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

FILED
Apr 17, 2024, 12:23 pm
OFFICE OF FAIR HEARINGS

[redacted],

PETITIONER, **AHCA Case No.: 24-FH0098**

vs.

AGENCY FOR HEALTH CARE ADMINISTRATION,

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic Fair Hearing on the instant case on February 16, 2024, at 10:00 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 first 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.

The second issue is whether Petitioner proved by a preponderance of the evidence that Respondent's decision to deny Petitioner's request for additional BA services was incorrect.

PRELIMINARY STATEMENT

All parties and witnesses appeared telephonically. [redacted] ("[redacted]"), Petitioner's Authorized Representative and President and Board Certified Behavior Analyst ("BCBA") for [redacted], appeared for the Fair Hearing to provide testimony on behalf of Petitioner. [redacted] ("[redacted]"), Petitioner's [redacted], appeared for the Fair Hearing as a witness for Petitioner.

Sandra Durden, Medical/Health Care Program Analyst for the Agency for Health Care Administration ("Agency" or "AHCA"), appeared for the Fair Hearing as representative for Respondent. Dr. David Bicard ("Dr. Bicard"), BCBA and Director of Clinical Operations for eQHealth Solutions Florida ("eQHealth"), appeared for the Fair Hearing as a witness for Respondent.

Prior to the hearing, Petitioner sent to the Office of Fair Hearings a seventy-nine (79)-page evidence packet, a fifty-five (55)-page evidence packet, and an eleven (11)-page evidence packet. The seventy-nine (79)-page packet appears in the Office of Fair Hearings' document management system as file title "24-FH0098 Evidence.pdf." The fifty-five (55)-page packet appears in the Office of Fair Hearings' document management system as file title "24-FH0098 Evidence(Part 2).pdf." The eleven (11)-page packet appears in the Office of Fair Hearings' document management system as file title "24-FH0098 Evidence(Part 3).pdf." Absent an objection from the Petitioner, the undersigned admitted the seventy-nine (79)-page packet into evidence as Petitioner's Composite Exhibit 1 ("PCE 1"), the fifty-five (55)-page packet as Petitioner's Composite Exhibit 2 ("PCE 2"), and the eleven (11)-page packet as Petitioner's Composite Exhibit 3 ("PCE 3").

Prior to the hearing, the Office of Fair Hearings received a one hundred and sixty-one (161)-page evidence packet and a fifty (50)-page evidence packet from Respondent. The one hundred and sixty-one (161)-page packet appears in the Office of Fair Hearings document management system as the file titles "[redacted] FH 02.16.2024 1-117.pdf" and "[redacted] FH 02.16.2024 118-161.pdf." The fifty (50)-page evidence packet appears in the Office of Fair Hearings document management system as the file title "23-FH0098 BA AHCA EVIDENCE PKT.pdf." Absent an objection from the Petitioner, the undersigned admitted the one hundred and sixty-one (161)-page evidence packet into evidence as Respondent's Composite Exhibit 1 ("RCE 1") and the fifty (50)-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 ("QIO") contracted by the Agency to review prior authorization requests for services. *See* RCE 2 at page 2.

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

3. As provided in the Individualized Behavior Program ("Treatment Plan" or "behavior plan") submitted by [redacted], Petitioner is engaging in the following maladaptive behaviors: [redacted], [redacted], [redacted], [redacted], [redacted], [redacted], [redacted], [redacted], [redacted] *Id*. at 134-142.

4. Petitioner requested ABA services for the certification period of November 6, 2023, to May 12, 2024; specifically, 2,250 units of code 97154; 1,650 units of code 97153; and 100 units of code 97155. *Id*. at 20, 25. The provider requested 2,250 units of 97154 represents an increase of 1050 units, or 10 hours, from the last authorization period. On November 30, 2023, Respondent issued a request for information ("PEND") to Petitioner's provider requesting as follows:

> Provider, the treatment plan indicates overlap of [redacted] with multiple others behaviors and therefore data collection that overlaps. The definitions of behaviors under treatment must be written according to generally accepted practice within the field of ABA and according to AHCA standards set in Florida Behavior Analysis Services 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 behaviors definitions, and not be a listing of behaviors that the recipient does not engage in. The behavior definitions in this treatment plan do not conform to generally accepted standards of care within the field of applied behavior analysis. Please submit updated definitions to meet the standard of care in the field of behavior analysis.
> Provider, the strategies for [redacted] involve requiring the recipient to [redacted] The is a punishment procedure and does not involve function based treatment strategies. The supporting documentation does not meet generally accepted practices within the field of applied behavior analysis and standards set forth in the Florida Behavior Analysis Services Coverage Policy. Specifically, the provider has failed to write an intervention plan that upholds the standards of care of applied behavior analysis. The plan lists procedures that include punishment and has not exhausted reinforcement-based strategies. There is no procedural safeguard or fading plan. In order to use punishment procedures, you must describe the need for the use of punishment based on medical necessity, all previous reinforcement-based treatment that has failed, the punishment procedures in detail, the procedural safeguards in place to protect the recipient and others from trauma and write a punishment fading plan.

Id. at 20, 50.

5. [redacted], President and BCBA for [redacted], submitted a letter in response to the PEND. The letter states as follows:

Reviewer, thank you for your comments on this behavior plan. Our staff take [Petitioner]'s data continuously throughout the day. Combining some in specific ways allows for more efficient and accurate data collection, particularly in groups with other individuals who may have as many or more behaviors to document. It also allows us to see if some behaviors are increasing or reducing in intensity.

Staff are trained in Professional Crisis Management, which has very specific criterion for implementation. PCM, in combination with the operational definitions, implementation, and the data collection sections, identifies specific levels of intervention regarding the behaviors.

Your first comment was as follows:

- Provider, the treatment plan indicates overlap of [redacted] with multiple other's behaviors and therefore data collection that overlaps. The definitions of behaviors under treatment must be written according to generally accepted practice within the field of ABA and according to AHCA standards set in Florida Behavior Analysis Services Coverage Policy (page 7, 6.2.2).

If by "overlapping data collection" you mean the data are recorded twice, I have never seen this as a problem in practical applications of ABA. We are not trying to make the individual's behavior appear worse, we combine behaviors, or separate behaviors by severity, to be more precise. With these populations in particular the severity, frequency and intensity of behavior means the difference between annoying, aggravating and/or marginally consequential challenging behavior and significant dangerous behavior.

In [redacted], the overarching condition is [Petitioner] is [redacted]. [redacted] behavior is given minimal attention except to move persons or things out of the way. And, if the [redacted] is to access a tangible or activity, [redacted] won't get it. [redacted] may be cycling between pre-crisis with or without singular incidences of dangerous behavior, before entering actual crisis, where the frequency and intensity of [redacted] behaviors meet criterion for PCM procedures, and physical management may be necessary to protect [Petitioner], [redacted] peers and staff.

[redacted] behavior is a combination of behaviors that occur for more than [redacted]. Our data are collected continuously, but data periods are separated into 15-minute intervals based on the time of day. There is no way to know if the challenging behaviors were occurring singularly in sequence during the 15-minute intervals, or multiple behaviors occurred together unless we have a construct (such as "[redacted]") to indicate multiple behaviors (or at least two) were occurring simultaneously. The combined behaviors are different than a singular emittance of an isolated behavior, as it indicates a increased effort. More importantly, the [redacted] becomes more consequential with target behaviors; the presence or absence of dangerous behavior, such as aggression, during a [redacted] is also an indicator of the severity and intensity of the [redacted]. Individual target behaviors are recorded in their own column to track if or how many [redacted] emitted during the episode. If no target behaviors occur it can indicate the specific [redacted] was relatively minor, and

over time, combined with reductions in frequency and duration, would indicate a measure of progress. To paraphrase Dr. Rob Horner, we use the measurement typically used in the environment. Over the years, parents indicate a preference to using [redacted]. The environments our kiddos come from and to which they will return, also use that term.

Your second part of the initial comment was:

- 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 behaviors definitions, and not be a listing of behaviors that the recipient does not engage in.

[redacted]

[redacted] behavior was mentioned above. The less serious counterpoint is [redacted]. [redacted]

We have discontinued [redacted] because we never saw the behavior, and [redacted] because it has not happened since [redacted], however, it is in [redacted] behavioral repertoire and thus it is included in [redacted] definition. It is not clear what is meant by "a listing of behaviors that the recipient does not engage in." It is not unusual for a recipient to "try out" a new behavior or one exhibited by another individual, such as [redacted]. Also, if a behavior is infrequently demonstrated, staff may make a note in the margins of the data sheet and we evaluate if it is consequential and frequent enough to add it to the data sheet. Sometimes the behavior is indirectly addressed when the intervention for other behaviors in the same functional class are reduced. Sometimes it is addressed later, if it becomes more consequential or if other behaviors have been reduced or eliminated and it makes sense to address it at that time.

Your next statement was:

- The behavior definitions in this treatment plan do not conform to generally accepted standards of care within the field of applied behavior analysis. Please

submit updated definitions to meet the standard of care in the field of behavior analysis.

I have been a behavior analyst for 30 years, and these definitions, and variations thereof, have been used for much of that time. However, the definitions have been revised to provide examples.

If you are referencing [redacted] time, this allows us to document times when temporary ratio reductions and/or additional staffing are needed when a recipient is engaging in precrisis behavior that is bordering on crisis or crisis is imminent. When restraint occurs, the actual restraint may only be for a few minutes, but the precursor and post crisis behavior are just as labor intensive and may be necessary for hours. Recipients in crisis can't be sent home immediately if still heightened, meaning several staff must remain until it is safe for the recipient to get in the car. Historically, behavior that "almost happened" is not recorded, though multiple staff may be needed to assist the assigned staff for the safety of all parties in the room. [redacted] time allows us to rectify that.

Your final statements:

- Provider, the strategies for [redacted] involve requiring the recipient to [redacted] The is a punishment procedure and does not involve function based treatment strategies. The supporting documentation does not meet generally accepted practices within the field of applied behavior analysis and standards set forth in the Florida Behavior Analysis Services Coverage Policy. Specifically, the provider has failed to write an intervention plan that upholds the standards of care of applied behavior analysis. The plan lists procedures that include punishment and has not exhausted reinforcement-based strategies. There is no procedural safeguard or fading plan. In order to use punishment procedures, you must describe the need for the use of punishment based on medical necessity, all previous reinforcement-based treatment that has failed, the punishment procedures in detail, the procedural safeguards in place to protect the recipient and others from trauma and write a punishment fading plan.

Reviewer, punishment is the reduction of a behavior, good or bad, following a consequence. If you are indicating this is an aversive consequence, I would ask why. This isn't a strategy. The [redacted] is listed with possible functions because of how and when it occurs. There appears to be no medical reason for it. The data suggests there may be occasions when the [redacted] is not accidental. We are taking data, but not intervening behaviorally because we have not yet seen a definitive data pattern to support the necessity.

[redacted]

See PCE 1 at 32-34.

6. In a Notice of Outcome ("NOO"), dated December 5, 2023, Respondent denied all units of Petitioner's requested ABA services. *See* RCE 1 at 25-26. The NOO explained the basis for the denial as follows:

> [T]he requested services are not medically necessary under the following standard(s):
>
> Necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain.
> 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 NOO further provided:

> Submitted information does not support the medical necessity for requested frequency and\or duration.
>
> PR Clinical Rationale - Denial: The supporting documentation does not meet generally accepted practices within the field of applied behavior analysis and standards set forth in the Florida Behavior Analysis Services Coverage Policy. Specifically, the provider has failed to write an intervention plan that upholds the standards of care of applied behavior analysis. The plan lists procedures that include punishment ([redacted]) and has not exhausted reinforcement-based strategies. The behavior is listed for decrease and intervention. There are reactive strategies listed that are not function based strategies. There is no procedural safeguard or fading plan. This request for services is denied.

Id.

7. Petitioner requested reconsideration of the Respondent's decision. In a Notice of Reconsideration Determination ("NRD"), dated December 19, 2023, Respondent upheld its decision. *Id.* at 37-38. The NRD explained the basis for the decision as follows:

> PR Recon Determination: At reconsideration all documents were carefully reviewed. The supporting documentation does not meet generally accepted practices within the field of applied behavior analysis and standards set forth in the Florida Behavior Analysis Services Coverage Policy. Specifically, the provider has failed to write an intervention plan that upholds the standards of care of applied behavior analysis. The plan lists procedures that include punishment and has not exhausted reinforcement-based strategies. There is no procedural safeguard or fading plan. Additionally, the provider has listed manual restraint in the plan. This is a specific noncovered service according to the behavior analysis service coverage policy. This reconsideration request has been reviewed, reconsidered and the partial denial is upheld.

Id. at 38.

8. On January 4, 2024, Petitioner requested a Fair Hearing to challenge the denial of additional of ABA services and termination of ABA services. On January 24, 2024, the undersigned issued an Order Scheduling Fair Hearing and Prehearing Instructions, setting the hearing for February 16, 2024, at 10:00 a.m. EST.

9. Dr. Bicard is a BCBA and Director of Clinical Operations for eQHealth. Dr. Bicard established the following at Fair Hearing:

a. EQHealth is contracted by AHCA to review requests for medical necessity of ABA services using a two-level review process. *See* RCE 2 at 7. eQHealth reviews behavior analysis cases to ensure ABA services are consistent with the standards enumerated in the Behavior Analysis Coverage Policy as well as professional medical standards of behavior analysis. *See* ¶ 16, 20.

b. Dr. Bicard contended that the Treatment Plan did not meet the second and third medical necessity criteria, and was far below the standards of care in the field of ABA and in the Behavior Analysis Services Coverage Policy. *See* ¶ 16, 19.

c. Dr. Bicard opined that standards of care in the field of behavior analysis require positive reinforcement strategies be used and exhausted first before implementing any punishment procedures.

d. Dr. Bicard also opined that punishment procedures must also be clearly detailed because punishment can result in negative effects or trauma. Punishment procedures may be used as a last resort but must specifically state how the provider will safeguard the recipient from trauma, with fading procedures and discontinuation for the punishment procedure.

e. In this case, Dr. Bicard contended that the provider included multiple punishment procedures without first exhausting reinforcement-based strategies. For [redacted] *See* RCE 1 at 154.

f. Dr. Bicard argued that restitution and restoring the environment are punishment procedures and aversive to decrease behavior. *See* ¶ 5. Dr. Bicard argued that the provider listed restoring environment contingent upon making a mess, requiring the individual to engage in the correct behavior after the maladaptive behavior, as a punishment procedure which is not covered under Florida Medicaid. *See* ¶ 5, 16. For the [redacted] behavior, the provider included restitution after

response blocking and deferential reinforcement of alternatives ("DRA"). *See* RCE 1 at 152-153.

g. Dr. Bicard opined that crisis management procedures ("PCM") that require manual restraint are non-covered services and should not be implemented. *See* ¶ 16. The provider included manual restraint procedures for the [redacted] and [redacted] behaviors. *See* RCE 1 at 150-153.

h. The provider listed "[redacted]" as a target behavior but its provided definition and antecedent is vague and unclear. *Id*. at 141.

i. The provider requested additional services under code 97154 for group therapy. *See* ¶ 4. Dr. Bicard pointed out there are no reported goals in the Treatment Plan that involve group activities to justify this request.

10. [redacted] is a BCBA for [redacted]. [redacted] testified to the following at Fair Hearing:

a. [redacted] asserted that staff are trained in crisis management procedures and have instructions to include fading, but these were not put in the Treatment Plan because PCM is copyrighted material.

b. [redacted] argued that the [redacted] procedures are included so staff know how to respond to it since this behavior and its antecedent were not in the previous provider's treatment plan.

c. [redacted] contended that the objective is to prevent dependence on staff and for Petitioner to take responsibility in returning to a normal environment. [redacted] argued that the expectation is that Petitioner would assist in cleaning a

mess whether it [redacted]. *See* ¶ 5.

d. [redacted] argued that there is no restraint data included in the Treatment Plan because Petitioner never received any restraints.

e. [redacted] argued that the requested additional hours are to work on Petitioner's social skills for group. [redacted] contended that by denying group therapy, the provider will not able incorporate social interaction with peers and will have reduced staffing to address some problem behaviors.

f. The behavior analysis policy does not indicate group treatment requires a specific class or any particular method. *See* ¶ 16.

11. [redacted] is Petitioner's [redacted]. [redacted] testified to the following at Fair Hearing:

a. Petitioner has been in multiple settings from day care to public school, ESE school, and now in this special setting with the ABA provider.

b. [redacted] argued that Petitioner had incidents of [redacted] with previous provider for task refusal or to escape responsibility, but with this current provider Petitioner does not do this.

c. [redacted] believes that Petitioner's behaviors such [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 (2022). 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 Rule 59G-1.100(17)(b), Florida Administrative Code ("Fla. Admin. Code R.").

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. Because Petitioner requested additional ABA services, 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.)

16. The Florida Medicaid Behavior Analysis Services Coverage Policy (September 2023) ("BA Policy"), incorporated by reference in Fla. Admin. Code. R. 59G-4.125, governs ABA 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.
>
> . . .
>
> **1.4.6 Medically Necessary/Medical Necessity**
> As defined in Rule 59G-1.010, F.A.C.
>
> . . .

4.0 Coverage Information

4.1 General Criteria

Florida Medicaid covers services that meet all of the following:

- Are determined medically necessary
- Do no duplicate another service
- Meet the criteria as specified in this policy

4.2 Specific Criteria

Florida Medicaid covers the following BA services in accordance with the applicable Florida Medicaid fee schedule(s), or as specified in this policy:

4.2.1 Behavior Assessment and Behavior Plan

A behavior assessment must be conducted prior to the initiation of behavior analysis interventions. The assessment must identify behavioral deficits that interfere with a major life activity including the events and subsequent interactions that elicit and sustain targeted behavior.

The initial assessment must include the administration, scoring, and reporting of two core standardized behavior instruments, as follows:

- Vineland-3 Comprehensive Parent Interview Form Including Maladaptive Behavior Domain, for all recipients
- Behavior Assessment System for Children, Third Edition, Parenting Relationship Questionnaire (BASC-3 PRQ), for all recipients 2 years old and less than 19 years old

The complete scoring report, including outcome measure scores, must be submitted with service prior authorization requests. Additional assessment tools may be used at the Lead Analyst's discretion.

The behavior plan identifies intervention strategies that are likely to eliminate, mitigate or replace the behavior to produce change sufficient to reengage the recipient in the major life activity. The plan must include specific behavior goal(s), intervention strategies for each goal, anticipated timeframes that are of sufficient duration to address the targeted behavior, and how the ongoing progress of intervention strategies will be reported.

The behavior plan must reflect the requested authorization period (up to six months).

A reassessment and updated behavior plan to renew prior authorization for continued services must be completed at least every six months. The core instruments must be included with reassessments every 12 months.

More frequent assessments must be conducted when:

- New behavior emerges that interferes with a recipient's participation in a major life activity

- Additional BA services are medically necessary and are likely to address the emergent behavior

A full assessment may be requested if there is a change in provider; however, a change of a practitioner status (e.g., an RBT becoming certified as a BCaBA) is not grounds for conducting a reassessment or updating a behavior plan.

4.2.2 Behavior Analysis Interventions

Florida Medicaid covers up to 40 hours per week of BA intervention services as indicated in the recipient's prior-authorized behavior plan. These services must be delivered to reduce maladaptive behaviors and assist the recipient reach the best possible functional level for that individual. The recipient's parent or guardian should participate in treatment when possible and clinically appropriate. The provider must make every effort to accommodate parental participation and must document those efforts in treatment plan updates. If parent or guardian participation is not possible, the treatment plan and session notes must document the reasons for nonparticipation. Documentation should also explain potential impacts of nonparticipation and how potential impacts are being mitigated.

Services include:

- Adaptive behavior treatment by protocol – behavior analysis services provided according to the authorized treatment protocol
  - Services may be provided by Lead Analyst, BCaBA, or RBT
- Adaptive behavior treatment with protocol modification – behavior analysis services provided with modifications to the authorized treatment protocol to address behavior and/or response changes or progress
  - Services may be provided by Lead Analyst or BCaBA
- Group adaptive behavior treatment by protocol – behavior analysis services provided in a group setting according to the authorized treatment protocol
  - Maximum group size is six recipients
  - Services may be provided by Lead Analyst, BCaBA, or RBT
- Group adaptive behavior treatment with protocol modification – behavior analysis services provided in a group setting with modifications to the authorized treatment protocol to address behavior and/or response changes or progress
  - Maximum group size is six recipients
  - Services may be provided by Lead Analyst or BCaBA

- Family adaptive behavior treatment guidance – parent, guardian, and/or caregiver training on the implementation of the behavior plan and intervention strategies
  - The recipient may or may not be present depending upon clinical appropriateness
  - Services may be provided by Lead Analyst or BCaBA
  - The Lead Analyst may provide up to two hours per week of training to parents or guardians via telemedicine in accordance with Rule 59G-1.057, Florida Administrative Code (F.A.C.)

4.2.3 Supervision

Florida Medicaid requires supervision of BCaBAs and RBTs in accordance with certification board requirements and specified in the supervision plan of the approved behavior plan.

4.2.4 Discharge

Recipients receiving Florida Medicaid BA services who meet one or more of the following will be considered for discharge from services:

- The recipient is no longer eligible for BA services as outlined in the Florida Medicaid Behavior Analysis Services Coverage Policy, incorporated by reference in Rule 59G-4.125, F.A.C.
- The recipient no longer meets medical necessity criteria as defined in Rule 59G- 1.010, F.A.C.
- The recipient no longer engages in maladaptive behaviors.
- Data indicates the frequency and severity of maladaptive behavior(s) or level of functional impairment no longer poses a barrier to the recipient's ability to function in his/her environment.
- The level of functional impairment as expressed through behaviors no longer justifies continued BA services.
- Parent or guardian withdraws consent for treatment

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 section 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 Authorization Requirements Policy.

. . .

5.2 Specific Non-Covered Criteria

Florida Medicaid does not cover the following as part of this service benefit:

- Any procedure or physical crisis management technique that involves the use of seclusion or manual, mechanical, or chemical restraint utilized to control behaviors
- Services for the delivery of recipient supervision, personal care assistance (e.g., acting as a 1:1 aid), companion, chaperone, or shadow regardless of activity or setting. This may include supports and services that are reimbursed through a different Florida Medicaid service benefit or are able to be provided by individuals without professional skills or training.
- Caregiver or childcare services
- Psychological testing, neuropsychology, psychotherapy, cognitive therapy, sex therapy, psychoanalysis, hypnotherapy, or long-term counseling
- Services funded under section 110 of the Rehabilitation Act of 1973
- Services not listed on the fee schedule
- Services on the same day as behavioral health overlay services*
- Services on the same day as therapeutic behavioral on-site services*
- Services on the same day as therapeutic group care services*
- Services provided simultaneously by more than one BA provider, unless determined to be medically necessary, prior authorized, and indicated in the approved behavior plan
- Travel Time

*These services include behavior analysis treatment

. . .

6.2.2 Behavior Assessment and Behavior Plan

The behavior assessment and behavior plan must be signed by the Lead Analyst and the recipient's parent or guardian. Each behavior assessment and behavior plan must include:

- Patient information
- Reason for referral
- Medical and developmental history, including medications prescribed to ameliorate behaviors
- Relevant family history
- Clinical interview
- Review of recent assessments/reports (file review)
- Assessment procedures and results
- Behavior plan
    - Treatment setting(s)
    - Proposed treatment targets, goals, and objectives related to medically necessary behavioral interventions
    - For each:
        - Definition in observable, measurable terms
        - Direct observation and measurement procedures
        - Current level (baseline)
        - Behavior reduction or acquisition procedures

        - Condition(s) under which behavior is to be demonstrated and mastery criteria
        - Date of introduction
        - Estimated date of mastery
        - Plan for generalization
        - Timely reporting of progress, including statements as to whether goal or objective is met; not met; or, modified (with explanation)
- Parent/guardian/caregiver training
    - Proposed targets, goals, and objectives (as above)
    - Training procedures
    - Date of introduction
    - Estimated date of mastery
- Number of units requested
    - Number of units for each billing code
    - Medical necessity for units requested
- Supervision plan, including name(s) of authorized supervisor(s)
- Care coordination with parents/caregivers, schools, state disability programs, and others as applicable
- Transition (fading) plan
- Crisis management plan
- Discharge plan

6.2.3 Assessment and Behavior Plan for Reauthorization and Continuation of Services

In addition to the documentation requirements indicated in 6.2.2, subsequent assessments and behavior plans for reauthorization and continuation of services must include:

- Data reflecting progress of all behaviors targeted for improvement. Each behavior under treatment must have its own data table and corresponding graph.
- A narrative discussion of progress and a statement of justification for continuation of care at the intensity level requested.

If significant clinical progress is not made over the course of an authorization period, the provider must explain why clinically significant progress was not made and treatment changes to promote progress.

See RCE 2 at 41, 43-47.

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 [redacted] request for services. However, a state may place medical necessity limitations on EPSDT services. *See* 42 C.F.R. §§ 440.230(a), (b), (d). Fla. Stat. § 409.905(2) limits EPSDT services with a medical necessity standard:

> The [Agency] shall pay for early and periodic screening and diagnosis of a recipient under age 21 to ascertain physical and mental problems and conditions and all services determined by the agency to be medically necessary for the treatment, correction, or amelioration of these problems and conditions, including personal care, private duty nursing, durable medical equipment, physical therapy, occupational therapy, speech therapy, respiratory therapy, and immunizations.

19. The Florida Medicaid Definitions Policy (August 2017) ("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.

Definitions Policy at page 7.

20. The Florida Medicaid Authorization Requirements Policy (June 2016) ("Authorization Policy"), incorporated by reference in Fla. Admin. Code R. 59G-1.053, provides general requirements for providers to obtain authorization to render Florida Medicaid services. *See* RCE 2 at 30-36. The Authorization Policy states as follows:

> **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 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.

See RCE 2 at 34.

21. In the instant case, Petitioner is under 21 years of age and is diagnosed with [redacted]. *See* ¶ 2. Petitioner requested recertification of ABA services and additional ABA services. *See* ¶ 4. In a NOO, dated December 5, 2023, Respondent denied Petitioner's request. *See* ¶ 6. Respondent cited to the lack of medical necessity as the basis for their decision, specifically that the requested ABA services must be "consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational." *See* ¶ 6. In addition, Respondent determined that the requested services were not "individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness under treatment, and not in excess of the patient's needs." *See* ¶ 6. Respondent has the burden of proof to show by a preponderance of evidence that the Respondent's termination of ABA services was correct. *See* ¶ 14. Petitioner has the burden of proof to show by a preponderance of evidence that the Respondent's denial of additional ABA services was incorrect. *See* ¶ 15.

22. As provided by the EPSDT requirements, the recipient must meet the medical necessity criteria as outlined in Fla. Admin. Code R. 59G-1.010. *See* ¶ 17-18. In the Definitions Policy, a component of medical necessity is that services must be "consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational." *See* ¶ 19.

23. The BA Policy maintains that the "[behavior] plan must include specific behavior goal(s), intervention strategies for each goal, anticipated timeframes that are of sufficient duration to address the targeted behavior, and how the ongoing progress of intervention strategies will be reported." *See* ¶ 16.

24. Using a two-level review process, Respondent reviews behavior analysis requests to ensure ABA services are consistent with the standards enumerated in the Behavior Analysis Coverage Policy as well as generally accepted professional medical standards in the field of behavior analysis. *See* ¶ 6-7, 9. Respondent provided considerable feedback in a PEND opportunity requesting the provider to make changes to the Treatment Plan. *See* ¶ 4. [redacted], on behalf of the provider, submitted a response with additional information for reconsideration. *See* ¶ 5. Dr. Bicard explained that the information within the Treatment Plan did not meet the second and third medical necessity criteria, and was far below the standards of care in the field of ABA and the Behavior Analysis Services Coverage Policy. *See* ¶ 9.

25. Much contention in the record revolved around the provider's inclusion of procedures for [redacted]. The Treatment Plan indicates this target behavior is "not a skill deficit" and has no identifiable function for this behavior. *See* RCE 1 at 140. The Treatment Plan further states, as also testified by [redacted], "there is no behavioral intervention, [redacted] is not shamed, there are no penalties for having an accident; no loss of reinforcers." *Id*. at 141. Dr. Bicard contended that the provider included multiple punishment procedures, including that for [redacted], without first exhausting reinforcement-based strategies. *See* ¶ 9. Dr. Bicard argued that the provider lists restoring the environment, i.e. "obtaining materials to clean up the [redacted]," contingent upon making a mess, thus requiring the individual to engage in the correct behavior following the maladaptive behavior. *See* ¶ 9. Dr. Bicard argued that restoring the environment is a punishment procedure and is aversive to decreasing behavior. *See* ¶ 9. [redacted] testified that [redacted] was included in the treatment plan for staff member's instruction on how to respond when it occurs, but not as a form of punishment. *See* ¶ 10. [redacted] contended that the objective is to prevent

dependence on staff and for Petitioner to take responsibility in returning to a normal environment. *See* ¶ 5, 10. In [redacted]'s response letter, [redacted] states "[w]e [the provider] are taking data, but not intervening behaviorally because we have not yet seen a definitive data pattern to support the necessity." *See* ¶ 5. [redacted] testified that Petitioner has not experienced [redacted] with this current provider. *See* ¶ 11. In full context of Petitioner's rare incidents of [redacted] or occurrences outside of [redacted] BA therapy sessions, this target behavior within the treatment plan appears unnecessary at this time. *See* ¶ 5, 10, 11. The undersigned finds that this target behavior does not appear to be a maladaptive behavior for the purpose of ABA treatment which serves an operative purpose aside from mere data collection of incidents. *See* ¶ 16. To the extent Dr. Bicard contended that its related procedure is a punishment procedure, the Treatment Plan is void of an appropriate transition (fading) plan or crisis management plan as required by the BA Policy. *See* ¶ 9, 16. In addition, Dr. Bicard opined that crisis management procedures that require manual restraint are non-covered services and should not be implemented. *See* ¶ 9. Dr. Bicard argued that the provider included manual restraint procedures for the [redacted] and [redacted] behaviors. *See* ¶ 9. For the [redacted] behavior, the provider included restitution after response blocking and deferential reinforcement of alternatives. *See* ¶ 9. Again, Dr. Bicard testified that restitution following the maladaptive behavior is a punishment procedure which did not first exhaust reinforcement-based strategies. *See* ¶ 9. [redacted] argued that there is no restraint data in the Treatment Plan because Petitioner never received any restraints. *See* ¶ 10. In consideration of Dr. Bicard's testimony that punishment procedures require heightened specificity, the record does not show the necessary safeguards from trauma and fading procedures if punishment was the intended purpose. *See* ¶

9, 10. Otherwise, the procedures for this target behavior do not appear to serve a clear purpose or conform to standards of care in the field of behavior analysis. *See* ¶ 9, 16.

26. Further, the provider requested 2,250 units of code 97154 which represents an increase of 1050 units, or 10 hours, from the last authorization period. *See* ¶ 4. Dr. Bicard argued that there is no accompanying justification for the requested units of code 97154 intended for group therapy. *See* ¶ 9. [redacted] argued that the requested additional hours are to work on Petitioner's social skills for group to address [redacted] lack of social interaction. *See* ¶ 10. As highlighted by [redacted], the behavior analysis policy does not indicate group treatment requires a specific class or any particular method. *See* ¶ 10, 16. However, the BA policy requires justification of the medical necessity for units requested for each "proposed treatment targets, goals, and objectives related to medically necessary behavioral interventions." *See* ¶ 16. In addition, ambiguity is noted where the provider listed "[redacted]" as a target behavior in the Treatment Plan but there is no clear definition or antecedent for proper observation of this behavior. *See* ¶ 9. Without specific and clear strategies outlined in the Treatment Plan at issue, the information does not justify Petitioner's request for additional ABA services. *See* ¶ 16, 20. The record shows that Petitioner's provider failed to include the proposed changes to the Treatment Plan that conformed to standards of care within the field of behavior analysis. *See* ¶ 4-7. All in all, the undersigned finds Dr. Bicard's testimony sufficient and persuasive to demonstrate that the Treatment Plan was not consistent with generally accepted professional medical standards within the field of behavior analysis. *See* ¶ 9, 19.

27. Upon consideration of the testimony provided, evidence submitted, and applicable policies, the undersigned concludes that Petitioner did not prove by a preponderance of the

evidence that the denial of additional ABA services was incorrect. Looking at all the evidence relevant to the particular needs of Petitioner, Petitioner has not demonstrated that the requested services, 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 additional ABA services was incorrect.

28. Lastly, as QIO for the Agency, eQHealth is authorized to terminate services when "the reviewing physician determines the recipient will not gain any additional benefit by continuing services at the current level." *See* ¶ 20. Medical necessity criteria apply not only to the recipient and [redacted] diagnosis, but also to the documents submitted as part of the request for services. *See* ¶ 16, 20. [redacted] testified that Petitioner has been in multiple settings from day care to public school, ESE school, and now in this special setting with the ABA provider. *See* ¶ 11. [redacted] argued that Petitioner's behaviors such [redacted] *See* ¶ 11. In the several opportunities for the provider to correct the Treatment Plan consistent with generally accepted professional medical standards, the provider failed to provide sufficient evidence of effective procedures to demonstrate that Petitioner will not gain any additional benefit by recertification of ABA services. *See* ¶ 4-7, 10, 20. As discussed, several discrepancies were noted in the submitted Treatment Plan which do not meet medical necessity criteria. *See* ¶ 24-26. Where it is clear Petitioner needs ABA therapy, the undersigned concludes that the submitted Treatment Plan does not justify the requested services to implement ABA therapy effectively. *See* ¶ 9-11, 16-20.

29. Upon consideration of the testimony provided, evidence submitted, and applicable policies, the undersigned concludes that Respondent proved by a preponderance of the evidence that the termination of ABA services was necessary. Looking at all the evidence relevant to the particular needs of Petitioner, Respondent has demonstrated that the previously authorized services, based on the treatment plan at issue in this case, are not necessary to correct or ameliorate a defect or a physical and mental illness or condition. Accordingly, Respondent proved by a preponderance of the evidence that Respondent's termination of ABA services was correct.

IT IS HEREBY ORDERED AND ADJUDGED THAT:

Respondent's termination of BA services is **AFFIRMED**. Petitioner's appeal based on Respondent's termination of BA services is **DENIED**.

Respondent's denial of additional BA services is **AFFIRMED**. Petitioner's appeal based on Respondent's denial of additional BA services is **DENIED**.

DONE AND ORDERED this 17th day of April, 2024 in Tallahassee, Leon County, Florida.

KIMBERLY ROCHE, 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
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