



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

FILED

Feb 21, 2024, 9:10 am

[REDACTED],

PETITIONER,

OFFICE OF FAIR HEARINGS
AHCA CASE NO.: 23-FH2980

vs.

AGENCY FOR HEALTH CARE
ADMINISTRATION,

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, Hearing Officer Debbie Winicki convened a telephonic Fair Hearing on the instant case on January 16, 2024, at 9:00 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 issue is whether Respondent proved by a preponderance of the evidence that Respondent’s decision to terminate Petitioner’s Applied Behavior Analysis services (“BA” or “ABA”) services was correct.

PRELIMINARY STATEMENT

All parties and witnesses appeared telephonically. Petitioner's Authorized Representative and [REDACTED], [REDACTED] ("[REDACTED]"), appeared on behalf of Petitioner. [REDACTED], Board Certified Assistant Behavior Analyst ("BCaBA") at [REDACTED], attended as a witness for Petitioner.

Doris Rivera, Medical/Health Care Program Analyst for the Agency for Health Care Administration ("Agency" or "AHCA"), appeared on behalf of Respondent. Dr. David Bicard ("Dr. Bicard"), BCBA at the Doctoral level for eQHealth Solutions Inc. ("eQHealth") attended as a witness for Respondent.

Prior to the hearing, Respondent sent to the Office of Fair Hearings and Petitioner a two hundred and ninety-six (296)-page evidence packet appearing in the Office of Fair Hearings' document management system as file titles "[REDACTED]-FH 12.28.2023 1-144.pdf" and "[REDACTED]-FH 12.28.2023 145-296.pdf"; and a fifty (50)-page evidence packet appearing in the Office of Fair Hearings' document management system as the file title "23-FH2980 AHCA BA Evidence-50 pgs.pdf." Absent an objection from the Petitioner, the Hearing Officer admitted the one hundred and ninety-six (296)-page evidence packet into evidence as Respondent's Composite Exhibit 1 ("RCE 1") and the fifty (50)-page evidence packet into evidence as Respondent's Composite Exhibit 2 ("RCE 2").

Prior to the hearing, Petitioner sent to the Office of Fair Hearings and Respondent a one hundred and one (101)-page evidence packet appearing in the Office of Fair Hearings' document management system as file title "23-FH2980 Email Correspondence-Supporting Documents.pdf."

Absent an objection from the Petitioner, the Hearing Officer admitted the one hundred and one (101)-page evidence packet into evidence as Petitioner’s Composite Exhibit 1 (“PCE 1”).

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.* Petitioner has participated in BA services with the current provider, [REDACTED] (“Provider”), since [REDACTED]. *Id.* at 105.

3. As provided in the Behavior Analysis Re-Assessment (“treatment plan”), Petitioner engages in the following maladaptive behaviors: [REDACTED], [REDACTED], [REDACTED], [REDACTED], [REDACTED], [REDACTED], [REDACTED], and [REDACTED]. *Id.* at 241 - 257. The treatment plan shows the following: for [REDACTED], Petitioner shows variable data, with no improvement; for [REDACTED], Petitioner shows variable data, with no improvement; for [REDACTED], Petitioner shows variable data, with no improvement; for [REDACTED], Petitioner shows variable data, with many instances of [REDACTED]; for [REDACTED], Petitioner shows variable data; for [REDACTED], Petitioner shows variable data; for [REDACTED], Petitioner shows variable data, with many instances of [REDACTED]; for [REDACTED], Petitioner shows variable data, with an increasing trend; and for [REDACTED], Petitioner shows variable data, with no improvement. *Id.* at 241 – 257.

4. Petitioner requested continuation of ABA services for the period from October 24, 2023, through April 20, 2024. *Id.* at 20 -21. Specifically, Petitioner requested 3,120 units of code 97153, intervention without protocol modification, per 15 minutes, Lead Analyst, BCaBA, or RBT; 208 units of code 97155, intervention with protocol modification, per 15 minutes; 104 units of code 97155 (HN), intervention with protocol modification, per 15 minutes; 52 units of code 97156, family training, per 15 minutes, Lead Analyst; and 52 units of code 97156 (HN), family training, per 15 minutes, Lead Analyst. *Id.*

5. In a Notice of Outcome (“NOO”), dated October 25, 2023, Respondent terminated Petitioner’s ABA services. 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. Specifically, the requested services are not medically necessary under the following standard(s):

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

The rationale for our decision is as follows:

PR Clinical Reason – Denial:

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

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 inconsequence-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.

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Pages 24 – 25 of RCE 1.

6. Petitioner requested reconsideration of the Respondent’s decision. In a Notice of Reconsideration Determination (“NRD”), dated November 29, 2023, Respondent upheld its decision. *Id.* at 36 - 39. The NRD explained the rationale 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 37.

7. On November 29, 2023, Petitioner requested a Fair Hearing to challenge the termination of ABA services. On December 27, 2023, the Hearing Officer issued an Order Scheduling Fair Hearing and Prehearing Instructions, setting the hearing for January 16, 2024, at 9:00 a.m. EST.

Id. at 8 - 12. Petitioner received administrative approval, or continuation of benefits, pending the outcome of the Fair Hearing. *Id.* at 20.

8. When reviewing the effectiveness of a treatment plan, what is looked at is whether maladaptive behaviors are being reduced. See, Appendix 9.0 of the BA Policy providing Review Criteria for Behavior Analysis Services, *infra* ¶ 18.

9. Dr. Bicard is a Board-Certified Behavior Analyst at the doctoral level. Dr. Bicard established that eQHealth reviews behavior analysis cases to ensure that providers are giving quality care consistent with the standards enumerated in the BA Policy as well as professional medical standards of applied behavior analysis (“ABA”). eQHealth reviewed the treatment plan submitted in this case to determine whether all five (5) conditions of medical necessity are met. The current treatment plan went through a peer review process conducted by three (3) Board Certified Behavior Analysts (BCBAs), including two at the doctoral level. The reviewing BCBAs each returned the treatment plan to the provider, requesting that the current treatment plan be revised to include additional information to show how the plan would effectively treat Petitioner to decrease ■ maladaptive behaviors and increase ■ replacement behaviors. The Provider revised the treatment plan, but each time the treatment plan was determined insufficient for effective treatment, therefore, the plan did not meet medical necessity criteria. See RCE 1 at 36.

10. Dr. Bicard established that, consistent with standards of care in the field of ABA, data graphs are the best way to measure progress in a recipient’s ABA treatment, and that progress is essential. Dr. Bicard explained that the Agency relies on data submitted by the lead analyst in the BA plan. For example, Dr. Bicard testified, the treatment plan for Petitioner shows the following graphical data: for the maladaptive behaviors of ■ there is no

progress with no breaks in treatment for modifications; for [REDACTED], the data bounces up and down and shows no progress; for [REDACTED], [REDACTED] and [REDACTED], the data shows those behaviors worsened during the authorization period with no intervention; for [REDACTED] the behavior increased with no intervention. Dr. Bicard testified that for the behavior of [REDACTED], for instance, that behavior is easy to decrease but this provider has not been treating it properly for [REDACTED] years and they should make changes. *Id.* at 242 – 254.

11. Dr. Bicard testified that the graphs for skills acquisitions show a high degree of variability with ineffective treatment. For instance, Dr. Bicard noted, the replacement behavior of “[REDACTED]” is more for the benefit of the provider and not the recipient. For “[REDACTED]” the data bounces from 0 to 100, indicating that the provider must make changes to the treatment. For “[REDACTED]” the graph shows that provider is either not running the program or data was not taken. For “[REDACTED]” the data shows Petitioner is only doing 5 seconds. *Id.* at 258 – 262.

12. Dr. Bicard acknowledged that ABA treatment is necessary for Petitioner, but the treatment [REDACTED] is receiving from the provider in the current plan is substandard and ineffective, therefore, the plan is not consistent with generally accepted professional medical standards, as determined by the Medicaid program. Dr. Bicard’s testimony established that the lack of improvement in Petitioner’s behaviors demonstrates that the applied behavior analysis services

provided to Petitioner under the treatment plan are not consistent with generally accepted professional standards as determined by the Medicaid program, and not experimental or investigational, and therefore, not medically necessary.

13. Petitioner's authorized representative and [REDACTED], [REDACTED], testified that Petitioner's behavior is getting better and [REDACTED] sees [REDACTED] progress firsthand. [REDACTED] contends that [REDACTED] would not keep Petitioner with this provider if [REDACTED] was not progressing, and that the analyst [REDACTED] is currently receiving treatment from is the best one for [REDACTED]. [REDACTED] testified that Petitioner's medications have recently been changed causing [REDACTED] to readjust. [REDACTED] testified that the provider has changed the treatment plan and that the latest plan has not considered in determining to terminate Petitioner's ABA therapy.

14. [REDACTED], Petitioner's BCABA, testified that [REDACTED] has worked with Petitioner for [REDACTED], and there is improvement: the maladaptive behaviors are less intensive. [REDACTED] testified that Petitioner should continue to receive ABA treatment with this provider and that changes to the plan have been made.

CONCLUSIONS OF LAW

15. 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).

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

17. Because Respondent terminated Petitioner's ABA services, 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.)

18. The 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
- 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 be 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 year 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.

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Pages 1 – 3 of the BA Policy.

19. 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. Provider 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 treatment 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

...

Pages 6 – 8 of the BA Policy.

20. 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.

21. 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.

22. The Florida Medicaid Definitions Policy, incorporated by reference in Fla. Admin. Code R. 59G-1.010, (the “Definitions Policy”), 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.

Page 23 of RCE 2.

23. The Florida Medicaid Authorization Requirements Policy (“Authorization Requirements Policy”) (June 2016), incorporated by reference in Fla. Admin. Code R. 59G-1.053, provides

general requirements for providers to obtain authorization to render Florida Medicaid services.

The Authorization Requirements Policy states, in pertinent part:

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 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.

Florida Medicaid Authorization Requirements Policy at pages 1-3.

24. Petitioner is under the age of 21 years and diagnosed with [REDACTED]. *See supra* ¶

2. The parties agree that Petitioner currently engages in maladaptive behaviors that interfere with [REDACTED] daily functioning. *See supra* ¶ 3. Respondent determined that the BA provider "has not addressed the lack of progress during the last observation period and did not amend the treatment plan in relation to lack of progress." *See supra* ¶ 5, 6.

25. In the instant case, Petitioner requested continuation of BA services for the period from October 24, 2023, through April 20, 2024. *See supra* ¶ 4. Specifically, Petitioner requested 3,120

units of code 97153, 208 units of code 97155, 104 units of code 97155 (HN), 52 units of code 97156, and 52 units of code 97156 (HN). *See supra* ¶ 4. In a NOO, dated October 25, 2023, and an NRD, dated November 29, 2023, Respondent terminated Petitioner’s ABA services with the current provider, *supra* ¶ 5, 6, determining that continuing services was not “medically necessary under the following standard: consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational. *See supra* ¶ 5, 6.

26. The medical necessity standards are expressly outlined in section 2.83 of the Definitions Policy and a critical element for behavior analysis services reassessments. *See supra* ¶ 22. The BA Policy mandates that the treatment plan must be detailed enough to warrant the requested services and include mechanisms to monitor and evaluate its effectiveness. *See supra* ¶ 23.

27. As Respondent bears the burden of proof, the Respondent must show that the BA services are issue no longer meet medical necessity criteria, *i.e.* the continuation of 3,120 units of code 97153, 208 units of code 97155, 104 units of code 97155 (HN), 52 units of code 97156, and 52 units of code 97156 (HN). Here, the record shows that Petitioner engages in the following maladaptive behaviors: [REDACTED], [REDACTED], [REDACTED], [REDACTED], [REDACTED], [REDACTED], [REDACTED], [REDACTED], [REDACTED], and [REDACTED]. *See supra* ¶ 3. However, Dr. Bicard provided credible and persuasive testimony the treatment plan is not consistent with generally accepted professional medical standards as determined by the Medicaid program because it is ineffective in that it shows no significant improvement over the course of treatment of maladaptive behaviors and replacement behaviors over the prior authorization period. As Dr. Bicard established, based on the ineffectiveness of the treatment

plan, Petitioner would no longer benefit from the continuation of ABA services with this provider. *See supra* ¶ 9 - 12. In all, Respondent showed that the lack of progress exhibited is not “consistent with generally accepted professional medical standards”. As such, Respondent showed that it was not medically necessary to continue services with this provider.

28. Moreover, the record reflects that Petitioner’s provider believes that BA services are medically necessary. *See supra* ¶ 4. However, 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 supra* ¶ 22.

29. 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 supra* ¶ 23. As discussed, *supra* ¶ 27, Petitioner has made minimal progress in reducing ■■■■ maladaptive behaviors and improving ■■■■ replacement behaviors treatment, and the slow progress outlined by the treatment plan is not beneficial to Petitioner’s improvement.

30. Accordingly, Respondent has met their burden of proof to show that the requested ABA services with this provider are no longer medically necessary. Looking at all the evidence relevant to the particular needs of Petitioner, the BA services at issue are not necessary to correct or ameliorate a defect or a physical and mental illness or condition. Upon consideration of the testimony provided, evidence submitted, and applicable policies, the undersigned finds that Respondent proved by a preponderance of the evidence that Respondent’s termination of the BA services at issue was correct.

IT IS HEREBY ORDERED AND ADJUDGED THAT:

Respondent's termination of Behavior Analysis services is **AFFIRMED**. Petitioner's appeal based on Respondent's termination of Behavior Analysis services is **DENIED**.

DONE and **ORDERED** this 21st day of February, 2024, in Tallahassee, Leon County, Florida.

Joseph Mabry
23-FH2980
2024.02.21
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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]
[REDACTED]

AHCA Medicaid Hearing Unit
MedicaidHearingUnit@ahca.myflorida.com