



FILED

Oct 23, 2023, 12:18 pm
OFFICE OF FAIR HEARINGS

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

[REDACTED],

PETITIONER,

AHCA Case No.: 23-FH1858

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 September 12, 2023, at 8:58 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 Behavior Analyst with [REDACTED] [REDACTED], appeared on behalf of Petitioner. Petitioner’s

██████████ and ██████████ appeared at the Fair Hearing as witnesses for Petitioner.

Marielisa Amador (“Ms. Amador”), Medical Health Care Program Analyst for the Agency for Health Care Administration (“Agency” or “AHCA”), appeared at the Fair Hearing as a representative for Respondent. Dr. Kathy Hurley (“Dr. Hurley”), a Board-Certified Behavior Analyst (“BCBA”) at the Doctoral Level (“BCBA-D”) and a Licensed Mental Health Counselor in the Department of Utilization Management for eQHealth Solutions, Inc. (“eQHealth”), appeared at the Fair Hearing as a witness for Respondent.

Prior to the Fair Hearing, Petitioner sent to the Office of Fair Hearings and Respondent a thirteen (13)-page evidence packet. The thirteen (13)-page packet appears in the Office of Fair Hearings’ document management system as the file titled “23-FH1858 Supporting Documents.pdf”. Absent any objections from Respondent, the undersigned admitted the thirteen (13)-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 one hundred and ninety-eight (198)-page evidence packet and a forty-nine (49)-page evidence packet. The one hundred and ninety-eight (198)-page packet appears in the Office of Fair Hearings’ document management system as the files titled “██████████ FH 09.12.20023 1 – 150.pdf” and “██████████ FH 09.12.20023 151 – 198.pdf”. The forty-nine (49)-page packet appears in the Office of Fair Hearings’ document management system as the file titled “23-FH1858 AHCA Evidence (Pages 1-49 of 49).pdf”. Absent any objections from Petitioner, the undersigned admitted the one hundred and ninety-eight (198)-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, 58.

3. As provided in the [REDACTED] Behavioral Assessment ("Behavioral Assessment"), Petitioner is engaging in the following maladaptive behaviors: [REDACTED]. *Id.* at 57.

4. Petitioner is receiving the following treatment procedures: [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED] *Id.* at 108 – 113.

5. As provided in the Behavioral Assessment, Petitioner is exhibiting variable data regarding the maladaptive behaviors. *Id.* at 81 – 91.

6. On July 6, 2023, Petitioner requested continuation of BA services; specifically, 3,120 units of code 97153; 312 units of code 97155; 468 units of code 97155 (HN); and 156 units of code 97156. *Id.* at 26.

7. In response to the request, eQHealth issued a Request for Additional information, dated July 13, 2023, which stated in pertinent part:

...

We received a request for authorization of services for the above referenced Medicaid beneficiary. Our review of this request has been pended because of a lack of information described below:

Provider, there are two separate requests for 97155 HN submitted. Please clarify the total number of units requested.

Provider, you were authorized for caregiver training units and there is no data for progress throughout the authorization. Please submit clarification.

Provider, please review and review your treatment plan. The definitions of behaviors under treatment must be written according to generally accepted practice within the field of ABA and according to AHCA standards of care (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 stages. The behaviors should be inclusive and not open ended, have definite on-set and off-set and should not overlap with other target behaviors definitions. Please review your plan carefully to ensure the accuracy of the information submitted for review.

Provider, the justification for this request for services is not clear. eQHealth Solutions reviewer requires more information on coping/self-regulation/self-calming/relaxation strategies and goals (pp52-53), social stories, and sensor activities/alternatives listed in

your plan. Please note that these methods may not conform to standards of care within the field of applied behavior analysis. Please explain all procedures in detail/remove strategies.

...

RCE 1 at 51 – 52.

8. In a Notice of Outcome (“NOO”), dated July 24, 2023, Respondent denied Petitioner’s request. *Id.* at 26 – 30. The NOO states as follows:

Code: 97153 Intervention without protocol modification, per 15 minutes, Lead Analyst, BCaBA, or RBT
From: 7/24/23
Thru: 1/19/24
Total Units: Denied 3,120

Code: 97155 Intervention without protocol modification, per 15 minutes
From: 7/24/23
Thru: 1/19/24
Total Units: Denied 312

Code: 97155 HN Intervention without protocol modification, per 15 minutes
From: 7/24/23
Thru: 1/19/24
Total Units: Denied 468

Code: 97156 Family training, per 15 minutes, Lead Analyst
From: 7/24/23
Thru: 1/19/24
Total Units: Denied 156

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. 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.

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:

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: Calming/Coping/self-regulation/self-calming/relaxation strategies (self-regulation) goals, social stories, and sensory activities/alternatives are not empirically supported procedures within the conceptual system of behavior analysis for treating the functions of maladaptive behavior. According to Behavior Analysis Services Coverage Policy (page – 6-7), treatment that does not meet generally accepted standards of care within the field of applied behavior analysis are not covered under the behavior analysis service coverage policy. Additionally, services cannot be provided on a speculative basis. The provider indicated the lack of caregiver training data is due to lack of availability. This request for BA services is denied.

...

RCE 1 at 26 – 27.

9. In a Notice of Reconsideration Determination (“NRD”), dated July 27, 2023, Respondent upheld its decision. *Id.* at 38 – 41. 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:

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 goals and protocols described in this treatment plan includes sensory enrichment strategies/coping strategies, alternative strategies, social stores are not empirically supported procedures within the conceptual system of behavior analysis for treating the functions of maladaptive behavior of children with [REDACTED] and related disabilities. According to Behavior Analysis Services Coverage Policy (page – 6-7), treatment that does not meet generally accepted standards of care within the field of applied behavior

analysis are not covered under the behavior analysis service coverage policy. This reconsideration has been reviewed, reconsidered and the denial is upheld.

...

RCE 1 at 39.

10. On July 28, 2023, Petitioner requested a Fair Hearing to challenge the termination of BA services. On August 18, 2023, the Office of Fair Hearings issued an Order Scheduling Fair Hearing and Prehearing Instructions, setting the hearing for September 12, 2023, at 9:00 a.m. EST.

11. Dr. Hurley, BCBA-D and a Licensed Mental Health Counselor with eQHealth, testified to the following:

a. ABA services are technical and scientific. The crux of the denial is that everything done in BA is to be done in a systematic methodology. The information submitted by Petitioner's provider is not presented in a way that is systematic and can be measurable and objective. Everything in Petitioner's treatment plan needs to be observable and measurable.

b. Regarding Petitioner's maladaptive behaviors, the treatment plan states Petitioner will become aware of the behavior and will redirect [REDACTED] to an appropriate behavior. See RCE at 105. Respondent is asking how this behavior can be measured.

c. The treatment plan states Petitioner will [REDACTED]; specifically, "For this skill, the expectation is both that [Petitioner] uses the strategy when prompted, and that using the strategy results in [Petitioner] [REDACTED]." See RCE at 106. Further, "the [REDACTED] strategies should be specific to [Petitioner] and the environment," as well as "[t]his skill may not be relevant for some children who can already [REDACTED]

[REDACTED] *Id.* Respondent does not know the definition of

“ [REDACTED] ” and believes it to be obtuse. “ [REDACTED] ” is an open-ended terminology that does not have any objective or measurable criteria, so it does not meet the criteria of BA.

- d. The treatment modality of relaxation does not fit with ABA yet. Relaxation can help ameliorate the function of maladaptive behaviors.
- e. The treatment plan needs to be re-worked in terms of ABA in order to be measurable and objective and actually have meaning for Petitioner.
- f. Petitioner’s provider has the opportunity to go to a peer to peer if they do not understand why BA services were denied.
- g. The provider’s treatment plan does not meet the standards of care of ABA, nor was there anything added to rectify that in terms of becoming measurable and objective. The provider’s treatment plan is more of a mental health treatment plan than a BA treatment plan.
- h. Dr. Hurley referred to Appendix 9.0 of the Behavior Analysis Services Coverage Policy (“BA Policy”), *see* RCE 2 at 45, and reviewed the criteria for BA services and reassessments.
- i. Respondent is looking to see that every part of the provider’s treatment plan is objective and measurable. The treatment plan fell short of all the criteria for medical necessity. Dr. Hurly reviewed the medically necessary criteria. *See* RCE 2 at 43.
- j. As the treatment plan stands, it does not meet the standards for medical necessity.

- k. The provider was asked on several occasions to be more specific and to add specific strategies. The justification for the request for services is not clear.

12. [REDACTED], Petitioner's Authorized Representative and [REDACTED], testified to the following:

- a. Petitioner started services with the provider on [REDACTED].
- b. There are thirty-three (33) targets in the treatment plan for Petitioner. See RCE 1 at 108 – 113.
- c. [REDACTED] believes that the respondent made its denial decision based only on the word "[REDACTED]".
- d. Regarding the goal of [REDACTED] it is not used to refer to a private or covert event. It was used to describe a group of behaviors to prompt Petitioner in engagement. See RCE 1 at 106. "[REDACTED]" is open for discussion.
- e. The provider received the request to provide more information for the use of coping regulations, self-calming goals and strategies. The provider responded with research and articles that stated the specific terminology and strategy.
- f. In response to the request for additional information, the provider made the behavioral definitions more inclusive, detailed, and objective.
- g. Other than the research articles,
- h. The provider believes it was not clear what information Respondent was requesting.
- i. The treatment plan is comprehensive.
- j. Petitioner has made great progress with the treatment plan.

13. [REDACTED], Petitioner's [REDACTED] testified to the following:
 - a. Petitioner has regressed since services were ended.
 - b. Petitioner needs constant re-direction.
14. [REDACTED], Petitioner's [REDACTED] testified to the following:
 - a. There have been changes since the last therapy session.

CONCLUSIONS OF LAW

15. 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).
16. This hearing was held as a *de novo* proceeding pursuant to Fla. Admin. Code R. 59G-1.100(17)(b).
17. 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.).
18. 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.

BA Policy at 1 – 3.

19. 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

...

BA Policy at 6 – 8.

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. 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.

22. 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.

Definitions Policy at 7.

23. 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.

24. In the instant case, Respondent terminated Petitioner's ABA services. See supra ¶ 8. Respondent requested more information on coping/self-regulation/self-calming/relaxation strategies and goals, social stories, and sensor activities/alternatives listed in the provider's plan.

See supra ¶ 7. In the NOO dated July 24, 2023, Respondent explained that continuing services with the current provider was not medically necessary, specifically, that the services 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 supra ¶ 8. Respondent further explained that “treatment that does not meet generally accepted standards of care within the field of applied behavior analysis are not covered under the behavior analysis service coverage policy” and that “services cannot be provided on a speculative basis.” See supra ¶ 8.

25. As provided by the EPSDT requirements, see supra ¶ 21, the recipient must meet the medical necessity criteria, as outlined in Fla. Admin. Code R. 59G-1.010. As provided in the Definitions Policy, a component of medical necessity is that services must be “consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational”. See supra ¶ 22. As shown by the record, Petitioner’s treatment plan from the provider has thirty-three (33) targets, including the target or goal of [REDACTED].” See supra ¶ 11, 12. Dr. Hurley testified that “[REDACTED]” is open-ended terminology that does not have any objective or measurable criteria, so it does not meet the criteria of BA. See supra ¶ 11. In the NRD dated July 27, 2023, Respondent explained that the treatment plan includes sensory enrichment strategies/coping strategies, alternative strategies, and social stores that are not empirically supported procedures within the conceptual system of behavior analysis for treating the functions of maladaptive behavior of children with [REDACTED] and related disabilities. See supra ¶ 9. Further, Dr. Hurley explained that the treatment plan needs

to be re-worked in terms of behavior analysis services in order to be measurable and objective. See supra ¶ 9. On behalf of petitioner, ██████ testified that the goal of ██████ in the treatment plan is open for discussion and that it is used to describe a group of behaviors to prompt Petitioner in engagement. See supra ¶ 12. However, Dr. Hurley testified that the treatment plan fell short of all the criteria for medical necessity, that the provider was asked on several occasions to be more specific, and that the justification for the request for services was not clear. See supra ¶ 11. In all, based on Dr. Hurley's credible testimony and the inclusion of open-ended terminology that does not have any objective or measurable criteria, Respondent demonstrated that the provider's treatment is not "consistent with generally accepted professional medical standards as determined by the Medicaid program".

26. 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 ¶ 23. As discussed, see supra ¶ 24, the current treatment plan is ineffective.

27. Upon consideration of the testimony provided, evidence submitted, and applicable policies, the undersigned concludes that Respondent proved by a preponderance of the evidence that the termination of ABA services was necessary. Looking at all the evidence relevant to the particular needs of Petitioner, Respondent has demonstrated that the previously authorized services, based on the treatment 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 23rd day of October, 2023 in Tallahassee, Leon County, Florida.




Kameisha Presley
23-FH1858
2023.10.23 10:46:19 -04'00'

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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