



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

FILED

Mar 25, 2024, 11:52 am

OFFICE OF FAIR HEARINGS

[REDACTED]

PETITIONER,

AHCA Case No.: 23-FH3110

vs.

AGENCY FOR HEALTH CARE
ADMINISTRATION,

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned Hearing Officer convened a telephonic Fair Hearing on the instant case on January 25, 2024, at 12:57 p.m. EST.

APPEARANCES

For the Petitioner:

[REDACTED]

Petitioner's Authorized Representative

For the Respondent:

Linda Latson
Registered Nurse Specialist, Fair Hearing Liaison
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") services was correct.

PRELIMINARY STATEMENT

All parties and witnesses appeared telephonically. Petitioner’s Authorized Representative and [REDACTED], [REDACTED] (“[REDACTED]”), appeared on behalf of the Petitioner.

Linda Latson, Registered Nurse Specialist, Fair Hearing Liaison for the Agency for Health Care Administration (“Agency” or “AHCA”), appeared on behalf of Respondent. Dr. Alissa Conway, (“Dr. Conway”), Board Certified Behavior Analyst at the doctoral level (“BCBA-D”) and second level reviewer of eQHealth Solutions, Inc. (“eQHealth”), attended as a witness for Respondent.

Petitioner did not submit any documents as evidence.

Prior to the hearing, Respondent sent to the Office of Fair Hearings and Petitioner a one hundred and ninety-three (193)-page evidence packet. The packet appears in the Office of Fair Hearings’ case management system as “[REDACTED] FH 01.25.2024 1-86.pdf” and “[REDACTED] FH 01.25.2024 87-193.pdf.” Absent an objection from the Petitioner, the undersigned admitted the evidence packet into evidence as Respondent’s Composite Exhibit 1.

Prior to the hearing, Respondent sent to the Office of Fair Hearings and Petitioner a forty-nine (49)-page evidence packet. The packet appears in the Office of Fair Hearings’ case management system as “23-FH3110 AHCA Evidence BA Svcx 49 Pages.pdf.” Absent an objection from the Petitioner, the undersigned admitted the evidence packet into evidence as Respondent’s Composite Exhibit 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 Respondent’s Composite Exhibit 2 at page 2.

2. Petitioner is [REDACTED]. See Petitioner’s Composite Exhibit 1 at page 2. Dr. Conway testified that this recipient has been in service with the current provider since [REDACTED]. The Petitioner’s diagnosis is [REDACTED]. *Id.* at 16.

3. Petitioner requested the continuation of the following BA services: 2,558 units of code 97153, 205 units of code 97155, and 409 units of code 97156 for the certification period of September 13, 2023, through March 10, 2024. *Id.* at 19-20. On September 21, 2023, a written request was sent to the provider for additional information. *Id.* at 95. Specifically, the request stated that the graphs for maladaptive behaviors indicated minimal progress. The provider was requested to submit new revisions such as procedures/interventions or replacement/acquisition skills that may assist in the reduction of the maladaptive behaviors or the increase of replacement skills based upon the function of the behaviors. *Id.* at 95. The provider did not submit any modifications to address the lack of progress. *Id.* at 18

4. On September 28, 2023, Respondent issued a Notice of Outcome (“NOO”), terminating Petitioner’s BA services. *Id.* at 23-24. 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.

...

The NOO further provided:

PR Principal Reason – Denial:

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

PR Clinical Rationale – Denial: 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 23-24.

5. Petitioner requested reconsideration of the Respondent’s decision. On October 13, 2023, Respondent issued a Notice of Reconsideration Determination (“NRD”) upholding its decision. *Id.* at 35-36. The NRD states, in pertinent part as follows:

Specifically the services must be:

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 under treatment, and not in excess of the patient’s needs.

...

At reconsideration, all documents were carefully reviewed. The provider did not submit modifications to address the lack of progress. According to the Florida Medicaid State Plan (page8, 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 35-36.

6. Dr. Conway 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. Dr. Conway asserted that Petitioner’s services were terminated because the treatment plan is not consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational.

7. Dr. Conway began her review of the treatment plan with the maladaptive behaviors. Dr. Conway testified that her testimony would concentrate on the most recent authorized time period of services, however, the graphs on pages 140 through 143 of the Respondent’s Composite Exhibit #1, are from prior services, these graphs show a very high variability of the maladaptive behaviors.

8. The first maladaptive behavior is identified as [REDACTED]. *Id.* at 144. The data summary and the graph for this behavior shows that the behavior is highly variable and has an increasing trend. *Id.* at 144.

9. The next maladaptive behavior for review is [REDACTED]. *Id.* at 145. As stated previously, this graph shows a high variability of the behavior and toward the end of the

authorization period, there is an increasing trend with several very high data marks for this behavior. *Id.* at 145.

10. The graph for [REDACTED] is found at page 144 of RCE #1. This graph shows the high variability of the behavior, however on the left side of the graph, the data points are consistently lower but with a slight increasing trend toward the end of the authorization period. *Id.* at 144.

11. The next graph is for the behavior of [REDACTED] to others. *Id.* at 145. This graph shows high variability of the behavior and an increasing trend at the end of the authorization period. *Id.* at 145.

12. The next maladaptive behavior graph is for [REDACTED]. *Id.* at 146. This graph shows a lower variability of the behavior during the most recent authorization period, however at the end of the authorization period the data point shows an increasing trend. *Id.* at 146.

13. The next graph is for [REDACTED]. *Id.* at 146. This graph shows high variability and an increasing trend in the maladaptive behavior. *Id.* at 146.

14. The next graph depicts a new behavior listed as [REDACTED]. *Id.* at 147. While there is insufficient data to graph this behavior, Dr. Conway testified that a new behavior occurring during active treatment is indicative that the treatment plan is not successful in gaining instructional control.

15. Thus, Dr. Conway summarized that the graphs of the maladaptive behaviors demonstrate high variability in the behaviors with increasing trends at the end of the current authorization period. Further, the provider has failed to include modifications within the plan to address the lack of progress.

16. For further review of the treatment plan, Dr. Conway reviewed the skill acquisition graphs for this recipient. The first graph is for the skill of [REDACTED]. *Id.* at 161. While the graph, at the outset for this skill, shows an increasing trend, for the last two months of the authorization period the recorded data shows a downward trend. The next skill graph is for [REDACTED]. *Id.* at 161. This graph shows high variability with lower performance toward the end of the authorization period. The third skills graph is for [REDACTED]. *Id.* at 161. This graph shows a downward trend throughout the authorization period. The next graph that Dr. Conway reviewed was for [REDACTED]. *Id.* at 161. This graph showed performance at [REDACTED] until the last few months of the authorization period when the data fell to a [REDACTED]. *Id.* at 161. The next skills graph for [REDACTED]. *Id.* at 161. This skill shows a high variability ranging from [REDACTED]. The last data entry put [REDACTED] at about [REDACTED] *Id.* at 161. As testified to by Dr. Conway, overall, the skills graphs show a high variability through multiple authorizations without showing any progress.

17. When the provider was questioned concerning the lack of progress in reducing the maladaptive behaviors and increasing the skills acquisitions, the provider responded with some supplemental documents indicating that no procedural modifications are considered warranted. *Id.* at 171. The lead analyst stated that environmental factors, loss of support staff and loss of support within the home affected the last 6 months of authorization services. *Id.* at 171. During the reconsideration of the denial of services, the provider submitted three modifications which Dr. Conway found to be generalized and not specific and repetitive of existing parts of the current plan. *Id.* at 184.

18. In summary, Dr. Conway found that the treatment plan submitted by the provider shows a lack of progress during the authorization period and no effective modifications have been included with the plan. While the recipient may meet the medical necessity criteria, the current treatment plan does not meet medical necessity based upon the standards of ABA, in particular, the treatment plan is not consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational.

19. [REDACTED], [REDACTED] and authorized representative for the Recipient also testified. From the very beginning there were many issues that [REDACTED] displayed. [REDACTED]. Once [REDACTED] established a routine, things began to improve. There were some disruptions with the therapy team with loss of employees. [REDACTED] was enrolled in school, but [REDACTED] behavior got worse, and it was learned that [REDACTED]. Also, the school did not provide services that would benefit [REDACTED] and ultimately [REDACTED] removed [REDACTED] from the school environment. [REDACTED] has seen [REDACTED] improve when everyone is working together. [REDACTED] stated that [REDACTED] is still trying to follow the ABA items [REDACTED] learned but that [REDACTED] will regress without a routine of therapy. [REDACTED] also testified that it was difficult to correct [REDACTED]'s behavior when the family is out in public. [REDACTED] wants what is best for [REDACTED] and [REDACTED] is willing to learn the ABA lessons and practice them even when the therapist is not present.

CONCLUSIONS OF LAW

20. 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).

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

22. Because Respondent terminated a previously approved service, Fla. Admin. Code R. 59-1.100(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.).

23. 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).

24. 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.

25. A state may place medical necessity limitations on EPSDT services. *See* 42 C.F.R. §§ 440.230(a), (b), (d).

26. Section 409.905(2), Florida Statutes, 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.

27. The Florida Medicaid 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.

Respondent’s Composite Exhibit 2 at page 23

28. The 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.

...

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

Respondent's Composite Exhibit 2 at page 40, 42.

29. 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

...

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:
 - 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 Self-stimulating, abnormal, inflexible, or intense preoccupations

- Self-care - difficulty recognizing risks or danger, grooming, eating, or toileting
- iii. Other- behaviors not identified above

...

5. Criteria for Discharge from Behavior Analysis Services - ONE or MORE of the following MUST

be satisfied:

- a. The critical elements are **no longer met**.
- b. The data provided shows that the frequency and severity of maladaptive behavior(s) has declined to the point that they no longer pose a barrier to the child's ability to function in his/her environment.
- c. The data provided shows the recipient has made no progress toward any goals in the last 12 consecutive months.
- d. The level of functional impairment as expressed through behaviors no longer justifies continued BA services.
- e. Parent/guardian withdraws consent for treatment.

Respondent's Composite Exhibit 2 at pages 45-47.

30. 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.

Respondent's Composite Exhibit 2 at pages 32-34.

31. In this case, Respondent terminated Petitioner's BA services. 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." *See supra* ¶ 4-5.

32. As provided in the BA policy (Appendix 9.0, section (a)), 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. Conway provided credible and persuasive testimony identifying several instances where the revised Treatment Plan did not follow generally accepted standards of BA. For example, the Treatment Plan fails to show that the frequency of Petitioner's maladaptive behaviors has decreased during the authorization period nor have the skill acquisition or replacement behaviors increased during the same period. Further, the Treatment Plan contains no modifications to address the lack of progress during the authorization period. *See supra* ¶ 15-16. 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* ¶ 6.

33. In this case, Petitioner’s provider recommended the continuation of BA services. However, 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. See supra ¶ 27.

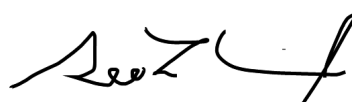
34. Accordingly, Respondent met their burden of proof to show that the requested BA services are no longer medically necessary. Looking at all the evidence relevant to the particular needs of Petitioner, the BA services at issue are not necessary to correct or ameliorate a defect or a physical and mental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

35. 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.

DECISION

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 25th day of March 2024, in Tallahassee, Leon County, Florida.

 George L. Winslow, Jr.
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GEORGE WINSLOW, 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]

AHCA Medicaid Hearing Unit
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