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OFFICE OF FAIR HEARINGS

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

[redacted],

PETITIONER, **AHCA Case No.: 23-FH2118**

vs.

AGENCY FOR HEALTH CARE ADMINISTRATION,

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic Fair Hearing on the instant case on October 17, 2023, at 9:00 a.m. Eastern Standard Time ("EST").

APPEARANCES

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

For the Respondent: Sandra Durden
Medical/Health Care Program Analyst
Agency for Health Care Administration

STATEMENT OF ISSUE

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

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

PRELIMINARY STATEMENT

All parties and witnesses appeared telephonically. Petitioner's Authorized Representative and [redacted], [redacted] ("[redacted]") appeared on behalf of Petitioner. Suzanna Wenzel ("Ms. Wenzel"), Board Certified Behavior Analyst ("BCBA"), appeared as a witness for Petitioner.

Sandra Durden, Medical/Health Care Program Analyst for the Agency for Health Care Administration ("Agency" or "AHCA"), appeared on behalf of Respondent. Dr. David Bicard ("Dr. Bicard"), BCBA at the doctoral level and Director of Clinical Operations for eQHealth Solutions Inc. ("eQHealth") appeared as a witness for Respondent.

Prior to the hearing, Respondent sent to the Office of Fair Hearings and Petitioner a 268-page evidence packet and a forty-nine (49)-page evidence packet. The 268-page packet appears in the Office of Fair Hearings' document management system as the file titles "[redacted] FH 10.17.2023 1-148.pdf" and "[redacted] FH 10.17.2023 149-268.pdf". The forty-nine (49)-page evidence packet appears in the Office of Fair Hearings document management system as the file title "23-FH2118 AHCA Evidence PKTS.pdf". Absent an objection from the Petitioner, the undersigned admitted 268-page evidence packet into evidence as Respondent's Composite Exhibit 1 ("RCE 1") and the forty-nine (49)-page evidence packet into evidence as Respondent's Composite Exhibit 2 ("RCE 2").

At the Fair Hearing, the record was held open to allow Petitioner to submit documents. On October 17, 2023, the Office of Fair Hearings timely received a five (5)-page evidence packet from Petitioner. The five (5)-page packet appears in the Office of Fair Hearings' document management system as file title "23-FH2118 Evidence.pdf". Absent an objection from

Respondent, the undersigned hereby admits Petitioner's five (5)-page document as Petitioner's Exhibit 1.

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* page 2 of RCE 2.

2. Petitioner is [redacted]. *See* page 16 of RCE 1. Petitioner is diagnosed with the following: [redacted] ("[redacted]"); [redacted] ("[redacted]"); [redacted]; [redacted]; [redacted]; [redacted]; and [redacted]. *Id.* at 233.

3. As provided by the Behavior Analysis Re-Assessment July 2023 ("treatment plan" or "behavior plan"), Petitioner is engaging in the following maladaptive behaviors: [redacted]; [redacted]; [redacted]; [redacted]; and [redacted]. *Id.* at 243 – 256.

4. As provided in the treatment plan, Petitioner is learning the following replacement behaviors: [redacted]; [redacted]; [redacted]; [redacted]; [redacted]; [redacted]; [redacted]; [redacted]; [redacted]; [redacted]; [redacted]; and [redacted]. *Id.* at 258 – 262. Graph data was not included for: [redacted]; [redacted]; and [redacted]. *Id.* at 260 – 262.

5. As testified to by Dr. Bicard, in the prior Petitioner received the following ABA services: 2,600 units of code 97153; 312 units of code 97155; and 104 units of code 97156. For the authorization period July 11, 2023, through January 6, 2024, Petitioner requested an increase in services; specifically, 3,640 units of code 97153; 416 units of code 97155; and 156 units of code 97156. *Id.* at 23. In a Notice of Outcome ("NOO"), dated July 21, 2023, Respondent terminated Petitioner's ABA services. *Id.* at 23 – 25. The NOO explained the basis for the termination as follows:

> [T]he 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 or injury under treatment, and not in excess of the patient's needs.

The NOO further provided:

> PR Principal Reason – Denial:
>
> Submitted information does not support the medical necessity for requested frequency and\or duration.
>
> Requested services are denied because documentation is neither showing [i]mprovement nor support for maintenance.
>
> PR Clinical Rationale – Denial: 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 states ([redacted]- describes intention). The behaviors should have clear boundaries, definite on-sets and off-sets, should not overall with other target behaviors definitions, and not be a listing of behaviors that the recipient is engaging in. The behavior definitions in this treatment plan do not conform to the generally accepted standards of care within the field of applied behavior analysis.

> According to the Behavior Analysis Services Coverage Policy (9.2.b) all treatment plans submitted for modification of care must include updated data for all behaviors under treatment as well as changes to the treatment plan, if necessary. The provider was requested to submit updated graphs for all behaviors under treatment. The provider has not submitted all the graphs (missing skill acquisition/replacement behavior graphs).
>
> Provider included graphs and clarifying information about not intervening on maladaptive behaviors for months, keeping them in baseline. The behaviors have shown variability but remain at significantly high levels without intervention. This does not meet the standards of care in the field of applied behavior analysis. 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 should include one or more of the following: antecedent manipulation modifications, modifications of prompting procedures used in acquisition, modification in consequence-based strategies—ones that eight reduce maladaptive behavior or reinforce replacement behavior (e.g., manipulation of reinforcement schedules, switch to a 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.
>
> . . .

Pages 23 – 24 of RCE 1.

6. Petitioner requested reconsideration of the Respondent's decision. In a Notice of Reconsideration Determination ("NRD"), dated August 28, 2023, Respondent upheld its decision. *Id.* at 35 – 37. The NRD explained the basis for the decision as follows:

> 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 eighter 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.

Pages 35 – 36 of RCE 1.

7. On August 25, 2023, Petitioner requested a Fair Hearing to challenge the termination and denial of ABA services. On September 13, 2023, the undersigned issued an Order Scheduling Fair Hearing and Prehearing Instructions, setting the hearing for October 17, 2023, at 9:00 a.m. EST.

8. Dr. Bicard is a BCBA at the doctoral level. Dr. Bicard testified to the following:

   a. In this case the services terminated because they did not meet the generally accepted standards of care. The provider was given multiple opportunities to amend and correct the treatment plan but did not do so. There are instances in the treatment plan where behavior has been in baseline – meaning the provider is measuring the behavior, but not intervening on the behavior.

   b. Additionally, there are goals and protocols in the treatment plan that are below medical necessity for ABA, and could be trained by someone without ABA services in a less costly manner.

   c. The provider has not provided graph data for behaviors in treatment – including baseline. Further, the graphs that were provided are unreadable. In the field of ABA graphs are the "currency" determining whether or not treatment is effective. Dr. Bicard found it impossible to review Petitioner's progress based on the graphs that were submitted.

d. There is no explanation for the request in the dramatic increase in the request for services, and they are far in excess of Petitioner's needs.

e. For the maladaptive behavior of [redacted] there are many months where there is no intervention. The provider stated as follows: "This behavior was added to baseline in [redacted] with baseline data being collected across 12 [consecutive] weeks. Base line data needs to be collected prior to intervention in order to establish experimental control and in order to know if an intervention has an effect on changing the behavior, baseline data needs to be stable; the client needs to be responding consistently emitting the behavior at a stable rate" *See* page 245 of RCE 1.

f. Dr. Bicard explained that this explanation is not true. Interventions can occur when behavior is going in a "counter therapeutic direction" – meaning that behavior is getting worse. The provider is not performing an experiment and does not need to establish experimental control. Rather the provider only needs to establish that the behavior is occurring and obtain sufficient data points to make an intervention. It is not a standard of care to keep a problem behavior from treatment simply to wait for a behavior to stabilize. This is below the standards of care for behavior analysis and should never happen.

g. For the maladaptive behavior [redacted] the data are variable – which means the graphs goes up and down. There is no clear trend in the data which suggests that the environment has not been stabilized by the provider. *See* page 252 of RCE 1. There is no improvement in the behavior and there is no intervention. Part of the

job of a provider is to modify and change the protocols – this is done by the BCBA observing the recipient's response to treatment and making changes to the treatment plan. Petitioner was approved for protocol modification (code 97155) but no modification was done. It does not matter whether there is a replacement behavior, if the replacement behavior is not affecting the maladaptive behavior.

h. Regarding [redacted], the same rationale for not intervening in [redacted] was given here. *See* pages 254 of RCE 1. Again, the provider should make an intervention as soon as they determined why the behavior is occurring.

i. [redacted] is occurring at a low level, but there is no improvement in the behavior and there is no intervention. *See* page 256 of RCE 1.

j. Regarding the replacement behaviors, the graphs were placed in a table, and are consequently unreadable. This is not an appropriate way to display data. *See* page 258. There are no graphs for '[redacted]'; "[redacted]"; and "[redacted]". *See* page 260.

k. "[redacted]" is not a behavior that meets medical necessity criteria, it is not related to the symptoms or a confirmed diagnosis, and is not related to a maladaptive behavior. *See* page 261 of RCE 1. It is not an appropriate behavior to be put in a treatment plan by a behavior analyst and is probably best taught through speech therapy.

l. It is Dr. Bicard's opinion that this treatment plan falls short of the standards of care of ABA.

9. Ms. Wenzel is Petitioner's BCBA. Ms. Wenzel testified to the following:

a. Ms. Wenzel asserted that there were graphs associated with the replacement behaviors – but could not explain why those were not included in the treatment plan.

b. It was not provided in the pend that the unreadable graphs were a basis for the denial – had that been the case Ms. Wenzel would have resubmitted the graphs.

c. "[redacted]" was approved in a prior plan.

d. There was a spike in [redacted]. This occurred after the behavior had been archived, but reoccurred after five (5) months. There are higher rates of maladaptive behaviors in the home sessions as compared to the clinic.

e. [redacted] and [redacted] behaviors have been removed due to improvements in the behavior.

f. The request for an increase in behaviors is due to an increase in [redacted] and [redacted].

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, regarding the termination of services. 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. Because Petitioner is requesting additional services, Fla. Admin. Code R. 59G-1.100(17)(g) assigns the burden of proof to the Petitioner, regarding the request for additional services. 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.)

14. 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.

. . .

Pages 1 – 3 of BA Policy.

15. 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

. . .
Pages 6 – 8 of BA Policy.

16. 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.

17. Petitioner is under age 21, and therefore EPSDT applies to the 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.

18. 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.

19. The Florida Medicaid Authorization Requirements Policy ("Authorization 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 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.
>
> . . .

Page 3 of Authorization Policy.

A. Termination of ABA Services

20. In the NOO, dated July 21, 2023, Respondent terminated Petitioner's ABA services. *See* ¶ 5. Respondent explained that continuing ABA services with Petitioner's current provider was not medically necessary, specifically that continuation was not "consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational" and that services were not "individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment" and were "in excess of the patient's needs". *Id.* Further, Respondent explained that "Provider included graphs and clarifying information about not intervening on maladaptive behaviors for months, keeping them baseline."

21. As Respondent bears the burden of proof, Respondent must show that ABA services are no longer medically necessary for Petitioner. Two (2) components of medical necessity are that services must 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" and services

must be "consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational". At the Fair Hearing, Dr. Bicard provided credible testimony that the treatment plan at issue was not consistent with generally accepted professional medical standards. *See* ¶ 8. For example, the maladaptive behaviors "[redacted]" and "[redacted]" untreated while provider waited to establish a baseline. *Id.* Dr. Bicard explained that it is not the standard to refrain from treating a behavior while waiting for a behavior to stabilize. *Id.* Further, Dr. Bicard noted that there is no improvement in the behavior of [redacted], and no intervention. *Id.* As explained by Dr. Bicard, a BCBA is required to make changes to the treatment plan, and no modification was done. *Id.* Moreover, Petitioner's provider did not provide graphs for multiple replacements behaviors, which is not within the standards of care for ABA. *See* ¶¶ 3, 8. In all, the record shows that the treatment plan at issue is not "consistent with generally accepted professional medical standards as determined by the Medicaid program. Accordingly, Respondent demonstrated that it is not medically necessary for Petitioner to continue receiving ABA services through this provider.

22. As QIO for the Agency, eQHealth is authorized to termination services when the reviewing physician determines the recipient will not gain any additional benefit by continuing services at the current level." *See* ¶ 19. Here, the record shows that Petitioner will not receive sufficient benefit continuing services with the current provider. *See* ¶ 21.

23. 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 with this provider was necessary. Looking at all the evidence relevant to the particular needs of Petitioner, Respondent has demonstrated that the previously

authorized services, based on the treatment plan at issue in this case, are not necessary to correct or ameliorate a defect or a physical and mental illness or condition. Accordingly, Respondent provided by a preponderance of the evidence that Respondent's termination of ABA services was correct.

B. Denial of Additional ABA Services

24. Petitioner was previously approved to receive the following services: 2,600 units of code 97153; 312 units of code 97155; and 104 units of code 97156. *See* ¶ 5. Petitioner requested an increase of services: 3,640 units of code 97153; 416 units of code 97155; and 156 units of code 97156. *Id.* Respondent denied Petitioner's request for additional services and terminated Petitioner's previously approved services. *Id.* Respondent explained that additional services were not "consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational" and were not "individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment" and were "in excess of the patient's needs". *Id.*

25. As Petitioner bears the burden of proof, Petitioner must show that additional ABA services are medically necessary for Petitioner. Two (2) components of medical necessity are that services must 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" and services must be "consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational". At the Fair Hearing, Dr. Bicard described the request as a "dramatic increase" and that it is far in excess of Petitioner's needs. *See* ¶ 8. Ms. Wenzel argued that the request for an increase in behaviors is due to an increase in

[redacted] and [redacted]. *See* ¶ 9. Ultimately, as Respondent demonstrated that continuing services with the current provider was not medically necessary, an increase in services is similarly not medically necessary. As such, Petitioner did not demonstrate that additional services were medically necessary for Petitioner.

26. Upon consideration of the testimony provided, evidence submitted, and applicable policies, the undersigned concludes that Petitioner did not prove by a preponderance of the evidence that the request for additional ABA services with this provider was necessary. Looking at all the evidence relevant to the particular needs of Petitioner, Petitioner has not demonstrated that additional services, based on the treatment plan at issue in this case, are necessary to correct or ameliorate a defect or a physical and mental illness or condition. Accordingly, Petitioner did not prove by a preponderance of the evidence that Respondent's denial of additional ABA services was incorrect.

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**.

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

DONE and **ORDERED** this 4th day of December 2023, in Tallahassee, Leon County, Florida.

Joseph Mabry
23-FH2118
2023.12.04 07:40:01
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JOSEPH MABRY, Hearing Officer
Agency for Health Care Administration
Office of Fair Hearings

2727 Mahan Drive, Mail Stop # 11
Tallahassee, FL 32308-5407

NOTICE OF A RIGHT TO JUDICIAL REVIEW

A PARTY WHO IS ADVERSELY AFFECTED BY THIS FINAL ORDER IS ENTITLED TO JUDICIAL REVIEW, WHICH SHALL BE INSTITUTED BY FILING THE ORIGINAL NOTICE OF APPEAL WITH THE AGENCY CLERK OF AHCA, AND A COPY, ALONG WITH THE FILING FEE PRESCRIBED BY LAW, WITH THE DISTRICT COURT OF APPEAL IN THE APPELLATE DISTRICT WHERE THE AGENCY MAINTAINS ITS HEADQUARTERS OR WHERE A PARTY RESIDES. REVIEW PROCEEDINGS SHALL BE CONDUCTED IN ACCORDANCE WITH THE FLORIDA APPELLATE RULES. THE NOTICE OF APPEAL MUST BE FILED WITHIN 30 DAYS OF THE RENDITION OF THE ORDER TO BE REVIEWED.

Copies Furnished To:

[redacted]

AHCA Medicaid Hearing Unit
MedicaidHearingUnit@ahca.myflorida.com