



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

**FILED**

Jan 12, 2024, 11:48 am  
OFFICE OF FAIR HEARINGS

[REDACTED]

PETITIONER,

AHCA Case No.: 23-FH2498

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 November 13, 2023, at 9:34 a.m. Eastern Standard Time (“EST”).

**APPEARANCES**

For the Petitioner:

[REDACTED]

Petitioner’s Authorized Representative

For the Respondent:

Suzanne Chillari  
Medical Health Care Program Analyst  
Agency for Health Care Administration

**STATEMENT OF ISSUE**

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

**PRELIMINARY STATEMENT**

All parties and witnesses appeared telephonically. [REDACTED] (“[REDACTED]”),  
Petitioner’s Authorized Representative and [REDACTED], appeared on behalf of Petitioner. [REDACTED]  
[REDACTED] (“[REDACTED]”), Board-Certified Behavior Analyst (“BCBA”) with [REDACTED]

█ (“provider” or “Petitioner’s provider”), appeared at the Fair Hearing as a witness for Petitioner.

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

Petitioner did not introduce any exhibits at the Fair Hearing.

Prior to the Fair Hearing, Respondent sent to the Office of Fair Hearings and Petitioner a one hundred and twenty-seven (127)-page evidence packet and a forty-nine (49)-page evidence packet. The one hundred and twenty-seven (127)-page packet appears in the Office of Fair Hearings’ document management system as the files titled “█ FH 11.13.2023.pdf”. The forty-nine (49)-page packet appears in the Office of Fair Hearings’ document management system as the file titled “Agency Evidence Legal Authorities 23-FH2498.pdf”. Absent any objections from Petitioner, the undersigned admitted the one hundred and twenty-seven (127)-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 was [REDACTED] at the date of the Fair Hearing. See RCE 1 at 16. Petitioner is diagnosed with [REDACTED], [REDACTED], [REDACTED], and [REDACTED]. *Id.* at 16, 50.

3. As provided in the [REDACTED] Behavior Analysis and Positive Support Plan (“Assessment”), dated August 23, 2023, Petitioner is engaging in the following maladaptive behaviors: [REDACTED], [REDACTED] ([REDACTED]), [REDACTED], [REDACTED], [REDACTED], [REDACTED], [REDACTED], and [REDACTED]. *Id.* at 54 – 58. Petitioner is learning the following replacement behaviors: [REDACTED], [REDACTED], [REDACTED], and [REDACTED]. *Id.* at 73 – 113.

4. As provided in the Assessment, Petitioner has made the following progress in reducing [REDACTED] maladaptive behaviors, between [REDACTED]: for [REDACTED], Petitioner’s incidents were variable and decreased to [REDACTED] at the end of the authorization period; for [REDACTED], Petitioner’s incidents were variable and increased at the end of the authorization period; for [REDACTED], Petitioner’s incidents were variable and increased at the end of the authorization period; for [REDACTED], Petitioner’s incidents were variable and increased at the end of the authorization period; for [REDACTED], Petitioner’s incidents were variable and decreased at the end of the authorization period; for [REDACTED], Petitioner’s incidents have remained consistent with [REDACTED] spikes; for [REDACTED], Petitioner’s incidents were variable and decreased at the end of the authorization period; and for [REDACTED], Petitioner’s incidents were variable and decreased at the end of the authorization period. *Id.* at 61 – 72.

5. On September 12, 2023, Petitioner requested continuation of BA services; specifically, 617 units of code 97155; 206 units of code 97156; and 3,084 units of code 97153. See RCE 1 at 23. In a Notice of Outcome (“NOO”), dated September 28, 2023, Respondent denied Petitioner’s request. *Id.* at 23 – 27. The NOO states as follows:

Code: 97155 Intervention without protocol modification, per 15 minutes  
From: 9/13/23  
Thru: 3/10/24  
Total Units: Denied 617

Code: 97156 Family training, per 15 minutes, Lead Analyst  
From: 9/13/23  
Thru: 3/10/24  
Total Units: Denied 206

Code: 97153 Intervention without protocol modification, per 15 minutes, Lead Analyst, BCaBA, or RBT  
From: 9/13/23  
Thru: 3/10/24  
Total Units: Denied 3,084

The NOO explained the basis for the termination as follows:

The request for services is denied in whole or in part because they are not medically necessary as defined in Rule 59G-1.010, Florida Administrative Code. Specially, the requested services are not medically necessary under the following standard(s):

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

The NOO further provided:

The rationale for our decision is as follows:

PR Principal Reason – Denial:

Requested services are denied because documentation is neither showing improvement nor support for maintenance.

PR Clinical Rationale – Denial: This recipient has received services with this provider since [REDACTED]. There are maladaptive behaviors that have been in treatment since [REDACTED] with consistent progress or mastery. 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 provider included modifications for movement strategies. Additionally, the recommendations for procedural modifications include: additions/changes to treatment plan to impact behaviors targeted for reduction. Procedural modifications should include one or more of the following: antecedent manipulation modifications, modifications of prompting procedures used in acquisition, modifications in consequence-based strategies – ones that either reduce maladaptive behavior or reinforce replacement behavior (e.g., manipulation of reinforcement schedules, switch to a different decelerative procedure), or if lack of progress was due to therapist error (e.g., poor data collection or poor training intervention methods), how you will address human error. Calming/coping skills/breathing skills/relaxation training/regulation training/exercise or movement strategies are not empirically supported procedures within the conceptual system of behavior analysis for treating the functions of maladaptive behavior. 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 or the proposed changes have little chance at improving behavior. The information submitted does not meet standards of care within the field of behavior analysis. The request is denied.

...

RCE 1 at 23 – 24.

6. In a Notice of Reconsideration Determination (“NRD”), dated October 10, 2023, Respondent upheld its decision. *Id.* at 35 – 38. The NRD explained the basis for the decision as follows:

...

PR Recon Determination: This request for assessment is denied. The previous BA services with this provider for this recipient were denied due to a lack of progress and held up at reconsideration. The interventions and data submitted by the provider for this request for services do not meet medical necessity criteria.

...

RCE 1 at 36.

7. On October 2, 2023, Petitioner requested a Fair Hearing to challenge the termination BA services. On October 24, 2023, the Office of Fair Hearings issued an Order Scheduling Fair Hearing and Prehearing Instructions, setting the hearing for November 13, 2023, at 9:30 a.m. EST.

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

- a. eQHealth is the quality improvement organization contracted by Florida Medicaid to review requests for BA services for medical necessity. Medical necessity means that the medical or allied cares, goods, or services must meet the medical necessity criteria. Dr. Conway read the five (5) medical necessity criteria into the record. *See RCE 2 at 7.*
- b. Petitioner has received BA services with this provider since [REDACTED], for [REDACTED] years. Petitioner has not made sufficient progress since the previous authorization period. The current denial is due to lack of sufficient progress and lack of modification to the treatment plan to address the lack of progress. The treatment plan does not meet condition three (3) of the medical necessity criteria: be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational. *See RCE2 at 7.*
- c. Dr. Conway reviewed the graphs regarding maladaptive behaviors. Some of the maladaptive behaviors are from the beginning of treatment, such as [REDACTED] in [REDACTED]. In general, the data shows no progress or level trends and significant increases across behaviors.

- d. The graph for [REDACTED] shows that there are [REDACTED] [REDACTED] occurrences per session, which means this behavior is still occurring multiple times per week. See RCE 1 at 60. This behavior has increased. The responsive/de-escalation strategies for [REDACTED] are not successful according to the data showing high variability in the authorization period.
- e. The graph for [REDACTED] shows that there are [REDACTED] or less occurrences per week. See RCE 1 at 61. The provider indicates that this behavior potentially functions for [REDACTED], but that is not a standard of care in ABA. One of the interventions of this behavior is [REDACTED], which is reinforcing an incompatible response or a response that cannot occur at the same time. The provider is prompting Petitioner to have a [REDACTED]. These cannot be done at the same time. It is confusing as to how that is going to occur. Throughout the authorization period [REDACTED] occurred at varying levels.
- f. The graph for [REDACTED] shows a baseline that [REDACTED] parent reported so Respondent cannot be certain if it is true. See RCE 1 at 64. The baseline does not align with the graph. The provider indicates there are alternative movement options for Petitioner; such strategies are not within the standard of care in ABA. They fall outside the target of ABA. The graph indicates the rate of the behavior of [REDACTED] to [REDACTED] times per hour. It is not clear how long the behavior is lasting; there is no indication of duration.
- g. The first graph for [REDACTED] shows an increase in behavior in the last weeks of the authorization period. See RCE 1 at 66. The rate of this behavior has doubled,

occurring at least [REDACTED] an hour. The second graph has no legend, so it is unclear where the difference is occurring.

- h. The graph for [REDACTED] is unclear. See RCE 1 at 68. There are no additional numbers on the Y axis; it is unclear what the highest data is. It looks like there are variable levels, at least [REDACTED] per hour per session.
- i. The graph for [REDACTED] shows the behavior is still occurring some days. See RCE 1 at 68. The Y axis only shows [REDACTED], so it is unclear how many times exactly this behavior is occurring. These graphs do not meet the standard of care in the field of ABA.
- j. The graph for [REDACTED] shows a slight decrease over time, but it is still occurring [REDACTED] to [REDACTED] times per hour at each session. See RCE 1 at 71.
- k. The graph for [REDACTED] shows the behavior has increased. See RCE 1 at 72. There are no sessions of [REDACTED] occurrences of [REDACTED].
- l. Overall, the graphs show a lot of variability. Respondent expects to see this type of variability early on in treatment when figuring out which interventions work best. However, when an individual has been in services for over [REDACTED] years and targeting the same behaviors, and still not seeing the behaviors extinguished, it is concerning.
- m. Throughout the Assessment there are many graphs for skill acquisition goals. However, many of these are at different prompt levels and the skills have been worked on across multiple years. There is some progress, but the skills are taking multiple years to show progress and the progress is with prompts. For example,

Petitioner is working on [REDACTED]. The graphs show high variability and low progress.

- n. It is unclear which strategies are being implemented.
  - o. The treatment plan indicates that the maladaptive behaviors show variability, some behaviors are increasing, and some behaviors have not shown changes or show very minimal changes. The skill acquisition goals show high variability and many prompts needed after [REDACTED] years of service.
  - p. The graphs provided do not indicate progress within care giver goals.
  - q. Petitioner may qualify for ABA services based on behaviors and skill deficits, Petitioner is not qualified for services with this provider because the treatment plan submitted indicates Petitioner has not made significant progress and the modifications are not addressing this.
9. [REDACTED], Petitioner's [REDACTED], testified to the following:
- a. [REDACTED] has seen progress in Petitioner on a day-to-day basis.
10. [REDACTED], Petitioner's BCBA, testified to the following:
- a. Petitioner has global delays and it takes [REDACTED] a lot longer to make progress.
  - b. [REDACTED] is [REDACTED] of the most concerning behaviors.
  - c. It is difficult for Petitioner to make requests while [REDACTED].
  - d. Petitioner is making gradual progress.
  - e. Petitioner requires prompts because of [REDACTED] learning style.
  - f. The environment that Petitioner is in is not ideal.

#### **CONCLUSIONS OF LAW**

11. 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).

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

13. 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.).

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 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.

...

RCE 2 at 40 – 42.

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 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

...  
RCE 2 at 45 – 46.

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.

...

RCE 2 at 4 – 5.

17. 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.

18. Section 2.83 of 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.

RCE 2 at 43.

19. 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.

RCE 2 at 34.

20. In the instant case, Respondent terminated Petitioner’s ABA services. See ¶ 5. The data did not show improvement in the maladaptive behaviors and the provider did not address the lack of progress. See ¶ 4, 5, and 8. In the NOO dated September 28, 2023, Respondent explained that continuing services with the current provider were not medically necessary, specifically, that it did not meet the requirements that services must be “consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigation.” See ¶ 5. Respondent further explained that the “[r]equested services are denied because documentation is neither showing improvement nor support for maintenance” and that “[t]he information submitted does not meet standards of care within the field of behavior analysis.” See ¶ 5.

21. As provided by the EPSDT requirements, the recipient must meet the medical necessity criteria as outlined in Fla. Admin. Code R. 59G-1.010. See ¶ 17. As provided in section 2.83 of the Definitions Policy, a component of medical necessity is that services must be “consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational”. See ¶ 18. As shown by the record, Petitioner’s submitted treatment plan shows no improvement regarding the reduction of maladaptive behaviors and little improvement in increasing Petitioner’s replacement behaviors. See ¶ 4, 8. Dr. Conway explained that there has been no sufficient progress and lack of modification to the treatment plan to address the lack of progress. See ¶ 8. Further, Dr. Conway explained that the maladaptive behaviors show no progress or level trends throughout a majority of the authorization period, that there were significant increases in all maladaptive behaviors above baseline levels, and that the replacement goals show some minimal progress. *Id.* In all, based on Dr. Conway’s credible and convincing testimony and the lack of progress in the treatment, Respondent demonstrated that the provider’s treatment is not “consistent with generally accepted professional medical standards as determined by the Medicaid program”.

22. 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 ¶ 19. As discussed, *supra* ¶ 21, the current treatment plan is ineffective. Here, Petitioner’s lack of improvement is well documented.

23. Upon consideration of the testimony provided, Respondent’s Composite Exhibit 1, Respondent’s Composite Exhibit 2, the EPSDT policy, and all other 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 12th day of January, 2024 in Tallahassee, Leon County, Florida.



Kameisha Presley  
23-FH2498  
2024.01.12 10:51:43  
-05'00'

---

**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.

**COPIES FURNISHED TO:**



**AHCA Medicaid Hearing Unit**  
**MedicaidHearingUnit@ahca.myflorida.com**