



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

FILED

Feb 14, 2024, 8:35 am

OFFICE OF FAIR HEARINGS
AHCA Case No.: 23-FH2731

[REDACTED]

PETITIONER,

vs.

AGENCY FOR HEALTH CARE
ADMINISTRATION,

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic Fair Hearing on the instant case on January 4, 2024, at 1:00 p.m. Eastern Standard Time ("EST").

APPEARANCES

For the Petitioner:

[REDACTED]

Petitioner's Authorized Representative

For the Respondent:

Lee Ann Williams
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]"), Quality Assurance Manager with [REDACTED], appeared on behalf of Petitioner.

Lee Ann Williams ("Ms. Williams"), Medical/Health Care Program Analyst and Fair Hearing Liaison for the Agency for Health Care Administration ("Agency" or "AHCA"), appeared on behalf of Respondent. Dr. Alyssa Conway ("Dr. Conway"), Second Level Reviewer and Board Certified Behavior Analyst for eQHealth Solutions Inc. ("eQHealth"), appeared as a witness for Respondent.

Prior to the hearing, Petitioner sent to the Office of Fair Hearings and Respondent a nine (9)-page evidence packet. The nine (9)-page evidence packet appears in the Office of Fair Hearings' document management system as the file title "23-FH2731 DAR and Evidence.pdf". Absent an objection from the Respondent, the undersigned admitted the nine (9)-page evidence packet into evidence as Petitioner's Composite Exhibit 1 ("PCE 1").

Prior to the 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 evidence packet appears in the Office of Fair Hearings' document management system as the file title "[REDACTED] FH 01.04.2024.pdf". The forty-nine (49)-page evidence packet appears in the Office of Fair Hearings' document management system as the file title "23-FH2731 Agency Evidence Legal Authorities 49 pages.pdf". Absent an objection from the Petitioner, the undersigned admitted the one-hundred and twenty-seven (127)-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 16 of RCE 1. Petitioner is diagnosed with [REDACTED]. *Id.*

3. As provided in Petitioner’s Behavior Analysis Service Plan (“treatment plan” or “behavior plan”), Petitioner is engaging in the following maladaptive behaviors: [REDACTED]; [REDACTED]; [REDACTED]; [REDACTED]; [REDACTED]; [REDACTED]; [REDACTED]; and [REDACTED]. *Id.* at 93. The treatment plan shows the following regarding Petitioner’s maladaptive behaviors: for [REDACTED], Petitioner’s incidents reduced from approximately [REDACTED]; for [REDACTED], Petitioner’s incidents increased from approximately [REDACTED]; for [REDACTED], Petitioner’s incidents increased from approximately [REDACTED]; for [REDACTED], Petitioner’s incidents decreased from approximately [REDACTED]; for [REDACTED], Petitioner’s incidents increased from approximately [REDACTED]; for [REDACTED], Petitioner’s incidents increased from approximately [REDACTED]; for [REDACTED], Petitioner’s incidents remained at approximately [REDACTED] for [REDACTED], Petitioner’s incidents increased from approximately [REDACTED]; and for [REDACTED], Petitioner’s incidents increased from approximately [REDACTED]. *Id.* at 94 – 97.

4. Petitioner requested continuation of BA services; specifically, 2,600 units of code 97153; 208 units of code 97155 HN; 104 units of code 97155; 104 units of code 97156 and 104 units of code 97156 HN. In a Notice of Outcome (“NOO”), dated October 17, 2023, Respondent terminated Petitioner’s ABA services. *Id.* at 23. The NOO explained the basis for the termination as follows:

[T]he 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.
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: 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 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 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 request is denied.

...

Pages 23 – 24 of RCE 1.

5. Petitioner requested reconsideration of the Respondent’s decision. In a Notice of Reconsideration Determination (“NRD”), dated October 26, 2023, Respondent upheld its decision. *Id.* at 35. The NRD explained the basis for the decision as follows:

PR Recon Determination: At reconsideration all documents were carefully reviewed. According to the Florida Medicaid State Plan (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 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 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.

...

Pages 35 – 36 of RCE 1.

6. On October 25, 2023, Petitioner requested a Fair Hearing to challenge the termination of ABA services. *Id.* at 8. On November 27, 2023, the undersigned issued an Order Scheduling Fair Hearing by Telephone and Prehearing Instructions, setting the hearing for January 4, 2024, at 1:00 p.m. EST. *Id.*

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

- a. This treatment plan has been reviewed by three (3) qualified Board Certified Behavior Analysts at the Masters and Doctoral levels to determine medical

necessity. Petitioner has participated in ABA services since [REDACTED] with this provider. Petitioner may qualify for ABA services with another provider, but does not meet medical necessity criteria with the current provider.

- b. The provider has not included baseline levels on the behavior graphs. See page 94 of RCE 1. Baseline levels for [REDACTED] were [REDACTED] occurrences per week. *Id.* at 91. The [REDACTED] graph depicts much higher levels than baseline at the beginning of the authorization, and levels remain between [REDACTED] [REDACTED] occurrences. *Id.* at 94. This behavior has not improved from baseline levels in [REDACTED]. *Id.* Baseline levels for [REDACTED] were [REDACTED] [REDACTED] occurrences per week. *Id.* at 91. The graph shows that the behavior is currently occurring [REDACTED] times per week, and the behavior exhibits variability and a significant increase near the end of the authorization. *Id.* at 95.
- c. [REDACTED] had a baseline level of [REDACTED] occurrences per week. *Id.* at 91. This behavior shows significant increases throughout the authorization and levels at the end of the authorization above baseline, at [REDACTED] occurrences per week, indicating lack of progress. *Id.* at 95. Baseline for [REDACTED] was [REDACTED] occurrences per week. *Id.* at 91. The graph shows that current levels are at [REDACTED] occurrences per week, an increase from baseline. *Id.* at 95.
- d. Baseline for [REDACTED] was [REDACTED] occurrences per week. *Id.* at 92. The graph shows significant increases in [REDACTED], with levels near [REDACTED] occurrences per week, or baseline levels. *Id.* at 96. Baseline for [REDACTED] was

██████████ occurrences per week. *Id.* at 92. The graph shows occurrences between ██████████ times per week, with most recent occurrences ██████████ times per week. *Id.* at 96. This is above baseline. *Id.* Baseline for ██████████ was ██████████ occurrences per week. *Id.* at 92. Current levels occur between ██████████ occurrences, with variability and no progress. *Id.* at 96.

- e. Baseline for ██████████ was ██████████ instances per week. *Id.* at 92. The graph depicts most recent levels at ██████████ times per week. *Id.* at 97. ██████████ ██████████ has shown significant increases since the beginning of the graph. *Id.* at 97. Overall, the maladaptive behavior graphs show increasing trends. The lead analyst has been authorized for protocol modification, which involves making changes to the interventions. The provider does not indicate modifications throughout the authorization, despite significant increases in multiple behaviors and a lack of progress.
- f. The scales on the replacement behavior graphs do not meet standards of care, as they distort visual analysis. *Id.* at 98. The graphs also lack baseline data. *Id.* Petitioner has been working on the skill of ██████████ for several authorizations, and performance is variable with a decreasing trend near the end of the authorization. *Id.* The behavior of ██████████ ██████████ is lower at the end of the authorization than at the beginning. *Id.* at 99. ██████████ ██████████ tasks has only increased from ██████████ ██████████ *Id.* at 100. ██████████ has increased slightly, but shows

higher performance in [REDACTED], with levels still at [REDACTED]

Id. [REDACTED] shows no progress and a decreasing trend. *Id.* at 101.

- g. [REDACTED] shows a decreasing trend and occurs at a lower level at the end of the authorization than at the beginning. *Id.* at 102. [REDACTED]

still occurs between [REDACTED] *Id.*

[REDACTED] shows variability and occurs at the same level at the beginning and end of the authorization, indicating no progress. *Id.* at 103.

[REDACTED] shows a decreasing trend. *Id.* at 104. [REDACTED]

shows a decrease with no progress from [REDACTED] through the end of the authorization.

Id. [REDACTED] shows a decreasing trend and occurs at a lower level at the end of the authorization. *Id.* at 105.

- h. [REDACTED] and [REDACTED] show variable performance and similar levels at the beginning and end of the authorization. *Id.* at 106. [REDACTED]

still occurs at [REDACTED] *Id.* at 107. [REDACTED] occurs close to

[REDACTED] *Id.* at 108. [REDACTED] occurs at [REDACTED]

at the end of the authorization, indicating lack of progress and a decreasing trend.

Id. at 109. [REDACTED] show lack of progress through the authorization. Modifications, if completed by the provider, are unclear.

- i. The provider does not indicate in the plan when Petitioner was placed in a new environment. It is a standard of care in ABA that an updated assessment be completed upon arrival at a new location when an individual experiences a significant setting change. The provider did not update the assessment until

[REDACTED], after the behaviors had been increasing for several months. Level lack of progress and increases in behavior were observed from [REDACTED]. The provider needed to address these barriers prior, during the previously authorized protocol modification hours.

8. [REDACTED] is the Quality Assurance Manager with [REDACTED]. [REDACTED]

testified to the following at the Fair Hearing:

a. [REDACTED] [REDACTED] [REDACTED] [REDACTED], to [REDACTED] [REDACTED] and [REDACTED] [REDACTED] [REDACTED].

b. [REDACTED] stated Petitioner's [REDACTED] did not provide the time and availability for treatment, and the providers could not implement the treatment plan consistently as required. [REDACTED] stated therapy was often rescheduled or cancelled, which explains the lack of progress, as there was no treatment and extreme inconsistency.

CONCLUSIONS OF LAW

9. 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).

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

11. 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.)

12. 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.

13. 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

14. 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.

15. 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.

16. 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.

17. 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.

18. In the instant case, Respondent terminated Petitioner's ABA services. See ¶ 4. In the NOO dated October 17, 2023, Respondent explained that continuing services at the prior level was 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," as well as "consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational." *Id.* Respondent further explained that "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." *Id.*

19. 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, two components of medical necessity are 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," as well as "consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational." As shown by the record, Petitioner's maladaptive and replacement behaviors are not showing improvement. See ¶¶ 4, 7. Several maladaptive behaviors exhibit increases and a lack of progress from baseline levels, while many of Petitioner's replacement skills show

decreasing trends. *Id.* Dr. Conway also provided credible testimony that the treatment plan does not meet standards of care within the field of ABA, as the graphs do not include baseline data and the replacement behavior graphs distort visual analysis due to the chosen scale. *Id.* Dr. Conway also asserted that the lead analyst was authorized for protocol modification units, which involve making changes to the plan. *Id.* Dr. Conway testified that the provider has not utilized the approved units to make modifications throughout the authorization. *Id.* Although [REDACTED] testified that Petitioner was not receiving consistent treatment, treatment was being rendered, evidenced by the presence of data on the graphs. *See* ¶ 8. As the provider has not utilized the approved protocol modification units to make changes to treatment to facilitate Petitioner's progress, the treatment plan is not "individualized, specific, and consistent" with Petitioner's treatment needs. Furthermore, as the treatment plan lacks evidence of sufficient progress and sufficient modification, and as the graphs lack baseline data and correct scales, the treatment plan is not "consistent with generally accepted professional medical standards." As such, Respondent has demonstrated that it is not medically necessary to continue services with the current provider.


20. 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* ¶ 17. As discussed, *supra* ¶ 18, Petitioner has not made progress in reducing [REDACTED] maladaptive behaviors, nor in improving [REDACTED] replacement behaviors. Here, Petitioner's lack of improvement and the insufficiencies of the treatment plan are well documented.

21. 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 14th day of February, 2024, in Tallahassee, Leon County, Florida.


Joseph Mabry
23-FH2731
2024.02.14
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JOSEPH MABRY, Hearing Officer
Agency for Health Care Administration
Office of Fair Hearings
2727 Mahan Drive, Mail Stop # 11
Tallahassee, FL 32308-5407

NOTICE OF A RIGHT TO JUDICIAL REVIEW

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

ACCORDANCE WITH THE FLORIDA APPELLATE RULES. THE NOTICE OF APPEAL MUST BE FILED WITHIN 30 DAYS OF THE RENDITION OF THE ORDER TO BE REVIEWED.

Copies Furnished To:

[REDACTED]
[REDACTED]

AHCA Medicaid Hearing Unit
MedicaidHearingUnit@ahca.myflorida.com