



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

FILED

Feb 22, 2024, 8:48 am

OFFICE OF FAIR HEARINGS
AHCA Case No.: 23-FH2833

[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 January 17, 2024, at 9:04 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 Petitioner proved by a preponderance of the evidence that Respondent's decision to deny Petitioner's request for additional Behavior Analysis ("BA" or "ABA") services was incorrect.

PRELIMINARY STATEMENT

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

Diana Hearod (“Ms. Hearod”), Medical/Health Care Program Analyst for the Agency for Health Care Administration (“Agency” or “AHCA”), appeared on behalf of Respondent. Dr. David Bicard (“Dr. Bicard”), Board Certified Behavior Analyst and Director of Clinical Operations for eQHealth Solutions Inc. (“eQHealth”), appeared as a witness for Respondent.

Freddy, interpreter number 371696, appeared to offer translation services for the Petitioner.

Petitioner did not introduce any exhibits at the Fair Hearing. Prior to the hearing, Respondent sent to the Office of Fair Hearings and Petitioner a three-hundred and seventy-two (372)-page evidence packet and a forty-nine (49)-page evidence packet. The three-hundred and seventy-two (372)-page evidence packet appears in the Office of Fair Hearings’ document management system as the file titles: “[REDACTED] FH 1.17.2024 1-76.pdf”; “[REDACTED] FH 1.17.2024 77-109.pdf”; “[REDACTED] FH 1.17.2024 110-143.pdf”; “[REDACTED] FH 1.17.2024 144-176.pdf”; “[REDACTED] FH 1.17.2024 177-209.pdf”; “[REDACTED] FH 1.17.2024 210-242.pdf”; “[REDACTED] FH 1.17.2024 243-275.pdf”; “[REDACTED] FH 1.17.2024 276-309.pdf”; “[REDACTED] FH 1.17.2024 310-335.pdf”; “[REDACTED] FH 1.17.2024 336-361.pdf”; and “[REDACTED] FH 1.17.2024 362-372.pdf”. The forty-nine (49)-page evidence packet appears in the Office of Fair Hearings’ document management system as the file title “23-FH2833_BA_AHCA Evidence_49 PGS_[PETITIONER].pdf”. Absent an objection from the Petitioner, the undersigned admitted the three-hundred and seventy-two (372)-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 21 of RCE 1. Petitioner is diagnosed with [REDACTED]. *Id.*

3. As provided in Petitioner’s treatment plan, Petitioner is engaging in the following maladaptive behaviors: [REDACTED]; [REDACTED]; [REDACTED]; [REDACTED]; [REDACTED]; [REDACTED]; [REDACTED]; [REDACTED]; [REDACTED]; [REDACTED]; [REDACTED]; and [REDACTED]. *Id.* at 61-85. Petitioner’s treatment plan shows the following progress: for [REDACTED], Petitioner reduced [REDACTED] incidents from approximately [REDACTED]; for [REDACTED], Petitioner reduced [REDACTED] incidents from approximately [REDACTED] for [REDACTED]; [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]; 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.*

4. Petitioner requested continuation of BA services; specifically, 3,120 units of code 97153; 232 units of code 97155; and 208 units of code 97156. In a Notice of Outcome (“NOO”), dated

October 6, 2023, Respondent approved 2,600 units of code 97153; 24 units of code 97155; 208 units of code 97155 (HN); and 208 units of 97156, but denied the remaining units. *Id.* at 28. 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.

The NOO further provided:

PR Clinical Rationale – Denial: According to Behavior Analysis Services Coverage Policy requests for services must be based on the medical necessity of the recipient's maladaptive behaviors and skill deficits. The recipient is engaging in problem behaviors that threaten access to typical environments and negatively affects activities of daily living. However, the frequency, intensity, or severity of the recipient's maladaptive behaviors does not justify the requested units of services. The requested units of BA services are in excess of medical necessity.

...

Pages 28 – 29 of RCE 1.

5. Petitioner requested reconsideration of the Respondent's decision. In a Notice of Reconsideration Determination ("NRD"), dated October 13, 2023, Respondent upheld its decision. *Id.* at 40. The NRD explained the basis for the decision as follows:

PR Recon Determination: At reconsideration all documents were carefully reviewed. The provider did not submit any new documentation that supports the medical necessity of this request. According to The Behavior Analysis Services Coverage Policy, (page 3, 2.2) the recipient of ABA therapy services must engage in maladaptive behavior that interferes with the recipient's daily functioning. Although the recipient is engaging in topographies of maladaptive behaviors, the frequency and intensity of the maladaptive do not support the request for services. This reconsideration request has been reviewed, reconsidered and the partial denial is upheld.

...

Pages 40 – 41 of RCE 1.

6. On November 7, 2023, Petitioner requested a Fair Hearing to challenge the denial of ABA services. *Id.* at 8. On December 5, 2023, the undersigned issued an Order Scheduling Fair Hearing by Telephone and Prehearing Instructions, setting the hearing for January 17, 2024, at 9:00 a.m. EST. *Id.*

7. [REDACTED] is the [REDACTED] of Petitioner. [REDACTED] testified to the following at the Fair Hearing:

- a. Petitioner is requesting an additional five (5) hours per week of services. A change in therapists has caused difficulties, and Petitioner's behavior has become aggressive. Petitioner attempts to [REDACTED]. This is why Petitioner is requesting more time with the therapist.
- b. Petitioner had thirty hours of services when first diagnosed, and Petitioner now has behaviors that [REDACTED] did not have when [REDACTED] was first diagnosed. Petitioner has become more aggressive. Due to the safety concerns regarding Petitioner and [REDACTED] classmates, it is important for Petitioner to have one-on-one services with the therapist.
- c. [REDACTED] stated Petitioner's neurologists have requested that Petitioner have the maximum amount of services possible. [REDACTED] stated that [REDACTED] and [REDACTED] show regression, not progress. Petitioner [REDACTED].
- d. [REDACTED] stated Petitioner's previous therapist could not manage Petitioner's behaviors. [REDACTED] stated Petitioner is now taking medication for [REDACTED] behavior. The current therapist is using prompts to facilitate Petitioner's progress. Petitioner's progress has been slow, which is why [REDACTED] requested more hours.

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

- a. Petitioner has participated in ABA services since [REDACTED], and has been with this provider since [REDACTED]. During the last authorization period, the provider was approved for 2,600 units of code 97153. The provider requested 3,120 units of code 97153 for this authorization, but was approved for 2,600 units. Petitioner was approved for roughly twenty-five (25) hours of therapy per week, and the provider has requested thirty (30) hours of therapy per week.
- b. A review of the provider's treatment plan shows that Petitioner is making adequate progress on goals, and therefore the additional requested hours were denied. All of Petitioner's maladaptive behaviors show improvement and decreasing trends, even with different therapists. See pages 61 – 85 of RCE 1. All of Petitioner's replacement skills are showing improvement and increasing trends. *Id.* at 95 – 114. For this reason, services were approved at the same level as in the previous authorization.

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 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.)

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 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 denied Petitioner's request for additional ABA services. See ¶ 4. In the NOO dated October 6, 2023, Respondent explained that approving additional units was not medically necessary, specifically, that it did not meet the requirement that services must be "individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness under treatment, and not in excess of the patient's needs." *Id.* Respondent further explained that "the frequency, intensity, or severity of the recipient's maladaptive behaviors does not justify the requested units of services." *Id.*

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, a component of medical necessity is that services must be "individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness under treatment, and not in excess of the patient's needs." As shown by the record, Petitioner has made progress across all maladaptive behavior and replacement goals. See ¶¶ 3, 8. Dr. Bicard provided credible testimony, based on the provider's treatment plan, that Petitioner has decreased the frequency of all maladaptive behaviors, and has increased the frequency of all replacement skills, evidenced by the trends in the treatment plan's data. *Id.* Petitioner bears the burden of proof in this case. See ¶ 11. ██████ testified that Petitioner requires an additional five (5) hours of services due to safety concerns, new severe behaviors, and the neurologist's recommendations. See ¶ 7. However, ██████ did not submit any evidence beyond ██████ testimony to support ██████ claims or justify the request for additional units. As Petitioner is making sufficient progress at the approved

level of services, Petitioner has not demonstrated that the requested units are “individualized, specific, and consistent” with Petitioner’s treatment needs and not in excess of medical necessity.


20. As QIO for the Agency, eQHealth is authorized to deny services when it is determined that “there is documented improvement in the recipient’s medical condition.” See ¶ 17. As discussed, *supra* ¶ 19, Petitioner has made progress in reducing [redacted] maladaptive behaviors and improving [redacted] replacement behaviors. Here, Petitioner’s improvement is well documented.

21. 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 ABA services was incorrect. Looking at all the evidence relevant to the particular needs of Petitioner, Petitioner has not demonstrated that the additional services requested, 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 22nd day of February, 2024, in Tallahassee, Leon County, Florida.

 Joseph Mabry
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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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AHCA Medicaid Hearing Unit
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