



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

**FILED**

Mar 11, 2024, 9:04 am

[REDACTED]

PETITIONER,

OFFICE OF FAIR HEARINGS  
AHCA Case No.: 23-FH2979

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 25, 2024, 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 Behavior Analysis ("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. [REDACTED],

("██████████"), Petitioner's provider and Licensed Clinical Social Worker ("LCSW"), appeared as a witness for Petitioner.

Sandra Durden, 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 at the doctoral level and Director of Clinical Operations for eQHealth Solutions Inc. ("eQHealth") appeared as a witness for Respondent.

Ariel, interpreter number 426091 of Language Line Solutions, appeared to offer translation services for the Petitioner.

Petitioner did not introduce any documents at the hearing. Prior to the hearing, Respondent sent to the Office of Fair Hearings and Petitioner a 340-page evidence packet and a forty-nine (49)-page evidence packet. The 340-page packet appears in the Office of Fair Hearings' document management system as the file titles "██████████ FH 01.25.2024 1-164.pdf"; "██████████ FH 01.25.2024 165-315.pdf"; and "██████████ FH 01.25.2024 316-340.pdf". The forty-nine (49)-page evidence packet appears in the Office of Fair Hearings' document management system as the file title "23-FH2979 ACHA EVIDENCE PKT.pdf". Absent an objection from the Petitioner, the undersigned admitted 340-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.



5. In the prior authorization period, Petitioner was approved to receive the following ABA services: 2,808 units of code 97153; 312 units of code 97155; and 208 units of code 97156. Petitioner requested an increase in ABA services; specifically, 3,120 units of code 97153; 312 units of code 97155; and 208 units of code 97156. In a Notice of Outcome (“NOO”), dated October 26, 2023, Respondent terminated Petitioner’s ABA services. *Id.* at 30 – 32. The NOO explained the basis for the termination as follows:

[T]he requested services are not medically necessary under the following standard(s):

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

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.

The NOO further provided:

PR Principal Reason – Denial:

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

Requested services are denied because documentation is neither showing [i]mprovement nor support for maintenance.

PR Clinical Rationale – Denial: The definitions of behaviors under treatment must be written according to generally accepted practice within the field of ABA and according to AHCA standards sent in Florida Behavior Analysis Coverage Policy (page 7, 6.2.2). 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 behavior definitions, and not be a listing of behaviors that the recipient does not [engage] in. The behavior definition, “tolerates” in this treatment plan ( [REDACTED], [REDACTED], pp43, 56) does not conform to generally accepted standards of care within the field of applied behavior analysis.

Provider, the recipient has been in services since at least [REDACTED]. The recipient has been working on the same goals since that time and still not mastered these goals. The provider submitted documents including data in graph that are not consistent with data that are typically reported in behavior analytic treatment. Many of the graphs for maladaptive behavior and skill acquisition show the same general pattern, level, and trend in the data. These data do not appear to have been accurately reported or observed and measured according to standards of care within the field of behavior analysis. 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 a 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.

...

Pages 30 – 31 of RCE 1.

6. Petitioner requested reconsideration of the Respondent’s decision. In a Notice of Reconsideration Determination (“NRD”), dated November 29, 2023, Respondent upheld its decision. *Id.* at 42 – 44. The NRD explained the basis 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 a 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.

Pages 42 – 43 of RCE 1.

7. On November 28, 2023, Petitioner requested a Fair Hearing to challenge the termination of ABA services. On December 19, 2023, the undersigned issued an Order Scheduling Fair Hearing and Prehearing Instructions, setting the hearing for January 25, 2024, at 9:00 a.m. EST.

8. At the Fair Hearing, [REDACTED] clarified that Petitioner was only seeking reinstatement of the terminated units and not the additional units referenced in the NOO and NRD.

9. Dr. Bicard is a BCBA-D. Dr. Bicard testified to the following:

- a. Petitioner has participated in services with this provider for more than [REDACTED] years. The services were denied due to lack of progress with [REDACTED] maladaptive and replacement behaviors. Dr. Bicard argued that the services have largely been ineffective for the Petitioner.
- b. Dr. Bicard asserted that the provided treatment plan is a “boilerplate” treatment plan – meaning that the interventions are not individualized for the recipient.
- c. Dr. Bicard explained that the inclusion of “[REDACTED] [REDACTED]” are not medically necessary as services are intended to treat serious maladaptive behaviors and skill deficits that interfere with a recipient’s access to typical environments. Moreover, these services can be furnished in a less costly manner.

- d. [REDACTED] is occurring at an extremely high level and has been worked on for [REDACTED] years. See page 272 of RCE 1. [REDACTED] has been worked on for [REDACTED] years. This treatment has been ineffective. See page 273 of RCE 1. [REDACTED] has been worked on for [REDACTED] years without improvement. See page 274 of RCE 1
  - e. With regard to [REDACTED], it is unclear how this behavior is measured, and does not meet medical necessity criteria.
  - f. [REDACTED] should have been treated within [REDACTED] months, but is still occurring. See page 279 of RCE 1. The fact that this is occurring after [REDACTED] years is ineffective treatment.
  - g. The replacement behavior [REDACTED] has been incorrectly identified – it should be noncontingent reinforcement. [REDACTED] [REDACTED] is not an intervention within the field of ABA.
  - h. The treatment plan looks as if the provider put in every single treatment available rather than draft a individualized treatment plan.
  - i. In all, this treatment is wholly ineffective and not individualized for the recipient. Petitioner may meet medical necessity for ABA services in general, but the provider at issue is not providing medically necessary services.
10. [REDACTED] is Petitioner's provider. [REDACTED] testified to the following:
- a. [REDACTED] has a Master's in ABA. [REDACTED] has worked with children for 25 years.
  - b. [REDACTED] has not worked with Petitioner since [REDACTED].

- c. Petitioner has had numerous environmental changes, such as the return of [REDACTED] and frequent moves.
  - d. [REDACTED] believes there has been significant improvement as all of the maladaptive behaviors have decreased and all of the replacement behaviors have increased.
11. [REDACTED] is Petitioner's [REDACTED]. [REDACTED] testified to the following:
- a. [REDACTED] is satisfied with Petitioner's behavior.
  - b. Petitioner's behavior has changed a lot.
  - c. Petitioner can [REDACTED].

#### **CONCLUSIONS OF LAW**

12. 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).

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

14. Because Respondent terminated a previously approved service, Fla. Admin. Code R. 59G-1.100(17)(g) assigns the burden of proof to the Respondent. The standard of proof in an administrative hearing is a preponderance of the evidence. The preponderance of the evidence standard requires proof by "the greater weight of the evidence" (Black's Law Dictionary at 1201, 7th Ed.)

15. 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.

...

Pages 1 – 3 of BA Policy.

16. 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

...

Pages 6 – 8 of BA Policy.

17. 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.

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

19. 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.

20. 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.

21. In the instant case, Respondent terminated Petitioner's BA services. *See* ¶ 5 - 6. The NOO and NRD explained that Petitioner's request for continuation of services did not meet medical necessity as the treatment plan was not "[c]onsistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational" and that it was not "[i]ndividualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment" and was "in excess of the patient's needs". *See supra* ¶ 5 - 6. Respondent further explained that "[t]he 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 . . .". *Id.*

22. As provided in the BA policy and the EPSDT requirements, the recipient must meet the medical necessity criteria as outlined in Fla. Admin. Code R. 59G-1.010. A component of medical necessity is that services must be "consistent with generally accepted professional medical standards." As outlined above, Dr. Bicard provided credible and persuasive testimony identifying several instances where the revised Treatment Plan did not follow generally accepted standards of BA. Here, the treatment plan shows that Petitioner has made minimal progress in reducing [REDACTED] maladaptive behaviors. *See supra* ¶¶ 3, 9. As Dr. Bicard testified, the data graphs for Petitioner's replacement behaviors show that behaviors targeted for improvement have made little improvement, and no intervention was made to change Petitioner's trajectory. *See supra* ¶ 9. Moreover, the Dr. Bicard provided credible and persuasive testimony that the interventions provided were not individualized for Petitioner. *See supra* ¶ 9. Thus, Respondent demonstrated that, based on the information in the record, the requested BA services are not "consistent with

generally accepted professional medical standards.” Because the services are not consistent with generally accepted professional medical standards, the critical element of medical necessity is not met. *See supra* ¶ 9.


23. Accordingly, Respondent met their burden of proof to show that the requested BA services no longer meet medical necessity criteria. Looking at all the evidence relevant to the particular needs of Petitioner, the BA services at issue are not necessary to correct or ameliorate a defect or a physical and mental illness or condition.

24. Upon consideration of the testimony provided, Respondent’s Composite Exhibit 1, Respondent’s Composite Exhibit 2, and the applicable law and policies, the undersigned finds that Respondent proved by a preponderance of the evidence that Respondent’s termination of BA services was correct.

**IT IS HEREBY ORDERED AND ADJUDGED THAT:**

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

**DONE and ORDERED** this 11th day of March 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]

**AHCA Medicaid Hearing Unit**  
**MedicaidHearingUnit@ahca.myflorida.com**