



FILED

Jul 24, 2023, 9:06 am
OFFICE OF FAIR HEARINGS

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

[REDACTED],

PETITIONER,

AHCA Case No.: 23-FH0535

vs.

AGENCY FOR HEALTH CARE
ADMINISTRATION,

RESPONDENT.

_____ /

Pursuant to notice, the undersigned convened a telephonic Fair Hearing on the instant case on June 14, 2023, at 10:01 a.m. Eastern Standard Time ("EST").

APPEARANCES

For the Petitioner:

[REDACTED]
Counsel for Petitioner

For the Respondent:

Joseph G. Hern, Jr., Esq.
Counsel for Respondent

STATEMENT OF ISSUE

The issue is whether Respondent proved by a preponderance of the evidence that Respondent's decision to terminate Petitioner's Behavior Analysis ("BA" or "ABA") services was correct.

PRELIMINARY STATEMENT

All parties and witnesses appeared telephonically.

[REDACTED] (" [REDACTED] "), appeared at the Fair Hearing as Counsel for Petitioner, and did not call any witnesses.

Joseph G. Hern, Jr., Esq. (“Mr. Hern”), Senior Attorney for the Agency for Health Care Administration (“Agency” or “AHCA”), appeared at the Fair Hearing as Counsel for Respondent. Marielisa Amador, Medical/Health Care Program Analyst for AHCA, appeared at the Fair Hearing as a witness for Respondent. Dr. David Bicard (“Dr. Bicard”), Board-Certified Behavior Analyst (“BCBA”) and Director for Clinical Operations for eQHealth Solutions Florida (“eQHealth”), appeared at the Fair Hearing as a witness for Respondent.

The following attended as observers: Diana Hearod, Medical/Health Care Program Analyst and Fair Hearing Liaison for AHCA; and Kyle Epperson, AHCA Paralegal for Mr. Hern.

Prior to the hearing, Petitioner sent to the Office of Fair Hearings and Respondent an eighty-five (85)-page evidence packet. The evidence packet appears in the Office of Fair Hearings document management system as the file titles “23-FH0535 Emailed Documents.pdf¹” and “23-FH0535 Notice of Supplemental Filings.pdf².” Absent an objection from the Respondent, the undersigned admitted the eighty-five (85)-page evidence packet into evidence as Petitioner’s Composite Exhibit 1 (“PCE 1”).

Prior to the hearing, Respondent sent to the Office of Fair Hearings and Petitioner a one hundred and eighty-nine (189)-page evidence packet, a forty-nine (49)-page evidence packet, and an eighteen (18)-page evidence packet. The one hundred and eighty-nine (189)-page packet appears in the Office of Fair Hearings document management system as the file titles “[REDACTED] FH 05.09.2023 1-126.pdf” and “[REDACTED] FH 05.09.2023 127-189.pdf.” The forty-nine (49)-page evidence packet appears in the Office of Fair Hearings document management system

¹ This file contains pages 1 – 4.

² This file contains pages 5 – 85.

within the file title “23-FH0535 Exhibits for Hearing.pdf³.” The eighteen (18)-page evidence packet appears in the Office of Fair Hearings document management system within the file title “23-FH0535 Exhibits for Hearing.pdf⁴.” Absent an objection from the Petitioner, the undersigned admitted the one hundred and eighty-nine (189)-page evidence packet into evidence as Respondent’s Composite Exhibit 1 (“RCE 1”), the forty-nine (49)-page evidence packet into evidence as Respondent’s Composite Exhibit 2 (“RCE 2”), and the eighteen (18)-page evidence packet into evidence as Respondent’s Composite Exhibit 3 (“RCE 3”).

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 RCE 2 at 2.

2. Petitioner is [REDACTED] ([REDACTED]-[REDACTED]) old. See RCE 1 at 16. Petitioner is diagnosed with [REDACTED] *Id.*

3. As provided in the Behavior Analysis Reassessment Service Plan (“Treatment Plan”), Petitioner is engaging in the following maladaptive behaviors: [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED] *Id.* at 54. The data in the Treatment Plan, for the period between [REDACTED] and [REDACTED], indicate the following regarding Petitioner’s incidents of maladaptive

behaviors: for [REDACTED] Petitioner’s incidents decreased from [REDACTED] per week to [REDACTED] per week; for

[REDACTED], Petitioner’s incidents decreased from [REDACTED] per week to [REDACTED] per week; for

³ The forty-nine (49)-page packet is found on pages 2 – 50.

⁴ The eighteen (18)-page packet is found on pages 240 – 257.

5. Petitioner requested continuation of BA services; specifically, 3,120 units of code 97153; 416 units of code 97155; and 208 units of code 97156. In a Notice of Outcome (“NOO”), dated March 1, 2023, Respondent terminated Petitioner’s ABA services. *Id.* at 22 – 24. The NOO explained the basis for the termination as follows:

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

Individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness under treatment, and not in excess of the patient's needs.

The NOO further provided:

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

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. The information submitted does not meet standards of care within the field of behavior analysis. This request is denied.

...

Id. at 22 – 23.

6. Petitioner requested reconsideration of the Respondent’s decision. In a Notice of Reconsideration Determination (“NRD”), dated March 13, 2023, Respondent upheld its decision. *Id.* at 34 – 35. The NRD explained the basis for the decision as follows:

The reason for the denial is that the services are not medically necessary as defined in 59G-1.010, Florida Administrative Code. Specifically the services must be:

Individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness under treatment, and not in excess of the patient's needs.

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

...

PR Recon Determination: At reconsideration all documents were carefully reviewed. 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 the provider will address human error. The recommendations are insufficient to support continued care. This reconsideration request has been reviewed, reconsidered and the denial is upheld.

...

Id. at 35.

7. On March 10, 2023, Petitioner requested a Fair Hearing to challenge the termination of ABA services. On April 18, 2023, the undersigned issued an Order Scheduling Fair Hearing and Prehearing Instructions, setting the hearing for May 9, 2023, at 10:00 a.m. EST. On May 4, 2023, the undersigned issued an Order Granting Continuance. On May 5, 2023, the undersigned issued a separate Order Rescheduling Fair Hearing, setting the hearing for June 14, 2023, at 10:00 a.m. EST.

8. Dr. Bicard is a Board-Certified Behavior Analyst at the Doctoral level and Director of Clinical Operations for eQHealth. At the Fair Hearing, absent an objection from Petitioner, Dr. Bicard was admitted as a field expert. Dr. Bicard established the following:

- a. The standards used when reviewing a treatment plan are based on the generally accepted professional medical standards, which are founded on reliable scientific evidence recognized by the medical community, peer-reviewed literature, or practitioner specialty associations' recommendations. See RCE 2 at 28. Additionally, the Behavior Analysis Certification Board developed practice guidelines for applied behavior analysis when reviewing for the effectiveness of a treatment plan. *Id.* While the reviewers determined it is medically necessary for Petitioner to receive ABA therapy, Dr. Bicard contends the three treatment plans submitted show ineffective treatment according to the standards for applied behavior analysis and, therefore, the services were terminated.
- b. In review of the documentation submitted by Petitioner, the Petitioner's diagnosis and behaviors are appropriate for therapy, but the behaviors occur at unacceptable levels and the provider has not shown progress to support medical necessity. See PCE 1 at 3, 7 – 85.
- c. Dr. Bicard contends that when there are no changes in a recipient's maladaptive behaviors, the provider in response should make appropriate modifications to the treatment plan, and any environmental changes need to be reflected in the graph so the provider can identify if treatment is effective. Dr. Bicard explained that replacement behavior graphs should trend in an upwards direction in order to

decrease the frequency of maladaptive behaviors. In the final Treatment Plan submitted by the provider, the data graphs for all of the maladaptive behaviors reflect a leveled trend indicating no progress throughout the authorization period. See RCE 1 at 146 – 148. The first graph for [REDACTED] [REDACTED], and [REDACTED], shows a downward trend, but each behavior is occurring at high levels. *Id.* at 146.

- d. Dr. Bicard asserts that for skill acquisition goals reported in percentage of successful opportunities, the percentage represents the client’s frequency to do each skill divided by the number of opportunities. Within the fields of behavior analysis, any data points below 50% is considered “chance level” responding. The graph data for Petitioner do not go up to 100%. *Id.* at 148 – 150. One such graph only caps at [REDACTED] which, in Dr. Bicard’s medical opinion, is tantamount to 0. *Id.* at 148. Further, the behavior reduction plan is not clear what the procedures are and is not clear why provider doing these as these are general instruction, not specific to the client. *Id.* at 150 – 152. Dr. Bicard asserts that the provider’s list of interventions is also not clear. *Id.* at 156. The provider’s replacement programs are not clear how they differ from other programs, and are not directed toward recipient. *Id.* at 157 – 158.
9. At the Fair Hearing, [REDACTED] presented the following:
 - a. [REDACTED] contends that because the provider’s recent reassessment was possibly submitted in error and is not indicative of the Petitioner’s progress, the termination of ABA services is incorrect. [REDACTED] argues that the stark

106.

CONCLUSIONS OF LAW

10. 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).

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

12. 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.)

13. The Florida Medicaid Behavior Analysis Services Coverage Policy (October 2017) (“BA Policy”), incorporated by reference in Fla. Admin. Code. R. 59G-4.125, governs BA services available under Florida Medicaid. The BA Policy provides as follows:

1.0 Introduction

Behavior analysis (BA) services are highly structured interventions, strategies, and approaches provided to decrease maladaptive behaviors and increase or reinforce appropriate behaviors.

...

1.4.5 Medically Necessary/Medical Necessity

As defined in Rule 59G-1.010, F.A.C.

...

4.0 Coverage Information

4.1 General Criteria

Florida Medicaid covers services that meet all of the following:

- Are determined medically necessary

- Do 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

One per fiscal year, per recipient, when completed within 30 days of the start of the assessment.

4.2.2 Behavior Analysis

Up to 40 hours per week, per recipient, consisting of services identified on the recipient’s behavior plan in order to reduce maladaptive behaviors and to restore the recipient to his or her best functional level. Services include:

- Implementing behavior analysis interventions, and monitoring and assessing the recipient’s progress towards goals in the behavior plan
- Behavior analysis interventions, for example, discrete trial teaching, task analysis training, differential reinforcement, non-contingent reinforcement, conducting task analyses of complex responses, and teaching using chaining, prompting, fading, shaping, response cost, and extinction
- Training the recipient’s family, caregiver(s), and other involved persons on the implementation of the behavior plan and intervention strategies (the recipient must be present when clinically appropriate)

...

4.3 Early and Periodic Screening, Diagnosis, and Treatment

As required by federal law, Florida Medicaid provides services to eligible recipients under the age of 21 years, if such services are medically necessary to correct or ameliorate a defect, a condition, or a physical or mental illness. Included are diagnostic services, treatment, equipment, supplies, and other measures described in sectioned 1905(a) of the Social Security Act, codified in Title 42 of the United States Code 1396d(a). As such, services for recipients under the age of 21 years exceeding the coverage described within this policy or the associated fee schedule may be approved, if medically necessary. For more information, please refer to Florida Medicaid’s General Policies on authorization requirements.

...

See RCE 2 at 40 – 42.

14. Appendix 9.0 of the BA Policy provides Review Criteria for Behavior Analysis Services.

These Review Criteria state as follows:

Review Criteria for Behavior Analysis Services

Behavior analysis (BA) services are considered as either the treatment of choice or as an adjunct treatment modality for a variety of conditions and disorders where maladaptive behaviors are part of the recipient’s clinical presentation,

including behavioral manifestations of diagnoses such as Autism Spectrum Disorder and other behavioral health conditions.

Critical Elements Necessary for ANY Type of Behavior Analysis Service:

The following critical elements **MUST** be satisfied to qualify for BA services:

- a. Eligibility – The recipient must meet all criteria for BA services as outlined in the Behavior Analysis Services Coverage Policy, Rule 59G-4.125, F.A.C.
- b. Medical necessity – The recipient must meet medical necessity criteria as outlined in Rule 59G-1.010, F.A.C.
- c. The recipient currently engages in maladaptive behaviors
- d. These maladaptive behaviors interfere with the recipient’s daily functioning

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

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

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

- a. **ALL** critical elements are met
- b. An assessment or, if applicable, a reassessment, authored by a lead analyst, is provided. An assessment of the maladaptive behavior(s) is a necessary element of the process of identifying the frequency and magnitude of the behaviors as well as the variables associated with the occurrence of the maladaptive behavior(s). This helps in defining what are the functional consequences of the problem behavior(s) so that an adequate behavior plan can be implemented. This (re)assessment **MUST** include, at a minimum, **ALL** of the following:
 - i. A clear operational description of the maladaptive behavior(s)
 - ...
- c. A behavior plan authored or updated by a lead analyst. The behavior plan is the cornerstone of the delivery of behavior analysis services and it is based on the information obtained in the assessment. It proposes specific interventions to reduce or eliminate the maladaptive behavior. These interventions take into consideration the variables, both present before the behavior, as well as after the behavior, that influence the occurrence of the maladaptive behavior(s). This plan also includes replacement appropriate behaviors for the recipient to engage in instead of the maladaptive behaviors in order to obtain the same function. The plan must be detailed enough to warrant the requested

services and include mechanisms to monitor its effectiveness. This **MUST** include, at a minimum, **ALL** of the following:

- i. Observable and measurable descriptions of the maladaptive behavior(s)
- ii. Identified function of the maladaptive behavior(s) behavior as a result of the assessment or reassessment conducted
- iii. Goals and strategies for changing the maladaptive behavior(s)
- iv. Written detailed description of when, where, and how often these goals will be addressed and proposed strategies will be implemented
- v. System for monitoring and evaluating the effectiveness of the plan
- vi. Safety and crisis plan, if applicable
- vii. Summary and recommendations
- viii. Discharge criteria
- ix. Transition plan (if applicable)

NOTE: Although the assessment and behavior plan were addressed separately in section 2, both of them can be submitted as a single document.

3. Criteria for Continuation of Treatment at the Present Level and/or Using Current Methods: Providers must ensure that ALL of the following criteria are met to request continuation of treatments at the present level or using the current methods. If criteria for 3a is met, but criteria for 3b and/or 3c are not met, then a reduction of the treatment level and/or change of treatment methods may be warranted.

- a. ALL criteria listed in 2a, 2b, and 2c regarding critical elements, assessment or reassessment, and behavior plan, are met.
- b. The data provided must show evidence that the frequency of the maladaptive behavior(s) has decreased since the last review and, if not, that there is a modification of the behavior plan.
- c. The level of functional impairment justifies continuation of BA services. The reviewer utilizes the information provided below as a guide as it relates to the level of functional impairment as expressed through the following behaviors:
 - i. Safety – aggression, self-injury, property destruction, elopement
 - ii. Communication – problems with expressive/receptive language, poor understanding or use of non-verbal communications, stereotyped, repetitive language
 - iii. Self-stimulating, abnormal, inflexible, or intense preoccupations
 - iv. Self-care – difficulty recognizing risks or danger, grooming, eating, or toileting
 - v. Other – behaviors not identified above

...

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.

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

...

Id. at 45 – 47.

15. 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.

16. Petitioner is under age 21, and therefore EPSDT applies to ■■■ request for services. However, a state may place medical necessity limitations on EPSDT services. *See* 42 C.F.R. §§

440.230(a), (b), (d). Fla. Stat. § 409.905(2) limits EPSDT services with a medical necessity standard:

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

17. 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.

...

See RCE 1 at 23.

18. 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.

...

Id. at 34.

19. In the instant case, Petitioner is under 21 years of age and is diagnosed with [REDACTED] See ¶ 2. In a NOO, dated March 1, 2023, Respondent terminated Petitioner’s ABA services. See ¶ 5. Respondent cited to the medical necessity criteria as the basis for their decision, specifically that the services must be “individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness under treatment, and not in excess of the patient's needs”. See ¶ 5. Upon reconsideration, Respondent upheld the decision in an NRD dated March 13, 2023, and noted

further that services must be “consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational”. See ¶ 6. Respondent has burden of proof to show by a preponderance of evidence that the Respondent’s determination was correct. See ¶ 12.

20. 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 ¶ 15 – 16. In the Definitions Policy, two components of medical necessity are that services must be “individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness under treatment, and not in excess of the patient's needs” and “consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational.” See ¶ 17. Appendix 9.0 of the BA Policy maintains that the “behavior plan is the cornerstone of the delivery of behavior analysis services.” See ¶ 14. In light of this, the BA Policy criteria for continuation of treatment at the present level and/or using current methods requires that providers must ensure that all criteria are met. This includes “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.” See ¶ 14. The BA Policy criteria for discharge from behavior analysis services outlines that one or more of the criteria must be satisfied. See ¶ 14. One such criteria, *supra*, maintains that data provided shows the recipient has made no progress toward any goals in the last 12 consecutive months.

21. The record shows that Petitioner requires ABA services as medically necessary. See ¶ 2 – 3. As provided in the Treatment Plan, Petitioner is engaging in the following maladaptive behaviors: [REDACTED]

appropriate modifications and interventions in the Treatment Plan in conformity with standards of care within the field of behavior analysis.

23. Assuming *arguendo* that the provider did not submit a treatment plan corresponding with the correct child as [REDACTED] contends, this theory leads to suggest that the provider has committed malpractice and, essentially, would not be a credible source to support their continued care for Petitioner. Petitioner did not introduce any evidence that the provider attempted to correct any such mistake in their submission of the Treatment Plan. Nonetheless, in totality of the circumstances, there does not appear to be evidence to support any additional benefit Petitioner would receive by continuing ABA services with the current provider.

24. 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 ¶ 18. According to Dr. Bicard’s testimony, the provider’s Treatment Plan shows ineffective treatment and has not shown progress to support medical necessity. See ¶ 8, 22. Petitioner’s argument rests on the summary in Petitioner’s IEP and support for continuation of services by professionals in the school setting. See ¶ 9. The IEP contains several rationale and provisions to address Petitioner’s [REDACTED]. See ¶ 9. The IEP also includes Petitioner’s [REDACTED] perception that Petitioner’s behavior has shown improvement. See ¶ 9. As previously discussed, even in the light most favorable to Petitioner, Petitioner’s goals showed very little to no progress with incidents of maladaptive behaviors occurring at high frequencies. See ¶ 3, 22. After [REDACTED] of therapy with this provider, the graph data recorded here do not reflect in an upwards direction but are all relatively leveled. See ¶ 3, 22. Further, the undersigned finds that the record demonstrates the provider’s lack of intervention or modification to the


Treatment Plan, and Petitioner's lack of progress in the last 12 consecutive months. What the undersigned finds as significantly unfortunate are the services rendered to Petitioner in the last [REDACTED] that have barely resulted in adequate therapy to address Petitioner's [REDACTED]. All in all, the undersigned finds that Respondent presented sufficient, persuasive evidence to demonstrate that ABA services with this provider are in excess of Petitioner's needs and that discharge from ABA services was warranted.

25. Upon consideration of the testimony provided, evidence submitted, and applicable polices, the undersigned concludes that Respondent proved by a preponderance of the evidence that the termination of ABA services was correct. 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 ABA services is **AFFIRMED**. Petitioner's appeal based on Respondent's termination is **DENIED**.

DONE AND ORDERED this 24th day of July, 2023 in Tallahassee, Leon County, Florida.

 Kimberly Roche
23-FH0535
2023.07.24 08:15:32
-04'00'

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:



Joseph G. Hern, Jr., Esq.
Counsel for Respondent
Joseph.Hern@ahca.myflorida.com

AHCA Medicaid Hearing Unit
MedicaidHearingUnit@ahca.myflorida.com