



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

**FILED**

Jan 25, 2024, 10:21 am

OFFICE OF FAIR HEARINGS

AHCA Case No.: 23-FH2648

[REDACTED]

PETITIONER,

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 December 1, 2023, at 12:57 p.m. Eastern Standard Time ("EST").

**APPEARANCES**

For the Petitioner:

[REDACTED]

Petitioner's Authorized Representative

For the Respondent:

Marielisa Amador  
Medical Health Care Program Analyst  
Agency for Health Care Administration

**STATEMENT OF ISSUE**

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

**PRELIMINARY STATEMENT**

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

Marielisa Amador, Medical Health Care Program Analyst for the Agency for Health Care Administration (“Agency” or “AHCA”), appeared for the Fair Hearing as a representative for Respondent. Dr. David Bicard (“Dr. Bicard”), BCBA at the doctoral level and Director of Clinical Operations for eQHealth Solutions Inc. (“eQHealth”), appeared for the Fair Hearing as a witness for Respondent.

Jocelyn, translator number 371645, and Alberto, translator number 355983, provided Spanish translation services during the hearing.

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 sixty-seven (167)-page evidence packet and a forty-nine (49)-page evidence packet. The one hundred and sixty-seven (167)-page packet appears in the Office of Fair Hearings’ document management system as the file titled “[REDACTED] FH 11.22.2023.pdf”. The forty-nine (49)-page packet appears in the Office of Fair Hearings’ document management system as the file titled “23-FH2648 AHCA Evidence.pdf”. Absent any objections from Petitioner, the undersigned admitted the one hundred and sixty-seven (167)-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”), respectively.

### **FINDINGS OF FACT**

1. Petitioner receives Medicaid services on a fee-for-service basis through the Agency. See RCE 1 at 21. eQHealth is a Quality Improvement Organization contracted by the Agency to review prior authorization requests for services. See RCE 2 at 2.

2. As of the date of the hearing, Petitioner is [REDACTED]. See RCE 1 at 21. Petitioner is diagnosed with [REDACTED] [REDACTED] *Id.* at 21, 51.

3. As provided in the provider’s Behavior Analysis Service Plan Reassessment (“Reassessment”), dated August 16, 2023, Petitioner is engaging in the following maladaptive behaviors: [REDACTED], [REDACTED], [REDACTED], [REDACTED], [REDACTED], [REDACTED], [REDACTED], [REDACTED], [REDACTED], and [REDACTED]. *Id.* at 51. The data graphs for maladaptive behaviors in the Reassessment show the following between April 2023 and August 2023: 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 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 decreased from approximately [REDACTED]; for [REDACTED], Petitioner’s incidents decreased from approximately [REDACTED] and for [REDACTED], Petitioner’s incidents decreased from approximately [REDACTED] *Id.* at 64 – 70.

4. On August 29, 2023, Petitioner requested continuation of BA services with the previous ABA provider; specifically, 208 units of code 97155; 104 units of code 97156; and 3,120 units of

code 97153. See RCE 1 at 28. In a Notice of Outcome (“NOO”), dated September 7, 2023,

Respondent denied Petitioner’s request. *Id.* at 28 – 32. The NOO states as follows:

Code: 97153 Intervention without protocol modification, per 15 minutes, Lead Analyst, BcaBA, or RBT  
From: 9/2/23  
Thru: 2/28/24  
Total Units: Denied 3,120

Code: 97155 Intervention without protocol modification, per 15 minutes  
From: 9/2/23  
Thru: 2/28/24  
Total Units: Denied 208

Code: 97156 Family training, per 15 minutes, Lead Analyst  
From: 9/2/23  
Thru: 2/28/24  
Total Units: Denied 104

The NOO explained the basis for the termination as follows:

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

Individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness under treatment, and not in excess of the patient’s needs.

...

The NOO further provided:

The rationale for our decision is as follows:

PR Principal Reason – Denial:

Submitted information does not support the medical necessity for requested frequency and/or duration.

PR Clinical Rationale – Denial: According to the Florida Medicaid State Plan (Appendix 9.3.b), the data provided must show evidence that the frequency of the maladaptive behavior(s) has decreased since the last review and, if not, that there is a modification of the behavior plan. The recommendations for procedural modifications include:

additions/changes to treatment plan to impact behaviors targeted for reduction. Procedural modifications should include one or more of the following: antecedent manipulation modifications, modifications of prompting procedures used in acquisition, modifications in consequence-based strategies – ones that either reduce maladaptive behavior or reinforce replacement behavior (e.g., manipulation of reinforcement schedules, switch to a different decelerative procedure), or if lack of progress was due to therapist error (e.g., poor data collection or poor training intervention methods), how you will address human error. The provider has not addressed the lack of progress during the last observation period and did not amend the treatment plan sufficiently 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.

...

RCE 1 at 28 – 29.

5. In a Notice of Reconsideration Determination (“NRD”), dated October 16, 2023, Respondent upheld its decision. *Id.* at 40 – 43. The NRD explained the basis for the decision as follows:

The reason for the denial is that the services are not medically necessary as defined in 59G-1.010, Florida Administrative Code. Specifically, the services must be:

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 rationale for our decision is as follows:

PR Recon Determination: At reconsideration all documents were carefully reviewed. The provider was denied for lack of progress and then submitted an updated plan with no progress data. According to the Florida Medicaid State Plan (page 8, 6.2.3), the data provided must show evidence that the frequency of the maladaptive behavior(s) has decreased since the last review and, if not, that there is a modification of the behavior plan. The recommendations for procedural modifications include: additions/changes to treatment plan to impact behaviors targeted for reduction. Procedural modifications should include one or more of the following: antecedent manipulation modifications, modifications of prompting procedures used in acquisition, modifications in consequence-based strategies – ones that either reduce maladaptive behavior or reinforce replacement behavior (e.g., manipulation of reinforcement schedules, switch to a different decelerative procedure), or if lack of progress was due to therapist error (e.g.,

poor data collection or poor training intervention methods), how you will address human error. The provider has not addressed the lack of progress during the last observation period 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. This denial is upheld.

...

RCE 1 at 41.

6. On October 13, 2023, Petitioner requested a Fair Hearing to challenge the termination BA services. On November 1, 2023, the Office of Fair Hearings issued an Order Scheduling Fair Hearing and Prehearing Instructions, setting the hearing for November 22, 2023, at 9:30 a.m. EST. On November 7, 2023, the Office of Fair Hearings issued an Order Granting Continuance *sua sponte*, effectively cancelling the November 22, 2023, hearing. On November 15, 2023, the Office of Fair Hearings issued an Amended Second Order Scheduling Fair Hearing and Prehearing Instructions, setting the hearing for December 1, 2023, at 1:00 p.m. EST.

7. Dr. Bicard testified as follows:

- 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. Bicard read the five (5) medical necessity criteria into the record. *See* RCE 2 at 7.
- b. A standard of care within the field of BA is that if a recipient's behavior does not respond to treatment, then the provider must make interventions. Here, there are no interventions for any of Petitioner's identified maladaptive behaviors and there is no improvement in the behaviors. It does not appear that there were any modifications made during the entire authorization period.

- c. The data graph for [REDACTED] shows that Petitioner has not made meaningful progress. See RCE 1 at 64.
  - d. The data graphs for [REDACTED] show that Petitioner is not making any progress.
  - e. The provider submitted a treatment plan dated August 16, 2023, and a new treatment plan after the denial of services, dated October 5, 2023. See pages 51 – 99 and 118 – 166, respectively. Instead of making changes to the treatment plan, the provider collected new baseline data that overlapped and contradicted the provider’s data. For example, the data graph for [REDACTED] shows the behavior was occurring less than [REDACTED] times during the observation period, but the originally dated showed the behavior occurring around [REDACTED] times. See RCE 1 at 145. This is the same case for all of Petitioner’s maladaptive behaviors and skill acquisition goals. Dr. Bicard opined that it is not clear what the provider is trying to do and there is no evidence that the treatment is going to change any of Petitioner’s behaviors. Instead of collecting new baseline data, Dr. Bicard explained that the provider should have made changes to the treatment plan.
  - f. Dr. Bicard agrees with the determination to uphold the denial for services based on the lack of medical necessity.
8. [REDACTED] testified as follows:
- a. Petitioner needs help to be a part of society.
  - b. [REDACTED] will have to take Petitioner out of school if [REDACTED] does not have a therapist.

9. Petitioner provided a prescription from [redacted] neurologist, [redacted], M.D., prescribing Petitioner with an evaluation and therapy. See RCE 1 at 100.

**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)(b) assigns the burden of proof to the Respondent. The standard of proof in an administrative hearing is a preponderance of the evidence. The preponderance of the evidence standard requires proof by “the greater weight of the evidence” (Black’s Law Dictionary at 1201, 7th Ed.).

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

**1.0 Introduction**

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

...

**1.4.5 Medically Necessary/Medical Necessity**

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

...

**4.0 Coverage Information**

**4.1 General Criteria**

Florida Medicaid covers services that meet all of the following:

- Are determined medically necessary

- Do not duplicate another service
- Meet the criteria as specified in this policy

#### **4.2 Specific Criteria**

Florida Medicaid covers the following BA services in accordance with the applicable Florida Medicaid fee schedule(s), or as specified in this policy:

##### **4.2.1 Behavior Assessment**

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

##### **4.2.2 Behavior Analysis**

Up to 40 hours per week, per recipient, consisting of services identified on the recipient’s behavior plan in order to reduce maladaptive behaviors and to restore the recipient to his or her best possible functional level. Services include:

- Implementing behavior analysis interventions, and monitoring and assessing the recipient’s progress towards goals in the behavior plan
- Behavior analysis interventions, for example, discrete trial teaching, task analysis training, differential reinforcement, non-contingent reinforcement, conducting task analyses of complex responses, and teaching using chaining, prompting, fading, shaping, response cost, and extinction
- Training the recipient’s family, caregiver(s), and other involved persons on the implementation of the behavior plan and intervention strategies (the recipient must be present when clinically appropriate)

...

#### **4.3 Early and Periodic Screening, Diagnosis, and Treatment**

As required by federal law, Florida Medicaid provides services to eligible recipients under the age of 21 years, if such services are medically necessary to correct or ameliorate a defect, a condition, or a physical or mental illness. Included are diagnostic services, treatment, equipment, supplies, and other measures described in section 1905(a) of the Social Security Act, codified in Title 42 of the United States Code 1396d(a). As such, services for recipients under the age of 21 years exceeding the coverage described within this policy or the associated fee schedule may be approved, if medically necessary. For more information, please refer to Florida Medicaid’s General Policies on authorization requirements.

See RCE 2 at 40, 42.

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

#### **4. Criteria to Assess the Intensity of Behavior Analysis Services: Providers may request up to**

40 hours of BA services per week, per recipient, based upon the following:

As a rule, higher number of maladaptive behaviors, higher severity and frequency of behaviors, as well as the multiplicity of settings where the behaviors occur, would usually justify a higher number of services hours. The greater the number of goals targeted to reduce maladaptive behaviors, the more the likelihood that a higher number of services hours could also be warranted.

Providers **MUST** ensure that proper justification for the requested hours of services is adequately documented in the behavior plan. Based on the information provided in the assessment, behavior plan, and any other supporting documentation, 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:

- vi. i. Safety - aggression, self-injury, property destruction, elopement
- vii. ii. Communication - problems with expressive/receptive language, poor understanding or use of
- viii. non-verbal communications, stereotyped, repetitive language
- ix. iii. Self-stimulating, abnormal, inflexible, or intense preoccupations
- x. iv. Self-care - difficulty recognizing risks or danger, grooming, eating, or toileting
- xi. v. Other- behaviors not identified above

#### **5. Criteria for Discharge from Behavior Analysis Services - ONE or MORE of the following **MUST** be satisfied:**

- a. The critical elements are **no longer met**.
- b. The data provided shows that the frequency and severity of maladaptive behavior(s) has declined to the point that they no longer pose a barrier to the child's ability to function in his/her environment.
- c. The data provided shows the recipient has made no progress toward any goals in the last 12 consecutive months.
- d. The level of functional impairment as expressed through behaviors no longer justifies continued BA services.
- e. Parent/guardian withdraws consent for treatment.

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

When applicable, the recipient would be transitioned to other appropriate services.

...

RCE 2 at 45 – 47.

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.

RCE 2 at 5.

16. Petitioner is under age 21, and therefore EPSDT applies to ■■■ request for services. However, a state may place medical necessity limitations on EPSDT services. *See* 42 C.F.R. §§ 440.230(a), (b), (d). Fla. Stat. § 409.905(2) limits EPSDT services with a medical necessity standard:

The [Agency] shall pay for early and periodic screening and diagnosis of a recipient under age 21 to ascertain physical and mental problems and conditions and all services determined by the agency to be medically necessary for the treatment, correction, or amelioration of these problems and conditions, including personal care, private duty nursing, durable medical equipment, physical therapy, occupational therapy, speech therapy, respiratory therapy, and immunizations.

RCE 2 at 13.

17. 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 23.

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

**3.2.1 Continued Authorization Requests**

The QIO shall not deny or reduce the amount, frequency, or duration of a service that is already being provided, unless:

- The reduction is to correct for factual errors or omissions in prior certifications.
- There is a documented improvement in the recipient’s medical condition.
- There is a documented change in the recipient’s circumstances.
- The reviewing physician determines the recipient will not gain any additional benefit by continuing services at the current level.

...

RCE 2 at 34.

19. In the instant case, Respondent terminated Petitioner's ABA services. *See* ¶ 4, 5. The data did not show significant improvement in the maladaptive behaviors. *See* ¶ 4, 5, 9. In the NOO dated September 7, 2023, Respondent explained that the BA services at issue were not medically necessary, specifically, that it did not meet the requirements that services must be "individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness under treatment and not in excess of the patient's needs." *See* ¶ 4. Respondent further explained that the "submitted information does not support the medical necessity for requested frequency and/or duration" and that "[t]he recommendations are insufficient to support continued care." *See* ¶ 4.

20. As provided by the EPSDT requirements, the recipient must meet the medical necessity criteria as outlined in Fla. Admin. Code R. 59G-1.010. *See* ¶ 16. As provided in section 2.83 of the Definitions Policy, a component of medical necessity is that services must be "individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness under treatment and not in excess of the patient's needs". *See* ¶ 17. As shown by the record, Petitioner's submitted Reassessment shows little improvement regarding the reduction of maladaptive behaviors and little improvement in increasing Petitioner's replacement behaviors. *See* ¶ 3, 7. Dr. Bicard established that there has been no significant progress and there is a lack of modification to the Reassessment to address the lack of progress. *See* ¶ 7. Further, Dr. Bicard testified that the Reassessment submitted by the lead analyst does not show any significant decrease in the Petitioner's maladaptive behaviors. *See* ¶ 7. Although Petitioner needs ABA therapy, the data graphs in the Reassessment demonstrate that Petitioner is not getting the effective therapy ■ should be getting. *See* ¶ 4, 9. In all, based on Dr. Bicard's credible and convincing testimony and

the lack of progress in the treatment, Respondent demonstrated that the provider's treatment is not "individualized and specific for Petitioner's needs".

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 ¶ 19 – 20, the current treatment plan is ineffective. Here, Petitioner's lack of improvement is well documented.

22. Lastly, although the record reflects that Petitioner's provider and neurologist recommended the ABA services, see ¶ 9, the recommendation does not make the service a covered service. Section 2.83 of the Definitions Policy mandates that "[t]he 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." See ¶ 17.

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 has not demonstrated that the requested behavior analysis services, through this provider, are necessary to correct or ameliorate a defect or a physical and mental illness or condition. Accordingly, Respondent showed that the termination of ABA 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 of BA services is **DENIED**.

**DONE AND ORDERED** this 25 day of January, 2024 in Tallahassee, Leon County, Florida.



Kameisha Presley  
23-FH32648  
2024.01.25  
10:11:28 -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**