scheduling Fair Hearing and Prehearing Instructions, setting the hearing for November 20, 2023, at 10:00 a.m. EST.

9. [redacted] is a BCBA for [redacted] Inc. [redacted] testified to the following at Fair Hearing:

a. [redacted] argued that [redacted] Inc. timely submitted their responses to eQHealth PENDs on July 11, 2023, and July 20, 2023.

b. For the initial assessment, interview-informed synthesized contingency analysis ("IISCA") was used instead of the functional behavioral assessment ("FBA") for the safety of the client to prevent [redacted] and [redacted]. *Id*. at 68-69.

c. The information in the Treatment Plan was gathered from an interview with the Petitioner's caregiver and observation of precursors of the problem behaviors.

d. [redacted] argued that baseline data was taken for each target behavior and compiled in the submitted chart because it was not accepted in the first PEND.

e. [redacted] argued that the Treatment Plan is individualized to Petitioner through the skills listed under "Functionally Equivalent Replacement Behavior" because they involve spending time with Petitioner to assess [redacted] behaviors and operate to replace each of [redacted] maladaptive behaviors. *Id*. at 70-71.

f. [redacted] argued that promoted emergence of advanced knowledge ("PEAK") was used for Petitioner's skill assessment. *Id*. at 71-73.

10. Dr. Bicard is a BCBA and Director of Clinical Operations for eQHealth. Dr. Bicard established the following at Fair Hearing:

a. EQHealth is contracted by AHCA to review requests for medical necessity of ABA services using a two-level review process. *See* RCE 2 at 7. eQHealth reviews behavior analysis cases to ensure ABA services are consistent with the standards enumerated in the Behavior Analysis Coverage Policy as well as professional medical standards of behavior analysis. *See* ¶ 14-15.

b. In this case, Dr. Bicard contended that the denial is due to an inadequate Treatment Plan that does not appear to show that a functional assessment was completed as there is no data collected on Petitioner's maladaptive behaviors or skill replacement behaviors. *See* RCE 1 at 69-76. Dr. Bicard argued that the Treatment Plan appears to be a boilerplate template since there is very little information individualized for Petitioner.

c. Dr. Bicard contended that the requested units did not meet recommended minimum requirements in accordance with ABA practice guideline standards. The current recommended standard ratio is 2:1 for hours of direct therapy delivered to hours of protocol modification. The provider requested about eleven (11) hours for protocol modification (code 97155) and about twenty-five (25) hours of direct therapy (code 97153) in excess of the standard ratio. *See* ¶ 4.

d. Dr. Bicard opined that the standard of care for ABA services is to include baseline data directly observed by the BCBA during the assessment. A behavior plan should include data graphs for each behavior along with dates when the behaviors were measured during the assessment.

e. Dr. Bicard pointed out that for the [redacted] and [redacted] behaviors, the Treatment Plan indicates "baseline [redacted] episodes per week" but there is no evidence this is actual data collected from direct observation by the analyst. *See* RCE 1 at 69. The Treatment Plan has no graphs for any behavior. *Id*. at 69-76.

f. The Treatment Plan includes a general listing of 45 goals under the subtitle "Targets", but includes no rationale on how they were identified, why they were included, or demonstrate individualization of services to Petitioner. *Id*. at 74-76.

g. Under the subtitle "Targets", the provider indicated "Baseline will be collected during the initial 3 sessions" for all skills. Dr. Bicard contended that baseline data, i.e. those that identify the frequency to which Petitioner can or cannot engage in these skills, must be collected prior to the commencement of treatment so that progress over the course of treatment can be accurately measured.

h. Dr. Bicard argued that the services within the Treatment Plan do not meet medical necessity criteria 2 and 3, and are far below the standard of care in the field of ABA and in the Behavior Analysis Services Coverage Policy. *See* ¶¶ 14, 15, 18.

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 (2022). 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 ("Fla. Admin. Code R.").

13. Because Petitioner requested new ABA services, Fla. Admin. Code R. 59G-1.100(17)(g) assigns the burden of proof to the Petitioner. The standard of proof in an administrative hearing is a preponderance of the evidence. The preponderance of the evidence standard requires proof by "the greater weight of the evidence" (Black's Law Dictionary at 1201, 7th Ed.)

14. The Florida Medicaid Behavior Analysis Services Coverage Policy (October 2017) ("BA Policy"), incorporated by reference in Fla. Admin. Code. R. 59G-4.125, governs ABA 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 no 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 38-44.

15. 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 than 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.

. . .

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

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

Providers **MUST** ensure that proper justification for the requested hours of services is adequately documented in the behavior plan. Based on the information provided in the assessment, behavior plan, and any other supporting documentation, the reviewer utilizes the information provided below as a guide as it relates to the level of functional impairment as expressed through the following behaviors:

i. Safety - aggression, self-injury, property destruction, elopement
ii. Communication - problems with expressive/receptive language, poor understanding or use of non-verbal communications, stereotyped, repetitive language
iii. Self-stimulating, abnormal, inflexible, or intense preoccupations
iv. Self-care - difficulty recognizing risks or danger, grooming, eating, or toileting
v. Other- behaviors not identified above

See RCE 2 at 45-47.

16. 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.

17. 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.

18. The Florida Medicaid Definitions Policy (August 2017) ("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.

Definitions Policy at page 7.

19. The Florida Medicaid Authorization Requirements Policy (June 2016) ("Authorization Policy"), incorporated by reference in Fla. Admin. Code R. 59G-1.053, provides general

requirements for providers to obtain authorization to render Florida Medicaid services. *See* RCE 2 at 30-36. The Authorization Policy states as follows:

> **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 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.

See RCE 2 at 34.

20. In the instant case, Petitioner is under 21 years of age and is diagnosed with [redacted]. *See* ¶ 2. Petitioner requested ABA services. *See* ¶ 4. In a NOO, dated July 28, 2023, Respondent denied the services. *See* ¶ 6. Respondent cited to the lack of medical necessity as the basis for their decision, specifically that the requested ABA services must be "consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational." *See* ¶ 6. In addition, Respondent determined that the requested services were not "individualized, specific, and consistent with symptoms or confirmed diagnosis

of the illness under treatment, and not in excess of the patient's needs." *See* ¶ 6. Petitioner has burden of proof to show by a preponderance of evidence that the Respondent's determination was incorrect. *See* ¶ 13.

21. As provided by the EPSDT requirements, the recipient must meet the medical necessity criteria as outlined in Fla. Admin. Code R. 59G-1.010. *See* ¶ 16-17. In the Definitions Policy, a component of medical necessity is that services must be "consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational." *See* ¶ 18.

22. Section 9.0 of the BA Policy maintains that the "behavior plan is the cornerstone of the delivery of behavior analysis services." *See* ¶ 15. The BA Policy criteria require that a behavior plan must be detailed enough to warrant the requested services and include mechanisms to monitor its effectiveness. *See* ¶ 15. The criteria for assessing the intensity of behavior analysis services requires that proper justification for the requested hours of services is adequately documented in the behavior plan. *See* ¶ 15.

23. Respondent provided two PEND opportunities requesting the provider to make changes to the Treatment Plan. *See* ¶¶ 4, 5. [redacted], the BCBA for [redacted] Inc., argued that responses to the PENDs were timely submitted. *See* ¶ 9. The information submitted by the provider in the Treatment Plan as a part of the request for services, however, did not satisfy the medical necessity criteria for ABA services according to three eQHealth reviewers. *See* ¶ 4-7. Dr. Bicard explained that the services within the Treatment Plan do not meet medical necessity criteria 2 and 3, and are far below the standards of care in the field of ABA and the Behavior Analysis Services Coverage Policy. *See* ¶ 10. Dr. Bicard provided testimony that the

provider submitted an inadequate Treatment Plan that does not appear to show that a functional assessment was completed as there is no data collected on Petitioner's maladaptive behaviors or skill replacement behaviors. *See* ¶ 10. For an initial assessment such as the Treatment Plan at issue, Dr. Bicard explained that the standard of care for ABA services is to include baseline data directly observed by the BCBA during the assessment and compiled into dated graphs for each behavior. *See* ¶ 10, 15. [redacted] testified that the information in the Treatment Plan was gathered from an interview with the Petitioner's caregiver and observation of precursors of the maladaptive behaviors. *See* ¶ 9. According to [redacted], the provider used the IISCA technique to prevent [redacted] and [redacted], and PEAK method for Petitioner's skill assessment. *See* ¶ 9. [redacted] pointed to the skills listed under "Functionally Equivalent Replacement Behavior" to demonstrate how the information collected was individualized to Petitioner. *See* ¶ 9.

24. Dr. Bicard argued that the Treatment Plan appears to be a boilerplate template since there is very little information individualized for Petitioner. *See* ¶ 10. For example, Dr. Bicard pointed out that for the [redacted] and [redacted] behaviors, the Treatment Plan indicates "baseline [redacted] episodes per week" but there is no evidence this is actual data collected from direct observation by the analyst. *See* ¶ 10. In addition, the Treatment Plan also includes a general listing of forty-five (45) goals under the subtitle "Targets", but does not also include how they were identified and why they were included, or demonstrate individualization of services to Petitioner. *See* ¶ 10. For all of these skills, the provider indicated "baseline will be collected during the initial 3 sessions" although baseline data must be collected prior to the commencement of treatment. *See* ¶ 10. The Treatment Plan contains no graphs for any of the maladaptive behaviors or

replacement skills. *See* ¶¶ 6, 7, 10. Lastly, Dr. Bicard opined that the requested units did not meet minimum requirements in accordance with ABA practice guideline standards. *See* ¶ 10. The provider requested about eleven (11) hours for protocol modification (code 97155) and about twenty-five (25) hours of direct therapy (code 97153) in excess of the standard ratio that is currently recommended as a 2:1 ratio. *See* ¶ 10.

25. The record shows that Petitioner's provider failed to include the proposed changes to the Treatment Plan that conformed to standards of care within the field of behavior analysis. *See* ¶ 23-24. The information in the Treatment Plan submitted by this provider does not justify Petitioner's request for ABA services. *See* ¶ 23-24. The undersigned finds Dr. Bicard's testimony persuasive and credible to demonstrate that the Treatment Plan was not consistent with generally accepted professional medical standards within the field of behavior analysis. Thus, Petitioner did not demonstrate that the requested ABA services are medically necessary.

26. Upon consideration of the testimony provided, evidence submitted, and applicable policies, the undersigned concludes that Petitioner did not prove by a preponderance of the evidence that the denial of ABA services was incorrect. Looking at all the evidence relevant to the particular needs of Petitioner, Petitioner has not demonstrated that the requested services, based on the Treatment Plan at issue in this case, are necessary to correct or ameliorate a defect or a physical and mental illness or condition. Accordingly, Petitioner did not prove by a preponderance of the evidence that Respondent's denial of ABA services was incorrect.

IT IS HEREBY ORDERED AND ADJUDGED THAT:

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

DONE AND ORDERED this 18th day of January, 2024 in Tallahassee, Leon County, Florida.

KIMBERLY ROCHE, 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
MedicaidHearingUnit@ahca.myflorida.com