



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

FILED

Dec 04, 2023, 8:47 am

OFFICE OF FAIR HEARINGS

[REDACTED]

PETITIONER,

AHCA Case No.: 23-FH2147

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 16, 2023, at 9:03 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 decision to terminate Petitioner's Behavior Analysis ("BA" or "ABA") services was correct.

PRELIMINARY STATEMENT

All parties and witnesses appeared telephonically. Petitioner's Authorized Representative, [REDACTED] (" [REDACTED] "), a Assistant Board Certified Behavior Analyst

("BCABA"), appeared on behalf of Petitioner. [REDACTED] (" [REDACTED]"), [REDACTED] of Petitioner, appeared as a witness for Petitioner.

Marielisa Amador ("Ms. Amador"), 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"), Board Certified Behavior Analyst and Director of Clinical Operations for eQHealth Solutions Inc. ("eQHealth"), appeared as a witness for Respondent.

Ethan, interpreter number 393141, appeared to offer translation services for the Petitioner.

Petitioner did not introduce any exhibits at the hearing. Prior to the hearing, Respondent sent to the Office of Fair Hearings and Petitioner a two-hundred and fifty-two (252)-page evidence packet and a forty-nine (49)-page evidence packet. The two-hundred and fifty-two (252)-page evidence packet appears in the Office of Fair Hearings' document management system as the file titles "[REDACTED] FH 10.16.2023 1-184.pdf" and "[REDACTED] FH 10.16.2023 185-252.pdf". The forty-nine (49)-page evidence packet appears in the Office of Fair Hearings' document management system as the file title "23-FH2147 AHCA Evidence (Pages 1-49 of 49).pdf". Absent an objection from the Petitioner, the undersigned admitted the two-hundred and fifty-two (252)-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").

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 21 of RCE 1. Petitioner is diagnosed with [REDACTED]. *Id.*

3. As provided in the Behavior Analysis Reassessment (“treatment plan” or “behavior plan”), Petitioner is engaging in the following maladaptive behaviors: [REDACTED]; [REDACTED]; [REDACTED]; [REDACTED]; [REDACTED]; [REDACTED]; [REDACTED]; [REDACTED]; [REDACTED]; and [REDACTED]. *Id.* at 61 – 65.

4. For the period of February 4, 2023, through July 15, 2023, Petitioner showed the following improvement in [REDACTED] maladaptive behaviors: for [REDACTED], Petitioner’s incidents decreased from approximately [REDACTED]; for [REDACTED], Petitioner’s incidents decreased from approximately [REDACTED]; for [REDACTED], Petitioner’s incidents decreased from approximately [REDACTED]; for [REDACTED], Petitioner’s incidents decreased from [REDACTED]; for [REDACTED], Petitioner’s incidents decreased from approximately [REDACTED]; for [REDACTED], Petitioner’s incidents decreased from approximately [REDACTED]; for [REDACTED], Petitioner’s incidents decreased from approximately [REDACTED]; for [REDACTED], Petitioner’s incidents decreased from approximately [REDACTED]; for [REDACTED], Petitioner’s incidents remained at approximately [REDACTED]; for [REDACTED], Petitioner’s incidents decreased from approximately [REDACTED]; for [REDACTED], Petitioner’s incidents from [REDACTED]

██████████; and for ██████████, Petitioner's incidents decrease from approximately ██████████. *Id.* at 91 – 97.

5. Petitioner requested continuation of BA services; specifically, 3,380 units of code 97153; 364 units of code 97155; and 208 units of code 97156. *Id.* at 29. In a Notice of Outcome (“NOO”), dated August 22, 2023, Respondent terminated Petitioner's ABA services. *Id.* 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.

The NOO further provided:

PR Clinical Rationale – Denial: The provider responded to the pend for lack of progress indicating the caregiver is taking the data. The data presented is to include data collected by the provider (RBT, analyst) during the authorized hours, not parent/caregiver report. Additionally, the recipient shows minimal progress and has been in services since ██████████. 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 graphs/data do not meet the standards of care in the field of ABA. According to the Florida Medicaid State Plan (Appendix 9.3.b), the data provided must show evidence that the frequency of the maladaptive behavior(s) has decreased since the last review and, if not, that there is a modification of the behavior plan. The recommendations for procedural modifications include: additions/changes to treatment plan to impact behaviors targeted for reduction. Procedural modifications should include one or more of the following: antecedent manipulation modifications, modifications of prompting procedures used in acquisition, modifications in consequence-based strategies- - ones that either reduce maladaptive behavior or reinforce replacement behavior (e.g., manipulation of reinforcement schedules, switch to a different decelerative procedure), or if lack of progress was due to therapist error (e.g., poor data collection or poor training on intervention methods), how you will address human error. The provider has not addressed the lack of progress during the last observation period and did not amend the treatment plan in relation to the lack of progress. The information submitted does not meet standards of care within the field of behavior analysis. This request is denied.

...

Pages 29 – 30 of RCE 1.

6. Petitioner requested reconsideration of the Respondent’s decision. In a Notice of Reconsideration Determination (“NRD”), dated September 2, 2023, Respondent upheld its decision. *Id.* at 41. The NRD explained the basis for the decision as follows:

PR Recon Determination: The provider responded to the pend for lack of progress indicating the caregiver is taking the data. The data presented is to include data collected by the provider (RBT, analyst) during the authorized hours, not parent/caregiver report. Additionally, the recipient shows minimal progress and has been in services since [REDACTED]. 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 graphs/data do not meet the standards of care in the field of ABA. According to the Florida Medicaid State Plan (Appendix 9.3.b), the data provided must show evidence that the frequency of the maladaptive behavior(s) has decreased since the last review and, if not, that there is a modification of the behavior plan. The recommendations for procedural modifications include: additions/changes to treatment plan to impact behaviors targeted for reduction. Procedural modifications should include one or more of the following: antecedent manipulation modifications, modifications of prompting procedures used in acquisition, modifications in consequence-based strategies- - ones that either reduce maladaptive behavior or reinforce replacement behavior (e.g., manipulation of reinforcement schedules, switch to a different decelerative procedure), or if lack of progress was due to therapist error (e.g., poor data collection or poor training on intervention methods), how you will address human error. The provider has not addressed the lack of progress during the last observation period and did not amend the treatment plan in relation to the lack of progress. Following denial the provider has not included any new documentation. The information submitted does not meet standards of care within the field of behavior analysis. This request is denied.

...

Pages 41 – 42 of RCE 1.

7. On September 1, 2023, Petitioner requested a Fair Hearing to challenge the termination of ABA services. *Id.* at 8. On September 13, 2023, the undersigned issued an Order Scheduling

Fair Hearing by Telephone and Prehearing Instructions, setting the hearing for October 16, 2023, at 9:00 a.m. EST. *Id.*

8. Dr. Bicard is a Board Certified Behavior Analyst at the doctoral level. Dr. Bicard testified to the following at the Fair Hearing:

- a. The treatment plan was reviewed by a Board Certified Behavior Analyst at the doctoral level. The reviewer determined that there were several pieces of information in the plan that did not meet standards of care within the field of behavior analysis, resulting in the denial of services. There were procedures in the original treatment plan that did not meet medical necessity because they were not procedures within the field of ABA. There were also behavioral definitions that did not meet medical necessity because they were not written to standards of care within the field of ABA.
- b. Petitioner has participated in BA services since [REDACTED] and has been with the current provider since [REDACTED]. Since [REDACTED], there has been a lack of progress in the provider's treatment regarding Petitioner's maladaptive behaviors and skill acquisition goals. The case was pended to the provider for more information. The provider submitted an updated treatment plan correcting some, but not all, of the issues with the plan. The provider responded to the pend for lack of progress, indicating that the caregiver was collecting data. Within the field of BA, it should be clearly identified whether the data are treatment data or caregiver data. It is not possible to determine Petitioner's progress regarding the provider's treatment when data are grouped together.

- c. There are inconsistencies in the information in the treatment plan which make it impossible to determine Petitioner's level of function. Each treatment plan submitted states Petitioner is [REDACTED]. See pages 58 and 59 of RCE 1. The plan indicates that Petitioner [REDACTED]. *Id.* However, the plan also states that Petitioner can [REDACTED]. *Id.* at 60.
- d. The data for the maladaptive behavior of [REDACTED] are somewhat variable with no general direction. *Id.* at 91. Petitioner has been working on t[REDACTED] goal with t[REDACTED] provider since [REDACTED]. *Id.* The behavior of [REDACTED], which began treatment in [REDACTED], demonstrates no improvement in the data. *Id.* at 92. The behavior of [REDACTED] began treatment in [REDACTED], and there is no improvement in the data. *Id.* eThe behavior of [REDACTED] began treatment in [REDACTED], and there is no improvement in the data. *Id.* at 93. The behavior of [REDACTED] began treatment in [REDACTED], and there is no improvement in the data. *Id.* at 94. There is no improvement for the behavior of [REDACTED]. *Id.* at 94. There is no improvement overall for any of Petitioner's maladaptive behaviors, most of which have been under treatment since [REDACTED].
- e. According to standards of care within the field of ABA, the lead analyst is responsible for reviewing the treatment plans frequently and making interventions when the recipient's maladaptive behaviors do not respond to

treatment. In the prior authorization, it does not appear that the lead analyst has implemented any intervention on any of the behaviors.

- f. Most of Petitioner's replacement skills occur at or below fifty percent (50%) correct. *Id.* at 98. Anything below the fifty percent (50%) threshold indicates that the provider does not have proper understanding of the behavior. Many of Petitioner's replacement skills have been under treatment since [REDACTED]. As with maladaptive behaviors, the lead analyst must make interventions when the recipient is not responding to treatment. There were no interventions made during the authorization period. Timely intervention is a standard of care within the field of BA. The provider has also included a general listing of treatment that is not individualized for Petitioner. *Id.* at 69-72. There are also still inappropriate procedures that are not evidenced to be effective in the field of ABA. These procedures fall outside of standards of care within the field of ABA.
- g. This provider is not unique in some respects in regards to the short term objectives. The providers do not write meaningful objectives that do not show progress and do not follow the objectives on the graphs. For example, Petitioner will reduce incidents of [REDACTED] from [REDACTED] per week for [REDACTED] months. See page 215 of RCE 1. This is not a meaningful goal for a dangerous maladaptive behavior, nor does it represent improvement in behavior. The provider has written goals that would take many years to meet. The fact that a recipient meets a short term objective is meaningless. Additionally, a short term objective should be identified within one (1) month to six (6) weeks.

- h. Petitioner is eligible to seek ABA services from a different provider who may be able to provide effective care.
9. [REDACTED] is a BCABA. [REDACTED] testified to the following at the Fair Hearing:
- a. Petitioner has been diagnosed with [REDACTED] and [REDACTED]. [REDACTED] stated that, without proper care, Petitioner's quality of life would diminish. [REDACTED] stated that the treatment plan has been tailored to Petitioner's medical history and challenges. [REDACTED] stated the treatment plan aligns with the best practices for treating Petitioner's condition and is grounded in evidence-based intervention.
- b. [REDACTED] stated it was clarified in the reconsideration that the clinicians collect the data, not the caregivers. [REDACTED] stated all requested changes were made, including redefining behaviors and removing unnecessary goals. [REDACTED] stated environmental and antecedent manipulations were implemented. [REDACTED] stated the preventative measures implemented range from visual schedules to clear instructions. [REDACTED] asserted that Petitioner's [REDACTED] condition and need for repeated training warrant a higher number of therapy hours.
- c. [REDACTED] stated the seemingly contradictory background information section of the plan reflects an earlier assessment, whereas the strengths section represents Petitioner's current [REDACTED]. Progress for Petitioner is very slow, and Petitioner's data has high variability. [REDACTED] stated two (2) short term objectives have been met for the behavior of [REDACTED]. The behavior of [REDACTED]

was removed from the plan in response to eQHealth's assessment. The behavior was not removed because Petitioner does not exhibit the behavior. The intervention of "appropriate expression of emotion," which was deemed outside of the field of BA, was removed from the plan. [REDACTED] stated treatment has been effective, as there is progress in short term objective tracking over time. [REDACTED] stated the long amount of time given for short term objectives is justified given Petitioner's [REDACTED]. [REDACTED] stated the provider does not believe a long term objective can be reached in one (1) authorization period due to the severity of Petitioner's condition.

- d. [REDACTED] is not the BCABA on Petitioner's case. [REDACTED] stated [REDACTED] does not have direct knowledge of Petitioner's response to treatment.

CONCLUSIONS OF LAW

10. The Agency's Office of Fair Hearings has jurisdiction over the subject matter of this proceeding and the parties pursuant to section 409.285(2), Florida Statutes (2019). This order is the final administrative decision of AHCA under section 409.285(2)(a).

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

12. Because Respondent terminated a previously approved service, Fla. Admin. Code R. 59G-1.100(17)(g) assigns the burden of proof to the Respondent. The standard of proof in an administrative hearing is a preponderance of the evidence. The preponderance of the evidence standard requires proof by "the greater weight of the evidence" (Black's Law Dictionary at 1201, 7th Ed.)

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

1.0 Introduction

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

...

1.4.5 Medically Necessary/Medical Necessity

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

...

4.0 Coverage Information

4.1 General Criteria

Florida Medicaid covers services that meet all of the following:

- Are determined medically necessary
- Do 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 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.

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

These Review Criteria state as follows:

Review Criteria for Behavior Analysis Services

Behavior analysis (BA) services are considered as either the treatment of choice or as an adjunct treatment modality for a variety of conditions and disorders where maladaptive behaviors are part of the recipient's clinical presentation, including behavioral manifestations of diagnoses such as Autism Spectrum Disorder and other behavioral health conditions.

Critical Elements Necessary for ANY Type of Behavior Analysis Service:

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

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

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

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

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

- a. **ALL** critical elements are met
- b. An assessment or, if applicable, a reassessment, authored by a lead analyst, is provided. An assessment of the maladaptive behavior(s) is a necessary element of the process of identifying the frequency and magnitude of the behaviors as well as the variables associated with the occurrence of the maladaptive behavior(s). This helps in defining what

are the functional consequences of the problem behavior(s) so that an adequate behavior plan can be implemented. This (re)assessment **MUST** include, at a minimum, **ALL** of the following:

- i. A clear operational description of the maladaptive behavior(s)
- ...
- c. A behavior plan authored or updated by a lead analyst. The behavior plan is the cornerstone of the delivery of behavior analysis services and it is based on the information obtained in the assessment. It proposes specific interventions to reduce or eliminate the maladaptive behavior. These interventions take into consideration the variables, both present before the behavior, as well as after the behavior, that influence the occurrence of the maladaptive behavior(s). This plan also includes replacement appropriate behaviors for the recipient to engage in instead of the maladaptive behaviors in order to obtain the same function. The plan must be detailed enough to warrant the requested services and include mechanisms to monitor its effectiveness. This **MUST** include, at a minimum, **ALL** of the following:
 - i. Observable and measurable descriptions of the maladaptive behavior(s)
 - ii. Identified function of the maladaptive behavior(s) behavior as a result of the assessment or reassessment conducted
 - iii. Goals and strategies for changing the maladaptive behavior(s)
 - iv. Written detailed description of when, where, and how often these goals will be addressed and proposed strategies will be implemented
 - v. System for monitoring and evaluating the effectiveness of the plan
 - vi. Safety and crisis plan, if applicable
 - vii. Summary and recommendations
 - viii. Discharge criteria
 - ix. Transition plan (if applicable)

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

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

- a. ALL criteria listed in 2a, 2b, and 2c regarding critical elements, assessment or reassessment, and behavior plan, are met.

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

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 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.

19. In the instant case, Respondent terminated Petitioner’s ABA services. See ¶ 5. In the NOO dated August 22, 2023, Respondent explained that continuing services with the current provider

was not medically necessary, specifically, that it did not meet the requirement that services must be “consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational.” *Id.* Respondent further explained that the “the recipient shows minimal progress and has been in services since [REDACTED].” *Id.*

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. 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.” As shown by the record, neither Petitioner’s maladaptive behaviors, nor [REDACTED] replacement behaviors, exhibits progress within the authorization period. See ¶¶ 4, 8. Dr. Bicard testified that the data in the provider’s treatment plan demonstrate no improvement overall for any of Petitioner’s maladaptive behaviors, most of which have been under treatment since [REDACTED]. *Id.* Furthermore, most of Petitioner’s replacement skills occur at or below fifty percent (50%) correct, although many of these behaviors have also been under treatment since [REDACTED]. *Id.* Dr. Bicard also asserted that there were no apparent interventions made during the authorization period, although timely intervention is a standard of care within the field of behavior analysis. As progress and intervention are both standards of care within the field of behavior analysis, and as Dr. Bicard provided credible testimony regarding Petitioner’s lack of progress and the lack of intervention in the treatment plan, the treatment plan in this case is not consistent with generally accepted professional medical standards. As such, Respondent demonstrated that continuing services with this provider was not medically necessary.


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, Petitioner has not made progress in reducing [redacted] maladaptive behaviors, nor in improving [redacted] replacement behaviors. Here, Petitioner’s lack of improvement in this authorization period 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 plan at issue in this case, are not necessary to correct or ameliorate a defect or a physical and mental illness or condition. Accordingly, Respondent proved by a preponderance of the evidence that Respondent’s termination of ABA services was correct.

IT IS HEREBY ORDERED AND ADJUDGED THAT:

Respondent’s termination of ABA services is **AFFIRMED**. Petitioner’s appeal based on Respondent’s termination is **DENIED**.

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

 Joseph Mabry
23-FH2147
2023.12.04
08:02:00 -05'00'

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]
[REDACTED]

AHCA Medicaid Hearing Unit
MedicaidHearingUnit@ahca.myflorida.com