



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

FILED

Jan 31, 2024, 8:47 am

OFFICE OF FAIR HEARINGS

AHCA Case No.: 23-FH2797

[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 20, 2023, at 9:37 a.m. Eastern Standard Time ("EST").

APPEARANCES

For the Petitioner:

[REDACTED]

Petitioner's Authorized Representative

For the Respondent:

Doris Rivera
Medical Health Care Program Analyst
Agency for Health Care Administration

STATEMENT OF ISSUE

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

The second issue is whether Petitioner proved by a preponderance of the evidence that Respondent's denial of Petitioner's request for additional 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]”), Analyst with Petitioner’s provider, [REDACTED] (“the provider”), appeared as a witness for Petitioner.

Doris Rivera, Medical Health Care Program Analyst 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.

The following Spanish translators appeared at the Fair Hearing to provide translation services: Miguel, ID Number 407003.

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 two hundred and twenty-three (223)-page evidence packet and a forty-nine (49)-page evidence packet. The two hundred and twenty-three (223)-page packet appears in the Office of Fair Hearings’ document management system as the files titled “[REDACTED] FH 12.20.2023 1 – 94.pdf”, “[REDACTED] FH 12.20.2023 95 - 141.pdf”, “[REDACTED] FH 12.20.2023 142 - 195.pdf”, and “[REDACTED] FH 12.20.2023 196 – 223.pdf”. The forty-nine (49)-page packet appears in the Office of Fair Hearings’ document management system as the file titled “23-FH2797 AHCA evidence BA 49 pgs.pdf”. Absent an objection from Petitioner, the undersigned admitted the two hundred and twenty-three (223)-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. At the time of the Fair Hearing, Petitioner was [REDACTED]. See RCE 1 at 16. Petitioner is diagnosed with [REDACTED].
Id. at 16.

3. Petitioner’s provider submitted the Reassessment (“Reassessment” or “treatment plan”), dated August 24, 2023. *Id.* at 140 – 220. According to the treatment plan, Petitioner is engaging in the following maladaptive behaviors: [REDACTED], [REDACTED], [REDACTED], [REDACTED], [REDACTED], [REDACTED], and [REDACTED]. *Id.* at 143 – 144. The data graphs for maladaptive behaviors in the Reassessment show the following between February 4, 2023, and July 15, 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]; and for [REDACTED], Petitioner’s incidents decreased from approximately [REDACTED]. *Id.* at 156 - 163. The maladaptive behavior of [REDACTED] is a new behavior, and the data graph has few points of data. *Id.* at 164.

4. As provided in the Reassessment, the data graphs for replacement behaviors show the following progress between February 4, 2023, and July 22, 2023: an increase [REDACTED] from [REDACTED]; a decrease in [REDACTED] from [REDACTED] an increase in [REDACTED] from [REDACTED] an increase in [REDACTED] from [REDACTED] a decrease in [REDACTED] from [REDACTED] an increase in [REDACTED] from [REDACTED] a decrease [REDACTED] from [REDACTED] an increase in [REDACTED] from [REDACTED] an increase in [REDACTED] from [REDACTED] an increase in [REDACTED] from [REDACTED] an increase in [REDACTED] from [REDACTED] and an increase in [REDACTED] from [REDACTED] *Id.* at 188 – 200. The replacement behaviors of [REDACTED], [REDACTED], [REDACTED], and [REDACTED], and the data graphs have few points of data. *Id.* at 202 – 204.

5. On July 20, 2023, Petitioner requested continuation of BA services; specifically, 3,120 units of code 97153; 312 units of code 97155; and 208 units of code 97156. *See* RCE 1 at 25. In a Notice of Outcome (“NOO”), dated August 8, 2023, Respondent terminated Petitioner’s BA services. *Id.* at 25 – 29. The NOO states as follows:

Code: 97153 Intervention without protocol modification, per 15 minutes, Lead Analyst, BCaBA, or RBT
From: 7/28/23
Thru: 1/23/24
Total Units: Denied 3,120

Code: 97155 Intervention without protocol modification, per 15 minutes
From: 7/28/23
Thru: 1/23/24
Total Units: Denied 312

Code: 97156 Family training, per 15 minutes, Lead Analyst
From: 7/28/23
Thru: 1/23/24
Total Units: Denied 208

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:

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

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

PR Clinical Rationale – Denial: Provider, there was an addendum stating additional documentation would be submitted but no updated treatment plan was included.

The supporting documentation does not meet generally accepted practices within the field of applied behavior analysis and standards set forth in the Florida Behavior Analysis Services Coverage Policy (Pages 6-7). The provider was approved to complete an assessment. The provider has not submitted all graphed data for skill acquisition goals and maladaptive behaviors that were to be completed during the assessment. The provider was requested to produce those graphed data to continue behavior analysis services. The provider has submitted graphed baseline data that do not reflect information in their treatment plan. The new baseline data ([REDACTED]) appear fabricated.

The supporting documentation does not meet generally accepted practices within the field of applied behavior analysis and standards set forth in the Florida Behavior Analysis Services Coverage Policy (Pages 6-7). Specifically, the provider has failed to write an intervention plan that upholds the standards of care of applied behavior analysis. The plan lists procedures that include punishment and has not exhausted reinforcement to provide a justification for punishment in the plan. The provider did not respond to the request.

[REDACTED] strategies and [REDACTED] are not empirically supported procedures within the conceptual system of behavior analysis for treating the functions of maladaptive behavior. According to Behavior Analysis Services Coverage Policy (page 6-7), treatment that does not meet generally accepted standards of care within the field of applied behavior analysis are not covered under the behavior analysis service coverage policy.

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 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 25 – 26.

6. In a Notice of Reconsideration Determination (“NRD”), dated September 15, 2023, Respondent upheld its decision. *Id.* at 37 - 41. The NRD explained the basis for the decision as follows:

PR Recon Determination: 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 in relation to the lack of progress. The information submitted does not meet standards of care within the field of behavior analysis. Additionally, The information submitted does not meet standards of care within the field of behavior analysis. The provider has included baseline data and graphs for skill acquisition goals and maladaptive behaviors that were based on parent report, extrapolated average (pg 25) and/or sourced from indirect interview; and were not directly observed or measured as standards of care within the field of behavior analysis. This request is denied.

RCE 1 at 38.

7. On October 27, 2023, Petitioner requested a Fair Hearing to challenge the termination BA services. On November 29, 2023, the Office of Fair Hearings issued an Order Scheduling Fair Hearing and Prehearing Instructions, setting the hearing for December 20, 2023, at 9:30 a.m. EST.

8. Dr. Conway is a BCBA and a Second Level Reviewer for eQHealth. Dr. Conway 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. 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 August of 2020, over three (3) years. The provider's treatment plan has been determined to not meet medical necessity criteria 2 and 3 due to lack of sufficient progress and lack of modifications to address the lack of progress.
- c. Petitioner may qualify for ABA services based on the maladaptive behaviors and skill deficits, but medically necessary criteria is not met with this provider.
- d. The provider requested a significant increase in the number of hours requested for both direct services and protocol modifications. This increase was deemed not medically necessary as well.
- e. A chart for Petitioner's maladaptive behaviors includes initial information that was collected by Petitioner's parent, and there was not an initial baseline that was observed by the provider before starting treatment which is a standard of care in the field of ABA. The provider submitted new baseline information in [REDACTED]. This is not a true baseline as there were interventions that took place for [REDACTED] before the provider took baseline data.
- f. Dr. Conway reviewed the graphs for Petitioner's maladaptive behaviors. The data graph for [REDACTED] does not show a significant difference from the beginning of the authorization period. See RCE 1 at 156. This behavior has been targeted for over [REDACTED] and has not shown significant changes. The data graph for [REDACTED] shows variability. See RCE 1 at 157. The data graph for [REDACTED] shows a slight decrease in the behavior but is variable. See RCE 1 at 158. The data graph for [REDACTED] shows the behavior is variable. See RCE

1 at 160. The data graph for [REDACTED] shows a recent decrease in the behavior but does not show significant changes from the beginning of the authorization period. See RCE 1 at 161. The data graph for [REDACTED] shows minimal decrease. See RCE 1 at 162. The data graph for [REDACTED] shows high variability. See RCE 1 at 163. The [REDACTED] is a new behavior and the data graph shows the behavior was occurring on daily basis the same number of instances as on a weekly basis. See RCE 1 at 164. Respondent pended this as the data did not align. The provider submitted the same plan.

- g. A caregiver is not a trained professional and should not provide data that is submitted. The data should be collected daily during session by a BCBA, registered behavior technician (“RBT”), and/or an analyst.
- h. Dr. Conway reviewed the graphs for Petitioner’s replacement skills and skill acquisition goals. The data graph for [REDACTED] shows minimal progress. See RCE 1 at 188. The data graph for [REDACTED] shows Petitioner is performing [REDACTED] of the time [REDACTED]. See RCE 1 at 191. The data graph for [REDACTED] shows Petitioner is only performing [REDACTED] of the time with a prompt. The data graph for [REDACTED] shows steady progress then a decrease when the prompt level changed, but it is unclear. See RCE 1 at 194. The data graph for [REDACTED] distorted information as the y-axis shows 0% to 80%, not 0% to 100%. See RCE 1 at 196. The data graph for remain seated shows Petitioner is performing at similar levels at the end of the authorization period as the beginning and the graph has a

distorted scale. See RCE 1 at 197. The data graph for [REDACTED] shows slight progress. See RCE 1 at 198. The data graph for [REDACTED] shows a significant increase in performance. See RCE 1 at 205. The data graph for [REDACTED] shows a significant decrease in the behavior. See RCE 1 at 207. Overall, the replacement skills and skill acquisition goals show minimal progress.

- i. The provider's treatment plan does not meet medical necessity criteria 2 and 3 and the request is in excess of Petitioner's needs. The treatment plan shows a lack of progress and a lack of modifications.
9. [REDACTED], Petitioner's Authorized Representative and [REDACTED], testified as follows:
- a. Petitioner hits [REDACTED] and [REDACTED].
 - b. [REDACTED] has observed improvements in Petitioner.

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 regarding the termination. Because Petitioner requested additional BA services, Fla. Admin. Code R. 59G-1.100(17)(g) assigns the burden of proof to the Petitioner regarding the additionally requested services. The standard of proof in an administrative hearing is a preponderance of the evidence. The preponderance of

the evidence standard requires proof by “the greater weight of the evidence” (Black’s Law Dictionary at 1201, 7th Ed.).

13. 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.

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:

- i. i. Safety - aggression, self-injury, property destruction, elopement
- ii. ii. Communication - problems with expressive/receptive language, poor understanding or use of
- iii. non-verbal communications, stereotyped, repetitive language
- iv. iii. Self-stimulating, abnormal, inflexible, or intense preoccupations
- v. iv. Self-care - difficulty recognizing risks or danger, grooming, eating, or toileting

- vi. 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 – 46.

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 4 – 5.

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

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

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 ¶ 5. The data did not show sufficient improvement in the maladaptive behaviors. See ¶ 3, 8. In the NOO dated August 8, 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 “[c]onsistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigation.” See ¶ 5. Respondent further explained that “[r]equested services are denied because documentation is neither showing improvement nor support for maintenance” and that 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.” See ¶ 5.

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 “consistent with generally accepted professional medical standards as determined by the Medicaid program, and

not experimental or investigational". See ¶ 17. [REDACTED] testified that [REDACTED] has observed improvements in Petitioner. See ¶9. However, as shown by the record, Petitioner's submitted Reassessment does not show sufficient improvement regarding the reduction of maladaptive behaviors and little improvement in increasing Petitioner's replacement behaviors. See ¶ 3 – 4, 8. As Dr. Conway testified there has been insufficient progress over the course of three (3) years of treatment and that Petitioner may qualify for ABA services based on the maladaptive behaviors and skill deficits, but medically necessary criteria is not met with this provider. See ¶ 8. Dr. Conway established that the provider's treatment plan has been determined to not meet medical necessity criteria 2, that services be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs, and criteria 3, that services be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational, due to lack of sufficient progress and lack of modifications to address the lack of progress. See ¶ 8. Further, the Reassessment included new baseline information which is true baseline as there were interventions that took place for [REDACTED] before the provider took baseline data. See ¶ 8. With regard to maladaptive behaviors, Dr. Conway established that the data graphs showed minimal decrease and high variability. See ¶ 8. With regard to replacement skills, Dr. Conway established that the data graphs for replacement skills and skill acquisition goals showed minimal progress. See ¶ 8. Finally, Dr. Conway established that the treatment plan shows a lack of progress and a lack of modifications. See ¶ 8. 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."

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 treatment plan is ineffective. Petitioner's lack of improvement is well documented.


22. Upon consideration of the testimony provided, Respondent's Composite Exhibit 1, Respondent's Composite Exhibit 2, the EPSDT policy, and other applicable policies, the undersigned concludes that Respondent proved by a preponderance of the evidence that the ABA services at issue do not meet medical necessity criteria. 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.

23. With regard to the second issue identified for resolution in this case, because Respondent demonstrated by a preponderance of the evidence that the termination of BA services was correct, the record does not show that an increase in BA services was warranted. Therefore, Petitioner did not prove by a preponderance of the evidence that Respondent's denial of the requested additional BA services was incorrect.

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 31st day of January, 2024 in Tallahassee, Leon County, Florida.

 Kameisha Presley
23-FH2797
2024.01.31
08:37:24 -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
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