



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

FILED

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OFFICE OF FAIR HEARINGS

[REDACTED]

PETITIONER,

AHCA Case No.: 23-FH2959

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 16, 2024, at 10:04 a.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 first issue is whether Petitioner proved by a preponderance of the evidence that Respondent's denial of Petitioner's request for behavior analysis ("BA" or "ABA") services was incorrect.

The second issue is whether Respondent proved by a preponderance of the evidence that Respondent's decision to terminate Petitioner's ABA services was correct.

PRELIMINARY STATEMENT

All parties and witnesses appeared telephonically. [REDACTED] (“ [REDACTED] [REDACTED]”), Petitioner’s Authorized Representative and [REDACTED], appeared for the Fair Hearing to offer testimony on behalf of Petitioner.

Lee Ann Williams, Medical Health Care Program Analyst and Fair Hearing Liaison for the Agency for Health Care Administration (“Agency” or “AHCA”), appeared for the Fair Hearing as representative for Respondent. Dr. Melissa Switzer (“Dr. Switzer”), Board Certified Behavior Analyst (“BCBA”) at the doctoral level and Second Level Reviewer for eQHealth Solutions Florida (“eQHealth”), appeared for the Fair Hearing as a witness for Respondent.

The following individuals appeared for Fair Hearing to provide translation services for Petitioner: Freddy, interpreter number 371696 of Language Line Solutions (“Language Line”); Henry, interpreter number 369975 of Language Line; and, Alex, interpreter number 383820 of Language Line.

Prior to the hearing, Petitioner sent to the Office of Fair Hearings a thirty-three (33)-page evidence packet. The thirty-three (33)-page evidence packet appears in the Office of Fair Hearings’ document management system as the file title “23-FH2959Received Mail DAR, Supporting Documents.pdf.” Absent an objection from the Respondent, the undersigned admitted the thirty-three (33)-page evidence packet into evidence as Petitioner’s Composite Exhibit 1 (“PCE 1”).

Prior to the hearing, the Office of Fair Hearings received a two hundred and thirty-one (231)-page evidence packet and a forty-nine (49)-page evidence packet from Respondent. The two hundred and thirty-one (231)-page packet appears in the Office of Fair Hearings document

management system as the file titles "[REDACTED] FH 01.16.2024 1-108.pdf," "[REDACTED] FH 01.16.2024 109-140.pdf," "[REDACTED] FH 01.16.2024 141-177.pdf," "[REDACTED] FH 01.16.2024 178-212.pdf," and "[REDACTED] FH 01.16.2024 213-231.pdf." The forty-nine (49)-page evidence packet appears in the Office of Fair Hearings document management system as the file title "23-FH2959 Agency Evidence Legal Authorities 49 pages.pdf." Absent an objection from the Petitioner, the undersigned admitted the two hundred and thirty-one (231)-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 ("QIO") contracted by the Agency to review authorization requests for services. See RCE 2 at page 2.

2. Petitioner is [REDACTED]. See RCE 1 at page 22. Petitioner is diagnosed with [REDACTED].
Id.

3. As provided in the Behavior Analysis Plan Assessment ("Treatment Plan") submitted by [REDACTED], Petitioner is engaging in the following maladaptive behaviors:

[REDACTED], [REDACTED], [REDACTED], [REDACTED], [REDACTED], [REDACTED], [REDACTED] ("[REDACTED]"), [REDACTED], [REDACTED], and [REDACTED]

[REDACTED]. *Id.* at 168-171. As provided in the Treatment Plan, Petitioner's incidents of maladaptive behaviors, for the period of May 2023 to October 2023, are as follows: for [REDACTED], Petitioner's incidents decreased from about [REDACTED] per week; for [REDACTED], Petitioner's incidents decreased from about [REDACTED] per week; for [REDACTED],

[REDACTED], Petitioner increased from [REDACTED] and for c [REDACTED]
[REDACTED], Petitioner increased from [REDACTED] *Id.* at 193-215.

5. Petitioner requested additional ABA services and recertification of ABA services for the authorization period of November 5, 2023, to May 2, 2024; specifically, 3,120 units of code 97153; 416 units of code 97155; and 312 units of code 97156. *Id.* at 29-31. This is an increase of approximately three (3) hours per week of total services. *Id.* at 24. In a Notice of Outcome (“NOO”), dated November 17, 2023, Respondent denied Petitioner’s requested increase of ABA services and terminated all previous units. *Id.* The NOO explained the basis for the denial and 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.

The NOO further provided:

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 (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.

Id. at 29-30.

6. Petitioner requested reconsideration of the Respondent's decision. In a Notice of Reconsideration Determination ("NRD"), dated December 4, 2023, Respondent upheld its decision. *Id.* at 41-42. 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.

Id. at 42.

7. On November 27, 2023, Petitioner requested a Fair Hearing to challenge the denial of additional ABA services and the termination of all ABA services. On December 13, 2023, the undersigned issued an Order Scheduling Fair Hearing and Prehearing Instructions, setting the hearing for January 16, 2024, at 10:00 a.m. EST.

8. [REDACTED] testified to the following at Fair Hearing:

a. Petitioner has been receiving ABA therapy for [REDACTED] with this provider.

- b. [REDACTED] believes Petitioner has made progress and it is due to the therapy received.
9. Dr. Switzer established the following at Fair Hearing:
- a. eQHealth is hired by AHCA to provide assurance of quality services to Medicaid recipients by following the five (5) “medically necessary” criteria. *See* RCE 2 at page 7. As Dr. Switzer testified, eQHealth uses a two-level peer review process for their determination that the information submitted did not meet standards of care in the field of ABA and was therefore denied. *See* RCE 1 at 24-25.
 - b. Dr. Switzer contended that Petitioner’s provider submitted a Treatment Plan that does not show sufficient progress has been made and does not include interventions to address the lack of effectiveness. *See* ¶ 3-4 and RCE 2 at 7.
 - c. Dr. Switzer opined that maladaptive behaviors typically have 1 or 2 hypothesized functions, and any more than that requires an additional assessment. Dr. Switzer pointed out that most of Petitioner’s behaviors, such as [REDACTED] and [REDACTED], contain 4 functions which do not appear to be part of an individualized assessment. *See* RCE 1 at 168-169.
 - d. All data graphs show similar level trends in frequency, indicating a lack of effective treatment and no progress. As an example, the graph for [REDACTED] indicates the frequency of this behavior occurred around [REDACTED] week, ending at about [REDACTED] period, demonstrating no significant clinical changes. *See* ¶ 3.
 - e. Dr. Switzer argued that many of the graphs show the same pattern of level trends with no variability atypical of expected human behavior.

- f. Dr. Switzer argued that the provider's interventions to implement differential reinforcement of alternative behavior ("DRA"), differential reinforcement of other behavior ("DRO"), and differential reinforcement of incompatible behaviors ("DRI") appear to be textbook definitions and not individualized to Petitioner's needs because they cannot be implemented simultaneously, in accordance with standards of care in the field of ABA. *Id.* at 178-179.
- g. Dr. Switzer contended that the replacement skills are not individualized to Petitioner where all short-term objectives ("STO") include prompt-level procedures, indicating that the provider would prompt Petitioner for a correct response until the behavior changed. *See* RCE 1 at 193-216.
- h. Dr. Switzer opined that in the field of ABA, as trials progress, Petitioner should reach at least 50% success in skill acquisition. When Petitioner indicates incorrect responses, the provider should change the prompt schedule to obtain accurate prompt probability.
- i. The graph for "[REDACTED]" shows an increase in successful response but the data does not show 50% success with verbal prompts which is less than chance level responding. *Id.* at 194.
- j. Regarding caregiver training objectives, the provider indicated that the caregiver would collect data on Petitioner's behavior. Dr. Switzer argued that a caregiver is not in a position to collect data and thus affects the integrity of the data. *Id.* at 217.

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 (2022). 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 Rule 59G-1.100(17)(b), Florida Administrative Code Rule (“Fla. Admin. Code R.”).

12. Because Petitioner requested additional ABA services, Fla. Admin. Code R. 59G-1.100(17)(g) assigns the burden of proof to the Petitioner. 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. 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.)

14. The Florida Medicaid Behavior Analysis Services Coverage Policy (October 2017) (“BA Policy”), incorporated by reference in Fla. Admin. Code. R. 59G-4.125, governs ABA 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.

See RCE 2 at 38-44.

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

These Review Criteria state as follows:

Review Criteria for Behavior Analysis Services

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

Critical Elements Necessary for ANY Type of Behavior Analysis Service:

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

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

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

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

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

- a. **ALL** critical elements are met
- b. An assessment or, if applicable, a reassessment, authored by a lead analyst, is provided. An assessment of the maladaptive behavior(s) is a necessary element of the process of identifying the frequency and magnitude of the behaviors as well as the variables associated with the occurrence of the maladaptive behavior(s). This helps in defining what are the functional consequences of the problem behavior(s) so that an adequate behavior plan can be implemented. This (re)assessment **MUST** include, at a minimum, **ALL** of the following:
 - i. A clear operational description of the maladaptive behavior(s)
 - ...
- c. A behavior plan authored or updated by a lead analyst. The behavior plan is the cornerstone of the delivery of behavior analysis services and it is based on the information obtained in the assessment. It proposes specific interventions to reduce or eliminate the maladaptive behavior. These interventions take into consideration the variables, both present before the behavior, as well as after the behavior, that influence the occurrence of the maladaptive behavior(s). This plan also includes

replacement appropriate behaviors for the recipient to engage in instead of the maladaptive behaviors in order to obtain the same function. The plan must be detailed enough to warrant the requested services and include mechanisms to monitor its effectiveness. This **MUST** include, at a minimum, **ALL** of the following:

- i. Observable and measurable descriptions of the maladaptive behavior(s)
- ii. Identified function of the maladaptive behavior(s) behavior as a result of the assessment or reassessment conducted
- iii. Goals and strategies for changing the maladaptive behavior(s)
- iv. Written detailed description of when, where, and how often these goals will be addressed and proposed strategies will be implemented
- v. System for monitoring and evaluating the effectiveness of the plan
- vi. Safety and crisis plan, if applicable
- vii. Summary and recommendations
- viii. Discharge criteria
- ix. Transition plan (if applicable)

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

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

- a. ALL criteria listed in 2a, 2b, and 2c regarding critical elements, assessment or reassessment, and behavior plan, are met.
- b. The data provided must show evidence that the frequency of the maladaptive behavior(s) has decreased since the last review and, if not, that there is a modification of the behavior plan.
- c. The level of functional impairment justifies continuation of BA services. The reviewer utilizes the information provided below as a guide as it relates to the level of functional impairment as expressed through the following behaviors:
 - i. Safety – aggression, self-injury, property destruction, elopement
 - ii. Communication – problems with expressive/receptive language, poor understanding or use of non-verbal communications, stereotyped, repetitive language
 - iii. Self-stimulating, abnormal, inflexible, or intense preoccupations

- iv. Self-care – difficulty recognizing risks or danger, grooming, eating, or toileting
- v. Other – behaviors not identified above

...

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. 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

See RCE 2 at 45-47.

16. States must provide Early and Periodic Screening, Diagnostic, and Treatment (“EPSDT”) services to Medicaid-eligible children under age 21 when requested under the Medicaid state plan. See 42 U.S.C. § 1396a(a)(43); 42 U.S.C. § 1396d(a)(4). According to 42 U.S.C. § 1396d(r)(5), EPSDT services mean, in relevant part, the following items and services:

Such other necessary health care, diagnostic services, treatment, and other measures described in subsection (a) of this section to correct or ameliorate defects and physical and mental illness and conditions discovered by the screen services, whether or not such services are covered under the state plan.

17. Petitioner is under age 21, and therefore EPSDT applies to [REDACTED] request for services.

However, a state may place medical necessity limitations on EPSDT services. See 42 C.F.R. §§ 440.230(a), (b), (d). Section 409.905(2), Florida Statutes, limits EPSDT services with a medical necessity standard:

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

18. The Florida Medicaid Definitions Policy (August 2017) (“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.

See RCE 2 at 23.

19. The Florida Medicaid Authorization Requirements Policy (June 2016) (“Authorization Policy”), incorporated by reference in Fla. Admin. Code R. 59G-1.053, provides general requirements for providers to obtain authorization to render Florida Medicaid services. See RCE 2 at 30-36. The Authorization Policy states as follows:

3.0 Determination Process

3.1 Review Criteria

The QIO may use a national standardized set of criteria, or other set of criteria, approved by AHCA, as a guide for authorizations performed at the first review level. If services cannot be approved at the first level review, the QIO’s physician peer reviewer will determine medical necessity using his or her clinical judgment, acceptable standards of care, state and federal laws, and AHCA’s medical necessity definition.

3.2 Review Process

The QIO will review each authorization request and will approve, deny, or request additional information. The QIO may deny a portion of the requested units of service if it cannot substantiate medical necessity based upon the information submitted.

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.

Id. at 34.

20. In the instant case, Petitioner is under 21 years of age and is diagnosed with [REDACTED]. See

¶ 2. Petitioner requested additional ABA services and recertification of previously authorized ABA services. See ¶ 5. In a NOO, dated November 17, 2023, Respondent denied the request and terminated all ABA services. See ¶ 5. Respondent cited the lack of medical necessity as the basis

for their decision, specifically that the requested ABA services must be “[i]ndividualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient’s needs.” See ¶ 5. The Definitions Policy defines a component of medical necessity as “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.” See ¶ 18. 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 ¶ 16-17. Petitioner has burden of proof to show by a preponderance of evidence that the Respondent’s denial of additional ABA services was incorrect. See ¶ 12. Respondent has burden of proof to show by a preponderance of evidence that the Respondent’s termination of ABA services was correct. See ¶ 13.

21. The record shows that Petitioner engages in maladaptive behaviors that qualify for ABA services. See ¶ 3. The Petitioner’s maladaptive behaviors as indicated in the Treatment Plan include [REDACTED], [REDACTED], [REDACTED], [REDACTED], [REDACTED], [REDACTED], [REDACTED], [REDACTED], and [REDACTED]. See ¶ 3. The record shows that Petitioner has received ABA services with this provider for the past [REDACTED]. See ¶ 8. [REDACTED] believes Petitioner has made progress with [REDACTED] behaviors and it has been due to the therapy received from the provider. See ¶ 8. Three eQHealth reviewers did not find that the data in the Treatment Plan showed evidence that the frequency of the maladaptive behavior(s) has decreased. See ¶ 5-6, 9. During testimony, Dr. Switzer contended that Petitioner’s provider submitted a Treatment Plan was not individualized, specific, and consistent with Petitioner’s confirmed diagnosis. See ¶ 9.

22. Section 9.0 of the BA Policy maintains that the “behavior plan is the cornerstone of the delivery of behavior analysis services.” See ¶ 15. The criteria for behavior analysis services require that a behavior plan must be detailed enough to warrant the requested services and include mechanisms to monitor its effectiveness. See ¶ 15. The criteria for assessing the intensity of behavior analysis services requires that proper justification for the requested hours of services is adequately documented in the behavior plan. See ¶ 15.

23. The record shows that Petitioner’s provider submitted a Treatment Plan that does not show sufficient progress has been made and does not include interventions to address the lack of effectiveness. See ¶ 3-4, 5-6, 9. At Fair Hearing, Dr. Switzer opined that maladaptive behaviors typically have 1 or 2 hypothesized functions, and any more than that requires an additional assessment. See ¶ 9. Most of Petitioner’s behaviors, such as [REDACTED], contain 4 functions which do not appear to be part of an individualized assessment. See ¶ 9. In addition, Dr. Switzer argued that the maladaptive behavior data graphs show similar level trends in frequency, indicating no progress. See ¶ 9. As an example, the graph for [REDACTED] indicates the frequency of this behavior began around [REDACTED] week, ending at about [REDACTED] period, demonstrating no significant clinical changes. See ¶ 3, 9. Dr. Switzer argued that many of the graphs show the same pattern of level trends with no variability atypical of expected human behavior. See ¶ 9. Generally accepted professional medical standards require modification of the treatment plan where there are no significant clinical changes in behaviors. See ¶ 15. Dr. Switzer argued that the provider’s plan to implement DRA, DRO, and DRI interventions appear to be textbook definitions and not appropriate ABA standards of care. See ¶ 9. The record also indicates Petitioner does not even show 50% success with verbal prompts, i.e. less than chance-level responding, nor has the

provider implemented changes to the prompt schedule to obtain accurate prompt probability for incorrect responses. See ¶ 4, 9. The record appears to clearly document Petitioner’s lack of progress over the course of the previous authorization period. See ¶ 3-4, 9. Based on these discrepancies, the undersigned finds that the Treatment Plan does not appear to justify the requested increase in services to implement ABA therapy effectively. See ¶ 14-15. All in all, the undersigned finds Dr. Switzer’s testimony persuasive and consistent with the evidence record to demonstrate that the Treatment Plan was “in excess of [Petitioner]’s needs.” See ¶ 9, 18.

24. Upon consideration of the testimony provided, evidence submitted, and applicable policies, the undersigned concludes that Petitioner did not prove by a preponderance of the evidence that the additional ABA services at issue are medically necessary. Looking at all the evidence relevant to the particular needs of Petitioner, Petitioner has not demonstrated that the requested services, based on the Treatment Plan at issue in this case, are necessary to correct or ameliorate a defect or a physical and mental illness or condition. Accordingly, Petitioner did not prove by a preponderance of the evidence that Respondent’s denial of additional ABA services was incorrect.

25. Lastly, as QIO for the Agency, eQHealth is authorized to terminate services when “the reviewing physician determines the recipient will not gain any additional benefit by continuing services at the current level.” See ¶ 19. As discussed, Petitioner’s maladaptive behaviors have not improved since the last authorization period and the provider did not show evidence of effective modification of the behavior plan to address the lack of progress with Petitioner’s behaviors. See ¶ 22-23. Respondent provided sufficient evidence to demonstrate that the request for continuation of ABA services is not “individualized, specific, and consistent with symptoms or

confirmed diagnosis of the illness or injury under treatment.” See ¶ 18, 22. Moreover, Dr. Switzer argued that where a caregiver’s goal is to collect data, this affects the integrity of the data. See ¶ 9. All in all, the undersigned concludes that the request for continuation of ABA services was not supported by the documentation in the submitted Treatment Plan. See ¶ 22-23.


26. Upon consideration of the testimony provided, evidence submitted, and applicable policies, the undersigned concludes that Respondent proved by a preponderance of the evidence that continuing ABA services was not medically necessary for Petitioner. Looking at all the evidence relevant to the particular needs of Petitioner, Respondent has demonstrated that the ABA services are not medically 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 denial of additional ABA services is **AFFIRMED**. Petitioner’s appeal based on Respondent’s denial is **DENIED**.

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

DONE AND ORDERED this 8th day of March, 2024 in Tallahassee, Leon County, Florida.

 Kimberly Roche
23-FH2959
2024.03.08
07:58:33 -05'00'

KIMBERLY ROCHE, Hearing Officer
Agency for Health Care Administration
Office of Fair Hearings
2727 Mahan Drive, Mail Stop # 11

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]
[REDACTED]
[REDACTED]

AHCA Medicaid Hearing Unit
MedicaidHearingUnit@ahca.myflorida.com