



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

FILED

Jan 30, 2024, 12:32 pm

OFFICE OF FAIR HEARINGS

[REDACTED]

PETITIONER,

AHCA CASE NO.: 23-FH2689

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 20, 2023, at 9:00 a.m. Eastern Standard Time ("EST").

APPEARANCES

For the Petitioner:

[REDACTED]

Petitioner's Authorized Representative

For the Respondent:

Sandra Durden
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 services ("BA" or "ABA") services was correct.

PRELIMINARY STATEMENT

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

approximately [REDACTED]; and for [REDACTED], Petitioner's incidents decreased from approximately [REDACTED] up to April 16, 2023, then spiked to approximately [REDACTED] June 14, 2023, then decreased to approximately [REDACTED] to August 23, 2023. *Id.* at 89.

4. The graphs show that from March 1, 2023 to August 23, 2023, Petitioner's replacement behaviors for [REDACTED] maladaptive behaviors achieve the following percentile of skills acquisition: for

[REDACTED]
[REDACTED]
[REDACTED] *Id.* at 92 - 95.

5. Petitioner requested continuation of ABA services for the period from September 22, 2023, through March 19, 2024, a. *Id.* at 22. Specifically, Petitioner requested 2,808 units of code 97153, intervention without protocol modification, per 15 minutes, Lead Analyst, BCaBA, or RBT; 208 units of code 97155, intervention with protocol modification, per 15 minutes; 208 units of code 97155 (HN), intervention with protocol modification, per 15 minutes; 104 units of code 97156, family training, per 15 minutes, Lead Analyst; 104 units of code 97156 (HN), family training, per 15 minutes, Lead Analyst *Id.* at 23.

6. In a Notice of Outcome ("NOO"), dated October 3, 2023, Respondent terminated Petitioner's ABA services. The NOO explained the basis for the termination as follows:

The request for services is denied in whole or in part because they are not medically necessary as defined in Rule 59G-1.010, Florida Administrative Code. Specifically, the requested services are not medically necessary under the following standard(s):

Individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness under treatment, and not in excess of the patient's needs.
Consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational.

The rationale for our decision is as follows:

PR Clinical Reason – Denial:

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

PR Clinical Rationale - Denial: The information submitted does not meet standards of care within the field of behavior analysis. According to the Florida Medicaid State Plan (Appendix 9.2.c), assessment results must be present in the plan. The provider has included baseline data and graphs for skill acquisition goals and maladaptive behaviors that were based on parent report, extrapolated average and/or sourced from indirect interview; and were not directly observed or measured by the lead analyst as standards of care within the field of behavior analysis. 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 amend the treatment plan in relation to the lack of progress or the proposed changes have little chance at improving behavior. The information submitted does not meet standards of care within the field of behavior analysis. This request is denied

...

Id. at 24.

7. Petitioner requested reconsideration of the Respondent's decision. In a Notice of Reconsideration Determination ("NRD"), dated October 19, 2023, Respondent upheld its decision. *Id.* at 35 – 39. The NRD explained the rationale for the decision as follows:

PR Recon Determination: At reconsideration all documents were carefully reviewed. According to the Florida Medicaid State Plan (page 8, 6.2.3), 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 amend the treatment plan in relation to the lack of progress or the proposed changes have little chance at improving behavior. The information submitted does not meet standards of care within the field of behavior analysis. This denial is upheld.

...

Id. at 36.

8. On October 10, 2023, Petitioner requested a Fair Hearing to challenge the termination of ABA services. On November 3, 2023, the undersigned issued an Order Scheduling Fair Hearing and Prehearing Instructions, setting the hearing for November 28, 2023, which hearing was rescheduled after Petitioner showed good cause for failure to appear. On November 29, 2023, the undersigned issued an Order Scheduling Fair Hearing and Prehearing Instructions, resetting the hearing for December 20, 2023, at 9:00 a.m., EST. All parties were duly notified. Petitioner received administrative approval, or continuation of benefits, pending the outcome of the Fair Hearing. *Id.* at 18.

9. When reviewing the effectiveness of a treatment plan, what is looked at is whether maladaptive behaviors are being reduced and whether replacement behaviors are being increased. See, Appendix 9.0 of the BA Policy providing Review Criteria for Behavior Analysis Services, *infra* ¶ 18.

10. Dr. Hurley is a Board-Certified Behavior Analyst at the doctoral level. Dr. Hurley established 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. The current treatment plan went through a peer review process conducted by three (3) Board Certified Behavior Analysts (BCBAs), including two at the doctoral level. The reviewing BCBAs each determined the treatment plan was insufficient for effective treatment, therefore, the plan did not meet medical necessity criteria. RCE 1 at 35 - 36.

11. Dr. Hurley established that, consistent with standards of care in the field of ABA, data graphs are the best way to measure progress in a recipient’s ABA treatment, and that progress is essential. Dr. Hurley explained that the Agency relies on data submitted by the lead analyst in the BA plan. Dr. Hurley explained that in the treatment plan, the graph data should show the rate of occurrences for maladaptive behaviors should be steadily decreasing, but that is not what is shown. For instance, for the maladaptive behavior of [REDACTED], there is basically no change all the way across; for [REDACTED], the graph shows some decreases, but at the end that data shows no decrease, almost [REDACTED] occurrences all the way across; for [REDACTED], from May through June, every third data point where there is no decrease, there should be a change made to the ABA treatment; for [REDACTED], [REDACTED], [REDACTED] behavior, [REDACTED], there is barely any progress to some progress, but then the graphs data stays stagnant. For the replacement behaviors, Dr. Hurley explained that they should steadily increase by constantly reinforcing and developing new training methods to keep a recipient interested in

different objects and activities for [REDACTED] to acquire skills, but the graphs do not show such quick and effective changes to Petitioner's treatment. Dr. Hurley further explained, there is no notation in the graphs as to why Petitioner's behavior is not progressing, for instance, due to environmental changes, and there was no change in the plan to adapt to Petitioner's behavior to get [REDACTED] to progress and address [REDACTED] lack of progress. Dr. Hurley testified that Petitioner should have the opportunity to have the best provider for [REDACTED] to progress in behavior improvement and skills.

12. Dr. Hurley's testimony established that the lack of improvement in Petitioner's behaviors demonstrates that the applied behavior analysis services provided to Petitioner under the treatment plan are not individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness under treatment; and consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational. As such, they are in excess of the patient's needs, and therefore, not medically necessary.

13. Petitioner's authorized representative, [REDACTED], is Petitioner's [REDACTED]. [REDACTED] testified that Petitioner needs applied behavior analysis to help improve [REDACTED] behavior and to learn skills that will allow [REDACTED] to stay in school. [REDACTED] acknowledged that the current provider is not giving Petitioner the best treatment because [REDACTED] is not progressing.

CONCLUSIONS OF LAW

14. 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).

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

16. Because Respondent terminated Petitioner’s ABA services, 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.)

17. The 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
- 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 be 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 year 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.

18. 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. Provider submits a valid written physician's order as stipulated in the Behavior Analysis Services Coverage Policy, Rule 59G-4.125, F.A.C.

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

- 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 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
 - 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

19. 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.

20. Petitioner is under age 21, and therefore EPSDT applies to 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.

21. The Florida Medicaid Definitions Policy, incorporated by reference in Fla. Admin. Code R. 59G-1.010, (the “Definitions Policy”), 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.

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

general requirements for providers to obtain authorization to render Florida Medicaid services.

The Authorization Requirements Policy states, in pertinent part:

3.0 Determination Process

3.1 Review Criteria

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

3.2 Review Process

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

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.

Florida Medicaid Authorization Requirements Policy at pages 1-3.

23. Petitioner is under the age of 21 years and diagnosed with [REDACTED]. *See supra* ¶

2. The parties agree that Petitioner currently engages in maladaptive behaviors that interfere with [REDACTED] functions of daily life. *See supra* ¶ 3, 4, 5. Respondent determined that the BA provider "has not addressed the lack of progress during the last observation period and did not amend the treatment plan in relation to lack of progress or the proposed changes have little chance at improving behavior." *See supra* ¶ 6, 7.

24. Respondent terminated Petitioner’s ABA services because the submitted documentation did not establish the medical necessity of the services. *See supra* ¶ 6, 7. Based on the record, Respondent determined that the documentation did not meet the following medical necessity standards: [i]ndividualized, specific, and consistent with symptoms or confirmed diagnosis of the illness under treatment, and not in excess of the patient’s needs” and “[c]onsistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational.” *See supra* ¶ 6, 7. The medical necessity standards are expressly outlined in section 2.83 of the Definitions Policy and a critical element for behavior analysis services reassessments. *See supra* ¶ 21. The BA Policy mandates that the treatment plan must be detailed enough to warrant the requested services and include mechanisms to monitor and evaluate its effectiveness. *See supra* ¶ 17.

25. In the instant case, Petitioner requested continuation of BA services for the period from September 22, 2023, through March 19, 2024. *See supra* ¶ 5. Specifically, Petitioner requested 2,808 units of code 97153; 208 units of code 97155, and 208 units of code 97155 (HN); 104 units of code 97156, and 104 units of code 97156 (HN). In an NOO, dated October 3, 2023, and an NRD, dated October 19, 2023, Respondent denied all of the requested units of ABA services, *supra* ¶ 6, 7, determining that Petitioner’s request was not “medically necessary under the following standard: [i]ndividualized, specific, and consistent with symptoms or confirmed diagnosis of the illness under treatment, and not in excess of the patient’s needs” and “[c]onsistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational.” *See supra* ¶ 6, 7.

28. Accordingly, Respondent has met their burden of proof to show that the requested ABA services are no longer medically necessary. Looking at all the evidence relevant to the particular needs of Petitioner, the ABA services with this provider are not necessary to correct or ameliorate a defect or a physical and mental illness or condition. Upon consideration of the testimony provided, evidence submitted, and applicable policies, the undersigned finds that Respondent proved by a preponderance of the evidence that Respondent's termination of the ABA services at issue was correct.

IT IS HEREBY ORDERED AND ADJUDGED THAT:

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 30th day of January, 2024, in Tallahassee, Leon County, Florida.



Debbie K. Winicki
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DEBBIE WINICKI, 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]
[REDACTED]
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