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OFFICE OF FAIR HEARINGS

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

,

PETITIONER, **AHCA Case No.: 22-FH1993**

vs.

AGENCY FOR HEALTH CARE ADMINISTRATION,

RESPONDENT.
_______________________________________/

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic Fair Hearing in the above-styled case on December 7, 2022, at 1:00 a.m. Eastern Standard Time ("EST").

APPEARANCES

For the Petitioner:
Petitioner's Authorized Representative

For the Respondent: Chrissie Simmons
Medical Health Care Program Analyst
Agency for Health Care Administration

STATEMENT OF ISSUES

The issue is whether Respondent proved by a preponderance of the evidence that Respondent's termination of Petitioner's Behavior Analysis ("BA") Services was correct.

PRELIMINARY STATEMENT

All parties and witnesses appeared telephonically. (""), Petitioner's Authorized Representative and , represented Petitioner at the hearing. Yamilla Autie, a Board Certified Behavior Analyst ("BCBA"), testified on behalf of Petitioner.

Chrissie Simmons, Medical Health Care Program Analyst for the Agency for Health Care Administration ("Agency" or "AHCA"), appeared as a representative for Respondent. Dr. David ("Dr. Bicard"), Board Certified Behavior Analyst and the doctoral level ("BCBA-D") and Clinical Director at eQHealth Solutions, Inc. ("eQHealth"), appeared as a witness for Respondent.

Interpreter George, ID No. 31578792 with Global Interpreting Network, provided translation services for Petitioner.

Petitioner did not introduce any exhibits at the hearing. Prior to the hearing, Respondent sent to the Office of Fair Hearings and Petitioner a two hundred and thirty-one (231)-page evidence packet. The evidence packet is maintained in the Office of Fair Hearings' case management system as "[redacted] FH 12.07.2022 1-157.pdf" and "[redacted] FH 12.07.2022 158-231.pdf." Absent an objection from Petitioner, the undersigned admitted the evidence packet into evidence as Respondent's Composite Exhibit 1.

Respondent also sent to the Office of Fair Hearings and Petitioner a forty-nine (49) page evidence packet. The evidence packet is maintained in the Office of Fair Hearings' case management system as "22-FH1993_Behavior Analysis_AHCA Evidence.pdf." Absent an objection from 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. *See* Respondent's Composite Exhibit 1 at page 21. eQHealth is a Quality Improvement Organization ("QIO") contracted by the Agency to review prior authorization requests for services. *See* Respondent's Composite Exhibit 2 at page 2. The Agency, through contractual agreement,

authorized eQHealth to make Medical Necessity determinations for services requiring prior authorizations, including Behavior Analysis services. *Id*.

2. As of the date of the Fair Hearing, Petitioner is [redacted] and diagnosed with [redacted].. *See* Respondent's Composite Exhibit 1 at page 21. Petitioner receives BA services from [redacted]. *Id*. Petitioner's Behavior Analysis Reassessment, updated October 3, 2022, ("Treatment Plan"), identifies the following maladaptive behaviors for reduction: [redacted], [redacted], [redacted], [redacted], [redacted], [redacted], and [redacted]. *Id*. at 176-177.

3. On October 6, 2022, Petitioner requested a continuation of BA services. *Id*. at 21. Specifically, Petitioner requested 3,120 units of code 97153 - intervention without protocol modification, per 15 minutes, 312 units of code 97155 - intervention with protocol modification, per 15 minutes, and 208 units of code 97156 - family training, per 15 minutes, Lead Analyst, for the certification period of November 1, 2022, through April 29, 2023. *Id*. at 24-25.

4. On October 13, 2022, eQHealth sent Petitioner's provider a Request for Additional Information letter. *Id.* at 51. The letter requested clarification on the definition of "[redacted]," and the use of punishment procedures in the Treatment Plan. *Id.*

5. On October 25, 2022, eQHealth issued a Notice of Outcome ("NOO") letter that denied Petitioner's request and thereby terminated BA services. *Id.* at 27-28. The NOO explained that the requested services were terminated because they are not medically necessary, and stated as follows:

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

> Consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational.
>
> The rational for our decision is as follows:
> . . .
> 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 (Pages 6-7). The plan includes procedures for punishment (response cost pg 2, 16). The provider was requested to 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. Further, the definition of [redacted] is missing. According to (the Florida Behavior Analysis Services Coverage Policy, page 6, 9.2.i), 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 engaging [sic] in. The provider was requested to submit an updated BASP with a definition of [redacted] and address the use of punishment. The provider submitted a plan without the definition of [redacted], and did not provide the requested information regarding the use of punishment. The punishment plan is not empirically valid. This request is denied.

Id.

6. Petitioner requested reconsideration and, on October 31, 2022, eQHealth issued a Notice of Reconsideration Determination ("NRD") upholding the termination of Petitioner's BA services. *Id.* at 39-40. The NRD explained as follows:

> The request for the denial is that the services are not medically necessary as defined in Rule 59G-1.010, Florida Administrative Code. 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.

> The rationale for our decision is 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 (Pages 6-7). 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 for using punishment and no punishment fading plan. Additionally, the provider has requested BA services that are in excess of medical necessity. This reconsideration request has been reviewed, reconsidered and the denial is upheld.

Id.

7. On October 31, 2022, Petitioner requested a Fair Hearing due to the termination of BA services. *Id*. at 8. The undersigned scheduled the hearing for December 7, 2022, at 1:00 p.m. EST, and all parties were duly notified. *Id*. at 8-11. Petitioner received administrative approval, or continuation of benefits, pending the outcome of the Fair Hearing. *Id*. at 24.

8. At the hearing, Dr. Bicard established that two Board Certified Behavior Analysts at the doctoral level reviewed the Treatment Plan and determined that the Treatment Plan does not meet standards of care for behavior analysis. Dr. Bicard testified that he reviewed all documentation submitted by Petitioner. He agreed with the determinations of the previous eQHealth reviewers that the definition of [redacted] and punishment procedures in the Treatment plan to not meet standards of care in BA.

9. With regard to the new maladaptive behavior of "[redacted]" contained in the Treatment Plan, Dr. Bicard provided credible and persuasive testimony that the new behavior is not properly defined and the proposed response cost intervention is a punishment procedure. *Id*. at 172. The response cost does not meet professional standards of applied behavior analysis. Punishment

procedures should only be used when all other procedures have been tried and have been shown to have failed. To utilize punishment procedures, the provider must describe the need, show that all else has failed, provide detailed data, provide safeguards to protect the recipient and others from trauma, and have a detailed fading plan or criteria for the discontinuation of the procedure based on appropriate response levels by the recipient. Here, "[redacted]" is a newly identified behavior and it is not appropriate to use a punishment procedure at the start of treatment for a new maladaptive behavior. eQHealth requested changes to the Treatment Plan and additional information in this area, and the provider's responses failed to address the definition of "[redacted]" and the use of a punishment procedure.

10. Ms. Autie asserted that she was not given an opportunity to remove the punishment procedures in the plan or she would have done so. [redacted] testified that BA services are medically necessary for Petitioner.

CONCLUSIONS OF LAW

11. 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. This order is the final administrative decision of AHCA under section 409.285(2)(a).

12. This hearing was held as a *de novo* proceeding pursuant to Florida Administrative Code Rule ("Fla. Admin. Code R.") 59G-1.100(17)(b), which states "[e]ach fair hearing shall be a de novo, evidentiary proceeding, and shall be conducted in a manner that meets the requirements of this rule."

13. The burden of proof in this proceeding is governed by Fla. Admin. Code R. 59G-1.100(17)(g), which provides as follows:

> The burden of proof is on the party asserting the affirmative of an issue, except as otherwise required by statute. The burden of proof is on the Agency or plan, whichever is applicable, when the issue presented is the suspension, reduction, or termination of a previously authorized service. The burden of proof is on the recipient or enrollee, when the issue presented is the denial or a limited authorization of a service. The party with the burden of proof shall establish its position to the satisfaction of the Hearing Officer by a preponderance of the evidence.

14. In the instant case, Respondent terminated an already-approved service. As such, 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 policy that applies to the requested services is the Behavior Analysis Services Coverage Policy (October 2017) (“BA Coverage Policy”). The BA Coverage Policy has been incorporated, by reference, into Fla. Admin. Code R. 59G-4.125. The BA Coverage 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.
>
> **1.1 Florida Medicaid Policies**
> This policy is intended for use by providers that render BA services to eligible Florida Medicaid recipients. It must be used in conjunction with Florida Medicaid’s General Policies (as defined in section 1.3) and any applicable service-specific and claim reimbursement policies with which providers must comply.
>
> Note: All Florida Medicaid policies are promulgated in Rule Division 59G, Florida Administrative Code (F.A.C.). Coverage policies are available on the Agency’s Web site at http://ahca.myflorida.com/Medicaid/review/index.shtml.
>
> . . .
>
> **2.2 Who Can Receive**

Florida Medicaid recipients under the age of 21 years requiring medically necessary BA services. Some services may be subject to additional coverage criteria as specified in section 4.0.

. . .

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:

. . .

4.2.2 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 possible 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; and
- 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)

4.2.3 Behavior Reassessment

Up to three per fiscal year, per recipient

BA Coverage Policy at pages 1-3.

16. The BA Coverage Policy contains the following additional review criteria for behavior analysis Services:

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 in Rule 59G-1.010, F.A.C.
c. The recipient currently engages in maladaptive behaviors
d. These maladaptive behaviors interfere with the recipient's daily functioning

1. Criteria for Initial Behavior Analysis Assessment – BOTH of the following **MUST** be satisfied:

a. **ALL** critical elements are met
b. Provider submits a valid written physician's order as stipulated in the Behavior Analysis Services Coverage Policy, Rule 59G-4.125, F.A.C.

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

a. ALL critical elements are met
b. An assessment or, if applicable, a reassessment, authored by a lead analyst, is provided. An assessment of the maladaptive behavior(s) is a necessary element of the process of identifying the frequency and magnitude of the behaviors as well as the variables associated with the occurrence of the maladaptive behavior(s). This helps in defining what are the functional consequences of the problem behavior(s) so that an adequate behavior plan can be implemented. This (re)assessment MUST include, at a minimum, ALL of the following:
    i. A clear operational description of the maladaptive behavior(s)
    ii. Baseline and/or updated treatment data (if reassessment)
    iii. Progress toward identified goals (if a reassessment)
    iv. Identification of the events, times, and situations that appear to be associated to the occurrence of the maladaptive behavior(s)
    v. Identification of the functional consequences of the maladaptive behavior(s)
    vi. Development of hypotheses and summary statements that describe the maladaptive behavior(s) and its(their) functions
    vii. Summary and recommendations
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 Goals and strategies for changing the maladaptive behavior(s)
iii. Written detailed description of when, where, and how often these goals will be addressed and proposed strategies will be implemented System for monitoring and evaluating the effectiveness of the plan Safety and crisis plan, if applicable Summary and recommendations Discharge criteria 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
    iii. Self-care – difficulty recognizing risks or danger, grooming, eating, or toileting
    iv. Other – behaviors not identified above

. . .

4. Criteria to Assess the Intensity of Behavior Analysis Services: Providers may request up to 40 hours of BA services per week, per recipient, based upon the following:

As a rule, higher number of maladaptive behaviors, higher severity and frequency of behaviors, as well as the multiplicity of settings where the behaviors occur, would usually justify a higher number of services hours. The greater the number of goals targeted to reduce maladaptive behaviors, the more the likelihood that a higher number of services hours could also be warranted.

Providers **MUST** ensure that proper justification for the requested hours of services is adequately documented in the behavior plan. Based on the information provided in the assessment, behavior plan, and any other supporting documentation, 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

BA Coverage Policy, Appendix 9.0, at pages 6-8.

17. The BA Coverage Policy states the following with respect to documentation requirements for behavior analysis services:

6.0 Documentation
6.1 General Criteria
For information on general documentation requirements, please refer to Florida Medicaid's General Policies on recordkeeping and documentation.
. . .
6.2 Specific Criteria
Providers must maintain the following documentation in the recipient's file:

- Behavior assessment, and assessment review that must be reviewed and signed by a lead analyst;
- Behavior plan, and behavior plan review that must be reviewed and signed by a lead analyst;

- Notations when the recipient's family or caregiver is not able to participate in BA services, and instances when it was clinically inappropriate for the recipient to be present during training services; and
- Written physician's order.

BA Coverage Policy at page 4.

18. The BA Coverage Policy states the following with respect to authorization requirements of behavior analysis services:

> **7.0 Authorization**
> **7.1 General Criteria**
> The authorization information described below is applicable to the fee-for-service delivery system. For more information on general authorization requirements, please refer to Florida Medicaid's General Policies on authorization requirements.
> **7.2 Specific Criteria**
> Providers must obtain authorization from the quality improvement organization (QIO) prior to the initiation of BA services and at least every 180 days thereafter.
>
> Providers may request authorization more frequently upon a change in the recipient's condition requiring an increase or decrease in services.
>
> The QIO uses the review criteria specified in section 9.0 for the first level review. For more information on how the QIO uses the criteria in the review process, please refer to Florida Medicaid's General Policies on authorization requirements.

BA Coverage Policy at page 4.

19. The Florida Medicaid Authorization Requirements Policy (June 2016) ("Authorization Requirements Policy"), incorporated by Fla. Admin. Code R. 59G-1.053, provides general requirements for providers to obtain authorization to render Florida Medicaid services. It states the following:

> **1.2 Definitions**
> The following definitions are applicable to this policy. For additional definitions that are applicable to all sections of Rule Division 59G, F.A.C., please refer to the Florida Medicaid definitions policy.
> . . .
> **1.3.1 Authorization**

The process of obtaining approval for reimbursement of a service based on medical necessity.

. . .

1.3.6 Provider

The term used to describe any entity, facility, person, or group that has been approved for enrollment or registered with Florida Medicaid.

1.3.7 Quality Improvement Organization

Entity designated to perform utilization review, quality assurance, and quality improvement activities for Florida Medicaid-covered services rendered by fee-for-service providers (also known as the QIO).

. . .

2.0 Authorization Requirements

. . .

2.4.2 Requests for Additional Information

The QIO may request additional information, as necessary, to determine medical necessity.

. . .

3.0 Determination Process

3.1 Review Criteria

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

3.2 Review Process

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

3.2.1 Continued Authorization Requests

The QIO shall not deny or reduce the amount, frequency, or duration of a service that is already being provided, unless:

- The reduction is to correct for factual errors or omissions in prior certifications.
- There is a documented improvement in the recipient's medical condition.
- There is a documented change in the recipient's circumstances.
- The reviewing physician determines the recipient will not gain any additional benefit by continuing services at the current level.

Florida Medicaid Authorization Requirements Policy, pages 1-3.

20. 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.

21. A state may place medical necessity limitations on EPSDT services. *See* 42 C.F.R. §§ 440.230(a), (b), (d). Pursuant to section 409.905(2), Florida Statutes:

> 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.

22. Once it is determined that EPSDT applies to a request for a service, the Florida Medicaid program determines the amount or necessity for that service based on the State of Florida's published definition of medical necessity. The Florida Medicaid Definitions Policy, which is incorporated by reference in Fla. Admin. Code R. 59G-1.010, defines "medically necessary or medical necessity" as follows:

> **2.83 Medically Necessary or Medical Necessity**
> 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 severe 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.

23. In the instant case, Petitioner is under the age of 21 and therefore EPSDT applies to ██ request for services. *See* supra ¶ 2. Petitioner's provider submitted a request to eQHealth for the continuation of Petitioner's BA services for the certification period of November 1, 2022, through April 29, 2023. *See* supra ¶ 3. As established on the record, eQHealth terminated Petitioner's BA services because Petitioner's provider failed to submit sufficient documentation to establish that the requested services were medically necessary. *See* supra ¶ 4-6.

24. Pursuant to the BA Coverage Policy, the critical elements necessary for any type of BA service are: (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 in Rule 59G-1.010, F.A.C; (c) the recipient currently engages in maladaptive behaviors; and (d) these maladaptive behaviors interfere with the recipient's daily functioning. *See* supra ¶ 16.

25. Pursuant to section 2.83 of the Definitions Policy, the five (5) conditions of medical necessity must be met in order for "medical or allied care, goods, or services furnished or ordered" to be determined medically necessary. *See* supra ¶ 22. Accordingly, all five (5) of the conditions must be met in order for eQHealth to approve requested BA services.

26. The termination of BA services is warranted in this case as the Treatment Plan submitted to eQHealth by Petitioner's provider does not conform to generally accepted professional medical standards within the field of applied BA. *See* supra ¶ 4-6, 8-9. Dr. Bicard, a Board-Certified Behavior Analyst at the doctoral level provided credible and persuasive testimony that the provider had an opportunity but failed to address the definition of "[redacted]" and the punishment procedures contained in the Treatment Plan. *See* supra ¶4-6, 8-9. The record shows that the Treatment Plan contains a response cost for "[redacted]." *See* supra ¶4-6, 8-9. The Treatment Plan inappropriately uses the response cost for a newly identified maladaptive behavior. The provider did not provide documentation showing that the punishment procedure would only be used when all other procedures have been tried and have been shown to have failed. The provider failed to describe the need, provide detailed data, provide safeguards to protect the recipient and others from trauma, and have a detailed fading plan or criteria for the discontinuation of the punishment procedure based on appropriate response levels by the recipient. *See* supra ¶4-6, 8-9. For the above reasons, the Treatment Plan does not meet standards of care in applied behavior analysis and is, therefore, not consistent with generally accepted professional medical standards as determined by the Medicaid program. Based on the foregoing, Respondent demonstrated that the BA services at issue are not medically necessary. The Petitioner will not gain any additional benefit by continuing BA services at the current level under a Treatment Plan that does not conform to BA standards of care.

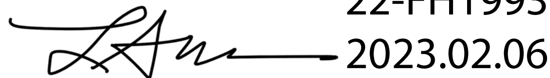
27. Looking at all of the evidence relevant to the particular needs of Petitioner, Respondent demonstrated that the requested BA services are not necessary to correct or ameliorate defects and physical and mental illness and conditions discovered by the screen services. Therefore, in

light of both parties' testimony, Respondent's Composite Exhibit 1, Respondent's Composite Exhibit 2, and the applicable laws and policies, the undersigned Hearing Officer finds that Respondent proved by a preponderance of the evidence that Respondent's termination of Petitioner's BA services was correct.

DECISION

Respondent's termination of Petitioner's Behavior Analysis Services is **AFFIRMED.** Petitioner's appeal based on Respondent's termination of Behavior Analysis Services is **DENIED**.

DONE and **ORDERED** this 6th day of February 2023, in Tallahassee, Leon County, Florida.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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.

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