FILED
Sep 26, 2023, 10:10 am
OFFICE OF FAIR HEARINGS

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

[redacted]

PETITIONER, **AHCA Case No.: 23-FH1682**

vs.

AGENCY FOR HEALTH CARE ADMINISTRATION,

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned Hearing Officer convened a telephonic Fair Hearing on the instant case on August 31, 2023, at 9:01 a.m. Eastern Standard Time ("EST").

APPEARANCES

For the Petitioner: [redacted]
Petitioner's Authorized Representative

For the Respondent: Marielisa Amador
Medical Health Care Program Analyst
Agency for Health Care Administration

STATEMENT OF ISSUE

The issue is whether Respondent proved by a preponderance of the evidence that Respondent's termination of Petitioner's behavior analysis ("ABA" or "BA") services was correct.

PRELIMINARY STATEMENT

All parties and witnesses appeared telephonically. [redacted] ("[redacted]"), Petitioner's Authorized Representative and [redacted] appeared on behalf of Petitioner.

Chrissie Simmons, Medical Health Care Program Analyst and Fair Hearing Liaison for the Agency for Health Care Administration ("Agency" or "AHCA"), appeared for the Fair Hearing as a representative for Respondent. Dr. Alissa Conway ("Dr. Conway"), Board-Certified Behavior Analyst at the Doctoral Level ("BCBA-D") and Second Level Reviewer for eQHealth Solutions, appeared for the Fair Hearing as a witness for Respondent.

Prior to the Fair Hearing, Petitioner sent to the Office of Fair Hearings and Respondent a one hundred and seventy-nine (179)-page evidence packet. The one hundred and ninety-two (192)-page packet appears in the Office of Fair Hearings' document management system as the file titled "23-FH1682 Petitioner Correspondence – FAX 7 17 2023 1 58 PM.pdf", "23-FH1682 Petitioner Correspondence – FAX 7 17 2023 2 21 PM.pdf", "23-FH1682 Petitioner Correspondence – FAX 7 17 2023 1 11 PM.pdf", and "23-FH1682 Petitioner Correspondence – FAX 7 17 2023 1 33 PM.pdf". Absent any objections from Respondent, the undersigned admitted the one hundred and seventy-nine (179)-page evidence packet as Petitioner's Composite Exhibit 1 ("PCE 1").

Prior to the Fair Hearing, Respondent sent to the Office of Fair Hearings and Petitioner a three hundred and ninety-two (392)-page evidence packet and a forty-nine (49)-page evidence packet. The three hundred and ninety-two (392)-page packet appears in the Office of Fair Hearings' document management system as the files titled "[redacted] FH 08.31.2023 1 – 152.pdf", "[redacted] FH 08.31.2023 153 – 298.pdf", and "[redacted] FH 08.31.2023 299 – 392.pdf". The forty-nine (49)-page packet appears in the Office of Fair Hearings' document management system as the file titled "23-FH1682 AHCA Evidence packet.pdf". Absent any objections from Petitioner, the undersigned admitted the three hundred and ninety-two (392)-

page evidence packet as Respondent's Composite Exhibit 1 ("RCE 1") and the forty-nine (49)-page evidence packet as Respondent's Composite Exhibit 2 ("RCE 2").

FINDINGS OF FACT

1. Petitioner receives Medicaid services on a fee-for-service basis through the Agency. *See* RCE 1 at 16. 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] old. *See* RCE 1 at 16. Petitioner is diagnosed with [redacted]. *Id*. at 16, 17,

3. As provided in the [redacted] Behavior Analysis Re-Assessment ("Reassessment"), dated [redacted], Petitioner is engaging in the following maladaptive behaviors: [redacted]. *Id.* at 51. Petitioner is learning the following replacement behaviors: [redacted]. *Id.* at 51 – 52.

4. As provided in the Reassessment, Petitioner has made the following progress in reducing [redacted] maladaptive behaviors, between [redacted]: for [redacted] Petitioner's incidents increased from approximately [redacted] to approximately [redacted] for [redacted], Petitioner's incidents increased from approximately [redacted] to approximately [redacted] for [redacted]

[redacted], Petitioner's incidents increased from approximately [redacted] to approximately [redacted] for [redacted], Petitioner's incidents increased from approximately [redacted] to approximately [redacted] for [redacted], Petitioner's incidents increased from approximately [redacted] to approximately [redacted] for [redacted] Petitioner's incidents increased from approximately [redacted] to approximately [redacted] for [redacted], Petitioner's incidents increased from approximately [redacted] to approximately [redacted] for [redacted], Petitioner's incidents increased from approximately [redacted] to approximately [redacted] for [redacted], Petitioner's incidents decreased from approximately [redacted] to approximately [redacted] and for [redacted] Petitioner's incidents increased from approximately [redacted] to approximately [redacted] *Id.* at 372 – 377.

5. On April 24, 2023, Petitioner requested continuation of BA services; specifically, 312 units of code 97155; 104 units of code 97156; and 2,600 units of code 97153. *See* RCE 1 at 22. In a Notice of Outcome ("NOO"), dated May 10, 2023, Respondent denied Petitioner's request. *Id.* at 22 – 26. The NOO states as follows:

> Code: 97155 Intervention without protocol modification, per 15 minutes
> From: 5/10/23
> Thru: 11/5/23
> Total Units: Denied 312
>
> Code: 97156 Family training, per 15 minutes, Lead Analyst
> From: 5/10/23
> Thru: 11/5/23
> Total Units: Denied 104
>
> Code: 97153 Intervention without protocol modification, per 15 minutes, Lead Analyst, BCaBA, or RBT
> From: 5/10/23
> Thru: 11/5/23
> Total Units: Denied 2,600

The NOO explained the basis for the termination 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. Specially, the 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.
>
> Consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational.

The NOO further provided:

> The rationale for our decision is as follows:
>
> > PR Principal Reason – Denial:
> >
> > 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 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. The justification submitted with this treatment is insufficient given the requested units and the recipient's maladaptive behaviors and skill deficits addressed in this treatment plan. This request is denied.

. . .
RCE 1 at 22 – 23.

6. In a Notice of Reconsideration Determination ("NRD"), dated July 13, 2023, Respondent upheld its decision. *Id*. at 34 – 37. The NRD explained the basis for the decision as follows:

> PR Principal Reason – Denial
>
> Submitted information does not support the medical necessity for requested frequency and/or duration.
>
> PR Clinical Rational – Denial: 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 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.
> . . .

RCE 1 at 35.

7. On July 12, 2023, Petitioner requested a Fair Hearing to challenge the termination BA services. On August 7, 2023, the Office of Fair Hearings issued an Order Scheduling Fair Hearing and Prehearing Instructions, setting the hearing for August 31, 2023, at 9:00 a.m. EST.

8. Dr. Conway is a BCBA and a Second Level Reviewer for eQHealth. Dr. Conway testified to the following:

a. eQHealth is the quality improvement organization contracted by Florida Medicaid to review requests for BA services for medical necessity. Medical necessity means that the medical or allied cares, goods, or services must meet the medical

necessity criteria. Dr. Conway read the five (5) medical necessity criteria into the record.

b. Petitioner has received BA services with this provider since [redacted], over [redacted] There has been no sufficient progress and lack of modification to the treatment plan to address the lack of progress. The treatment plan does not meet condition three (3) of the medical necessity criteria: be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational. *See* RCE2 at 7.

c. One of the criteria for discharge from receiving BA services is if there is no progress for twelve (12) months in addition to lack of modification for that lack of progress.

d. Dr. Conway reviewed the graphs regarding problem behaviors. In general, the data shows no progress or level trends and significant increases across behaviors.

e. The graph for [redacted] shows data from [redacted] through [redacted]. *See* RCE 1 at 372. There were significant increases in this maladaptive behavior and the increases continued through the end of the authorization period. It is expected that the behavior would go in a downward or decreasing trend.

f. The graph for [redacted] shows level trends through the beginning of the authorization period and then the maladaptive behavior increased in [redacted] when the new registered behavior technician (RBT) started. *See* RCE 1 at 373. The levels continued to increase and maintain above baseline levels.

g. The maladaptive behavior of [redacted] is a new behavior and progress cannot be determined. *See* RCE 1 at 373.

h. The graph for [redacted] shows that the behavior levels continued to increase to above [redacted] ([redacted] which is significantly above the baseline level. *See* RCE 1 at 374.

i. The graph for [redacted] has an inappropriate scale because the Y-Axis does not start at zero (0). *See* RCE 1 at 374. After an initial decrease in this maladaptive behavior, the behavior increased with a new RBT and remained above levels of [redacted] after a [redacted] of service.

j. The graph for [redacted] also has an inappropriate scale because the Y-Axis does not start at zero (0). *See* RCE 1 at 375. The levels of this maladaptive behavior increased throughout the authorization period. The decrease was minimal due to the scale provided here. The behavior increased to levels above baseline levels at the end of the authorization period.

k. The graph for [redacted] shows levels maintained throughout the beginning of the authorization period and then a significant increase throughout the remainder of the authorization period. *See* RCE 1 at 375.

l. The graph for [redacted] shows an increase in the behavior to levels significantly above the baseline level. *See* RCE 1 at 376.

m. The graph for [redacted] shows an increase in the behavior before and after the new RBT, to levels above the baseline level. *See* RCE 1 at 376.

n. The graph for [redacted] also has an inappropriate scale because the Y-Axis does not start at zero (0). *See* RCE 1 at 377. This behavior has continued to increase throughout the authorization period.

o. The graph for [redacted] shows continued increasing trends throughout the authorization period. *See* RCE 1 at 377.

p. Overall, the maladaptive behaviors show no progress or level trends throughout the majority of the authorization period. Also, there were significant increases in all maladaptive behaviors above baseline levels from [redacted].

q. The graphs for the replacement goals of [redacted] and [redacted] show an increasing trend throughout the authorization period, but the levels end at about [redacted] to [redacted] performance after [redacted] ([redacted] years of service. *See* RCE 1 at 302 – 303.

r. The graph for the replacement goal of [redacted] shows levels at [redacted] or below. *See* RCE 1 at 304. The provider discontinued the goal instead of adding teaching skills, prompts, or something to improve Petitioner's performance. *Id.* The same goes for the goals of [redacted]. *See* RCE 1 at 305 – 307, 310, 316.

s. The graph for the replacement goal of [redacted] shows performance around [redacted] during the last two weeks of service, but this was after [redacted] ([redacted] of service and still includes prompts for Petitioner. *See* RCE 1 at 308.

t. The graph for the replacement goal of [redacted] shows performance at about [redacted] to [redacted] with verbal prompts. *See* RCE 1 at 309.

u. The graph for the replacement goal of [redacted] shows performance at about [redacted] to [redacted] at the end of the authorization period with modeling prompts. *See* RCE 1 at 311.

v. The graph for the replacement goal of [redacted] for [redacted] shows performance at about [redacted] to [redacted] with verbal prompts. *See* RCE 1 at 312.

w. The graph for the replacement goal of [redacted] shows levels at [redacted] with modeling prompts. *See* RCE 1 at 313. This goal was started in [redacted] and has been worked on for [redacted].

x. The graph for the replacement goal of [redacted] shows performance still around [redacted] to [redacted] at the end of the authorization period. *See* RCE 1 at 314.

y. The graph for the replacement goal of [redacted] shows performance of [redacted] still with a verbal prompt. *See* RCE 1 at 315.

z. The graphs for the new replacement goals of [redacted], cannot determine progress because they are baseline skills that have one to a few data points. *See* RCE 1 at 318 – 324.

aa. The replacement goals do show some minimal progress, but the progress is extremely limited for over [redacted] of service and all goals have some sort of prompt or assistance still in place.

bb. Some of the replacement goals also have inappropriate scales because the Y-Axis should end at 100% but many of the graphs end lower than that, which makes the graph indicate more progress than what actually occurred.

cc. In response to the lack of progress, the provider stated that some of the issues were surrounding the new RBT. The provider responded to the lack of progress with minimal modifications to the treatment plan, such as [redacted], [redacted] [redacted]

dd. Overall, Petitioner shows increases across all maladaptive behaviors throughout the authorization period and minimal progress through all replacement skills over [redacted] of service.

9. [redacted], Petitioner's [redacted] testified to the following:

a. Petitioner is currently diagnosed with [redacted].

b. The services provided were not being done correctly.

c. Petitioner's previous RBT was not collecting data.

d. Petitioner's new RBT was starting to make a difference.

e. [redacted] would like to continue the services for Petitioner.

f. [redacted] feels Petitioner will not pass [redacted] if [redacted] does not keep the services and that Petitioner will need to be placed in a smaller classroom without individual support.

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 second 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)(b) 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 not duplicate another service
> - Meet the criteria as specified in this policy
>
> **4.2 Specific Criteria**
> Florida Medicaid covers the following BA services in accordance with the applicable Florida Medicaid fee schedule(s), or as specified in this policy:
> **4.2.1 Behavior Assessment**

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

4.2.2 Behavior Analysis

Up to 40 hours per week, per recipient, consisting of services identified on the recipient's behavior plan in order to reduce maladaptive behaviors and to restore the recipient to his or her best 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
- 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 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 General Policies on authorization requirements.

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 than 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

. . .
BA Policy at 6 – 8.

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 [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.

17. The Definitions Policy, incorporated by reference in Fla. Admin. Code R. 59G-1.010, defines "Medically Necessary" or "Medical Necessity" as follows:

> The medical or allied care, goods, or services furnished or ordered must meet the following conditions:
>
> - Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate pain
> - Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs
> - Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational
> - Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available statewide
> - Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider

> The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services does not, in itself, make such care, goods or services medically necessary or a medical necessity or a covered service.

18. The Florida Medicaid Authorization Requirements Policy ("Authorization Requirements Policy") incorporated by reference in Fla. Admin. Code R. 59G-1.053, provides as follows:

> **3.2.1 Continued Authorization Requests**
> The QIO shall not deny or reduce the amount, frequency, or duration of a service that is already being provided, unless:
> - The reduction is to correct for factual 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.

19. In the instant case, Respondent terminated Petitioner's ABA services. *See* ¶ 5. The data did not show improvement in the maladaptive behaviors. *See* ¶ 4, 8. In the NOO dated May 10, 2023, Respondent explained that continuing services with the current provider were not medically necessary, specifically, that it did not meet the requirements 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 investigation." *See* ¶ 5. Respondent further explained that "[t]he information submitted does not meet standards of care within the field of behavior analysis" and that "[t]he justification submitted with this treatment is insufficient given the requested units and the recipient's maladaptive behaviors and skill deficits addressed in this treatment plan." *See* ¶ 5.

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* ¶ 16. As provided in section 2.83 of 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* ¶ 17. As shown by the record, Petitioner's submitted treatment plan shows no improvement regarding the reduction of maladaptive behaviors and little improvement in increasing Petitioner's replacement behaviors. *See* ¶ 4, 8. Dr. Conway explained that there has been no sufficient progress and lack of modification to the treatment plan to address the lack of progress. *See* ¶ 8. Further, Dr. Conway explained that the maladaptive behaviors show no progress or level trends throughout a majority of the authorization period, that there were significant increases in all maladaptive behaviors above baseline levels, and that the replacement goals show some minimal progress. *Id.* In all, based on Dr. Conway's credible and convincing testimony and the lack of progress in the treatment, Respondent demonstrated that the provider's treatment is not "consistent with generally accepted professional medical standards as determined by the Medicaid program".

21. 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. As discussed, supra ¶ 20, the current treatment plan is ineffective. Here, Petitioner's lack of improvement is well documented.

22. 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 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 plans 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 BA 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 is **DENIED**.

DONE AND ORDERED this 26th day of September, 2023 in Tallahassee, Leon County, Florida.

KAMEISHA PRESLEY, 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.

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[redacted]

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