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

FILED

Feb 09, 2024, 8:20 am

OFFICE OF FAIR HEARINGS

[redacted],

PETITIONER,

AHCA Case No.: 23-FH2684

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 18, 2023, at 9:00 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 request for a Behavior Analysis ("BA" or "ABA") assessment was incorrect.

PRELIMINARY STATEMENT

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

Marielisa Amador ("Ms. Amador"), Medical/Health Care Program Analyst for the Agency for Health Care Administration ("Agency" or "AHCA"), appeared on behalf of Respondent. Dr. Alyssa Conway ("Dr. Conway"), Second Level Reviewer and Board Certified Behavior Analyst for eQHealth Solutions Inc. ("eQHealth"), appeared as a witness for Respondent.

Petitioner did not introduce any exhibits at the hearing. Prior to the hearing, Respondent sent to the Office of Fair Hearings and Petitioner a forty-six (46)-page evidence packet and a forty-nine (49)-page evidence packet. The forty-six (46)-page evidence packet appears in the Office of Fair Hearings' document management system as the file title "[redacted] FH 12.18.2023.pdf". The forty-nine (49)-page evidence packet appears in the Office of Fair Hearings' document management system as the file title "23-FH2684 AHCA Evidence (Pages 1-49 of 49).pdf". Absent an objection from the Petitioner, the undersigned admitted the forty-six (46)-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* page 2 of RCE 2.

2. Petitioner is [redacted]. *See* page 16 of RCE 1. Petitioner is diagnosed with [redacted]. *Id*.

3. Petitioner requested a behavior analysis assessment (code 97151). In a Notice of Outcome ("NOO"), dated October 13, 2023, Respondent denied Petitioner's request. *Id*. at 20. The NOO explained the basis for the denial 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.

The NOO further provided:

> PR Clinical Rationale – Denial: This request for assessment is denied. The previous BA services with this provider for this recipient were denied due to a lack of progress and held up at reconsideration. The interventions and data submitted by the provider for this request for services do not meet medical necessity criteria.
> . . .

Page 20 of RCE 1.

4. Petitioner requested reconsideration of the Respondent's decision. In a Notice of Reconsideration Determination ("NRD"), dated October 27, 2023, Respondent upheld its decision. *Id.* at 29. 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 reconsideration request has been reviewed, reconsidered and the denial is upheld.
> . . .

Pages 29 – 30 of RCE 1.

5. On October 19, 2023, Petitioner requested a Fair Hearing to challenge the denial of an ABA assessment. *Id*. at 8. On November 20, 2023, the undersigned issued an Order Scheduling Fair Hearing by Telephone and Prehearing Instructions, setting the hearing for December 18, 2023, at 9:00 a.m. EST. *Id*.

6. [redacted] is the [redacted] of Petitioner. [redacted] testified to the following at the Fair Hearing:

a. [redacted] is requesting that ABA services be immediately reinstated, as Petitioner has been without services for [redacted] months and has experienced regression. Petitioner previously had ABA services for [redacted].

b. [redacted] months ago, Petitioner's thirty (30) hours of ABA services were denied in total. [redacted] stated there has not been a big improvement, but there has been some improvement. [redacted] confirmed [redacted] is requesting services through the same provider that Petitioner had previously.

7. Dr. Conway is a Board Certified Behavior Analyst at the doctoral level. Dr. Conway testified to the following at the Fair Hearing:

a. The submitted documentation for the assessment was reviewed by three (3) qualified Board Certified Behavior Analysts at the Masters and Doctoral levels to determine whether the information met medical necessity criteria. The assessment request did not meet medical necessity criteria.

b. Petitioner had been in services with this provider since [redacted]. Petitioner was in services for over [redacted] prior to the previous denial for lack of sufficient progress and lack of modification to the plan. The provider did not submit additional documentation for reconsideration and did not request a Fair Hearing at that time.

c. The provider then requested a reassessment, although no services were authorized since [redacted]. The provider submitted progress notes for the reassessment, which reveal that the Board Certified Behavior Analyst has very limited involvement in the case and utilizes Zoom and telehealth services, which

are not authorized apart from family training. RBT training and protocol modifications need to be done in person.

d. None of the information provided submits modifications to address the lack of progress from the previous denial, and no information was ever submitted to address the lack of progress and lack of modification. Petitioner may qualify for ABA services, but Petitioner does not qualify with the current provider.

CONCLUSIONS OF LAW

8. The Agency's Office of Fair Hearings has jurisdiction over the subject matter of this proceeding and the parties pursuant to section 409.285(2), Florida Statutes (2019). This order is the final administrative decision of AHCA under section 409.285(2)(a).

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

10. Because Petitioner is requesting a new service, 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.)

11. The Florida Medicaid Behavior Analysis Services Coverage Policy (October 2017) ("BA Policy"), incorporated by reference in Fla. Admin. Code. R. 59G-4.125, governs BA services available under Florida Medicaid. The BA Policy provides as follows:

> **1.0 Introduction**
> Behavior analysis (BA) services are highly structured interventions, strategies, and approaches provided to decrease maladaptive behaviors and increase or reinforce appropriate behaviors.
> . . .
> **1.4.5 Medically Necessary/Medical Necessity**

As defined in Rule 59G-1.010, F.A.C.

. . .

4.0 Coverage Information

4.1 General Criteria

Florida Medicaid covers services that meet all of the following:

- Are determined medically necessary
- Do 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.

12. Appendix 9.0 of the BA Policy provides Review Criteria for Behavior Analysis Services.

These Review Criteria state as follows:

Review Criteria for Behavior Analysis Services
Behavior analysis (BA) services are considered as either the treatment of choice or as an adjunct treatment modality for a variety of conditions and disorders where maladaptive behaviors are part of the recipient's clinical presentation, including behavioral manifestations of diagnoses such as Autism Spectrum Disorder and other behavioral health conditions.

Critical Elements Necessary for ANY Type of Behavior Analysis Service:
The following critical elements **MUST** be satisfied to qualify for BA services:

a. Eligibility – The recipient must meet all criteria for BA services as outlined in the Behavior Analysis Services Coverage Policy, Rule 59G-4.125, F.A.C.
b. Medical necessity – The recipient must meet medical necessity criteria as outlined in Rule 59G-1.010, F.A.C.
c. The recipient currently engages in maladaptive behaviors
d. These maladaptive behaviors interfere with the recipient's daily functioning

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

a. **ALL** critical elements are met
b. Provide submits a valid written physician's order as stipulated in the Behavior Analysis Services Coverage Policy, Rule 59G-4.125, F.A.C.

2. Criteria for Behavior Analysis Services and Reassessments – ALL of the following **MUST** be satisfied:

a. **ALL** critical elements are met
b. An assessment or, if applicable, a reassessment, authored by a lead analyst, is provided. An assessment of the maladaptive behavior(s) is a necessary element of the process of identifying the frequency and magnitude of the behaviors as well as the variables associated with the occurrence of the maladaptive behavior(s). This helps in defining what are the functional consequences of the problem behavior(s) so 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.

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 <u>evidence that the frequency of the maladaptive behavior(s) has decreased</u> since the last review and, if not, that there is a <u>modification of the behavior plan.</u>
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

13. States must provide Early and Periodic Screening, Diagnostic, and Treatment ("EPSDT") services to Medicaid-eligible children under age 21 when requested under the Medicaid state plan. *See* 42 U.S.C. § 1396a(a)(43); 42 U.S.C. § 1396d(a)(4). According to 42 U.S.C. § 1396d(r)(5), EPSDT services mean, in relevant part, the following items and services:

> Such other necessary health care, diagnostic services, treatment, and other measures described in subsection (a) of this section to correct or ameliorate defects and physical and mental illness and conditions discovered by the screen services, whether or not such services are covered under the state plan.

14. 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.

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

> The medical or allied care, goods, or services furnished or ordered must meet the following conditions:
>
> - Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate pain
> - Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs

- Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational
- Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available statewide
- Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider

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

16. The Florida Medicaid Authorization Requirements Policy ("Authorization Policy"), incorporated by reference in Fla. Admin. Code R. 59G-1.053, provides as follows:

3.2.1 Continued Authorization Requests
The QIO shall not deny or reduce the amount, frequency, or duration of a service that is already being provided, unless:

- The reduction is to correct for factual error or omissions in prior certifications.
- There is a documented improvement in the recipient's medical condition.
- There is a documented change in the recipient's circumstances.
- The reviewing physician determines the recipient will not gain any additional benefit by continuing services at the current level.

17. In the instant case, Respondent denied Petitioner's request for an ABA assessment with Petitioner's prior provider. *See* ¶ 3. In the NOO dated October 13, 2023, Respondent explained that receiving an assessment and subsequent treatment from the previous provider was not medically necessary, specifically, that it did not meet the requirement that services must be "consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational." *Id.* Respondent further explained that "the interventions and data submitted by the provider for this request for services do not meet medical necessity criteria." *Id.*

18. As provided by the EPSDT requirements, the recipient must meet the medical necessity criteria as outlined in Fla. Admin. Code R. 59G-1.010. As provided in section 2.83 of the Definitions Policy, a component of medical necessity is that services must be "consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational." As shown by the record, Petitioner previously received services with the requesting provider. *See* ¶ 3. Services with the prior provider were terminated in May due to lack of modification to the plan. *See* ¶ 7. At the hearing, Dr. Conway explained that the provider did not at any point submit evidence of modifications to the plan to address the lack of progress from the previous denial of services. *Id*. Furthermore, this provider utilizes telehealth services for services which should be conducted in person. *Id*. Petitioner bears the burden of proof in this case. *See* ¶ 10. Petitioner submitted no evidence supporting the approval of this assessment with the previous provider. As the provider's assessment request did not meet medical necessity criteria due to the lack of progress, absence of modification, and utilization of telehealth services, the request is not "consistent with generally accepted professional medical standards." As such, Petitioner has not demonstrated that it is not medically necessary to receive an assessment with the previous provider.

19. Upon consideration of the testimony provided, evidence submitted, and applicable polices, the undersigned concludes that Petitioner did not prove by a preponderance of the evidence that the denial of an ABA assessment was incorrect. Looking at all the evidence relevant to the particular needs of Petitioner, Petitioner has not demonstrated that an assessment *with the previous provider*, is necessary 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 an ABA assessment was incorrect.

IT IS HEREBY ORDERED AND ADJUDGED THAT:

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

DONE and **ORDERED** this 9th day of February 2024, in Tallahassee, Leon County, Florida.

Joseph Mabry
23-FH2684
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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]

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