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

FILED

Mar 25, 2024, 8:29 am

OFFICE OF FAIR HEARINGS

[redacted],

PETITIONER,

AHCA Case No.: 23-FH3038

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 February 6, 2024, at 9:01 a.m. Eastern Standard Time ("EST").

APPEARANCES

For the Petitioner: [redacted]
Petitioner's Authorized Representative

For the Respondent: Marielisa Amador
Medical/Health Care Program Analyst
Agency for Health Care Administration

STATEMENT OF ISSUE

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

PRELIMINARY STATEMENT

All parties and witnesses appeared for the scheduled Fair Hearing telephonically. [redacted] ("[redacted]"), Petitioner's Authorized Representative and Board Certified Behavior Analyst ("BCBA"), appeared for the Fair Hearing on behalf of Petitioner, provided testimony, and did not call any witnesses. [redacted], Petitioner's [redacted], attended as a witness for Petitioner.

Marielisa Amador, Medical Health Care Program Analyst for the Agency for Health Care Administration ("Agency" or "AHCA"), appeared for the Fair Hearing as the representative for Respondent. Dr. Alissa Conway ("Dr. Conway"), a Board-Certified Behavior Analyst at the doctoral level ("BCBA-D") for eQHealth Solutions and Second Level Reviewer, appeared for the Fair Hearing as a witness for Respondent.

Prior to the hearing, Petitioner filed with the Office of Fair Hearings and sent to Respondent a seventy-seven (77)-page document and 164-page document. The seventy-seven (77)-page document appears in the Office of Fair Hearings' case management system as "23-FH3038 Supporting Documents.pdf" and the 164-page document appears as "23-FH3038 Evidence.pdf". Without objection, the seventy-seven (77)-page evidence packet was admitted into evidence as Petitioner's Composite Exhibit 1 ("PCE 1") and the 164-page evidence packet was admitted into evidence as Petitioner's Composite Exhibit 2 ("PCE 2").

Prior to the Fair Hearing, Respondent filed with the Office of Fair Hearings and sent to Petitioner a 481-page evidence packet. The evidence packet appears in the Office of Fair Hearings' case management system as "[redacted] FH 02.06.2024 1-163", "[redacted] FH 02.06.2024 164-320", "[redacted] FH 02.06.2024 321-477", and "[redacted] FH 02.06.2024 478-

481". Without objection, the 481-page evidence packet was admitted into evidence as Respondent's Composite Exhibit 1 ("RCE 1").

Prior to the Fair Hearing, Respondent filed with the Office of Fair Hearings and sent to Petitioner a fifty (50)-page evidence packet. The evidence packet appears in the Office of Fair Hearings' case management system as "23-FH3038 AHCA Evidence (Pages 1-50 of 50).pdf" Without objection, the evidence packet was admitted into evidence as Respondent's Composite Exhibit 2 ("RCE 2").

FINDINGS OF FACT

1. Petitioner receives Medicaid services on a fee-for-service basis from the Agency. eQHealth is a Quality Improvement Organization contracted by the Agency to review prior authorization requests for services. *See* Respondent's Composite Exhibit 2 at page 2.

2. Petitioner is [redacted]. *See* RCE 1 at 16. Petitioner is diagnosed with [redacted]. *Id.* at 16.

3. As provided in Petitioner's Treatment Package ("treatment plan" or "behavior plan"), Petitioner is engaging in the following maladaptive behaviors: [redacted]; [redacted]; [redacted]; [redacted]; [redacted]; [redacted]; [redacted]; [redacted]; [redacted]; [redacted]; [redacted]; and [redacted]. *Id.* at 331 – 332. The graphs of the maladaptive behaviors show the following: for [redacted], Petitioner's incidents remained at [redacted] throughout the authorization period; for [redacted], Petitioner's incidents remained at [redacted] throughout the authorization period; for [redacted], Petitioner's incidents remained at [redacted] throughout the authorization period; for [redacted], Petitioner's incidents remained at [redacted]

throughout the authorization period; for [redacted], Petitioner reduced [redacted] incidents from [redacted]; for [redacted], Petitioner reduced [redacted] incidents from [redacted]; for [redacted], Petitioner reduced [redacted] incidents from [redacted]; for [redacted], Petitioner reduced [redacted] incidents from [redacted]; for [redacted], Petitioner's incidents remained at [redacted]; and for [redacted], Petitioner's incidents remained at [redacted]. *Id.* at 347 – 361. Petitioner mastered [redacted]. *Id.* at 361.

4. Petitioner requested the following BA services: 2,808 units of code 97153; 208 units of code 97155; and 208 units of code 97153, for the certification period of November 22, 2023, through May 19, 2024. This is an increase from the prior authorization period. *Id.* at On December 4, 2023, Respondent issued a Notice of Outcome ("NOO"), terminating Petitioner's BA services. *Id.* at 23 – 24. The NOO explained the basis for the termination as follows:

> [T]he requested services are not medically necessary under the following standard(s):
>
> Individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness under treatment, and not in excess of the patient's needs.
> . . .

The NOO further provided:

> Submitted information does not support the medical necessity for requested frequency and\or duration.
>
> PR Clinical Rationale – Denial: This request for behavior Analysis Services is denied. The previous BA services with this provider for this recipient were denied due to a lack of progress and held up at reconsideration. The interventions and data submitted by the provider for this request for services do not meet medical necessity criteria.

Id. at 23 – 24.

5. Petitioner requested reconsideration of the Respondent's decision. On December 8, 2023, Respondent issued a Notice of Reconsideration Determination ("NRD") upholding its decision. *Id.* at 34 - 35. The NRD states, in pertinent part as follows:

> Specifically the services must be:
>
> Individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness under treatment, and not in excess of the patient's needs.
> Consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational.
> . . .
> PR Recon Determination: At reconsideration all documents were carefully reviewed. The provider was previously authorized to implement BA services for this recipient. The services were denied due to a lack of progress and held up at reconsideration. This denial is upheld.

Id.

6. On December 4, 2023, Petitioner requested a Fair Hearing based on the termination of BA services. *Id*. at 8. On January 3, 2024, the undersigned Hearing Officer issued a notice to the parties of record scheduling the Fair Hearing for February 6, 2024, at 9:00 a.m. EST. *Id*.

7. Dr. Conway is a BCBA-D for eQHealth. Dr. Conway testified to the following:

a. Petitioner has been receiving ABA services from the current provider since [redacted]. The services were terminated due to lack of sufficient progress and no modifications made to the treatment plan.

b. The graphs of the maladaptive behaviors show the first date of the authorization period as the baseline, which is incorrect. *See* pages 347.

c. The graphs of the maladaptive behaviors largely show either minimal or no change, and there was no modification to the treatment plan. For example, the maladaptive behaviors [redacted], [redacted], [redacted],

[redacted], [redacted]; [redacted]; and [redacted] all show this trend. *See* pages 347 – 393.

d. There are many new behaviors. When we have this many new behaviors this indicates that the current interventions are not generalizing across topographies. There are four main functions of behavior: [redacted], [redacted], [redacted], and [redacted]. Here, there are interventions that are individualized to the behaviors but overall the individual should be taught replacement skills to address each of those functions and they should generalize across behaviors.

e. The BCBA is authorized to provide protocol modification during the authorization period – not after a denial or reconsideration have been made.

f. The Petitioner is not working on the replacement skills independently; [redacted] still requires gesture prompts for many of [redacted] replacement skills. *See* pages 395 – 425 of RCE 1.

g. [redacted] is a basic skill and should already have been worked on. *See* page 403 of RCE 1. This is a verbal skill, but the provider uses physical prompts which does not match the topography of the behavior.

h. The duration graphs for [redacted] and [redacted] show the same amount of time, which is unlikely. *See* pages 407 and 409 of RCE 1.

i. The modifications are generalized strategies that overlap with other strategies. The modifications were not included in the graphs during the previous authorization period.

j. Petitioner may qualify for ABA services, but not with this provider.

8. [redacted] is Petitioner's BCBA. [redacted] testified to the following:

a. There is not sufficient progress, but there is progress. Petitioner is showing improvement, but it is slow. All of Petitioner's maladaptive behaviors have shown improvement.

b. Petitioner has mastered [redacted], [redacted], [redacted], and [redacted]. *See* page 164 of PCE 2.

c. Petitioner has met many of [redacted] short term objectives.

d. The request for an increase in service is due to the emergence of new behaviors.

CONCLUSIONS OF LAW

9. The Agency's Office of Fair Hearings has jurisdiction over the subject matter of this proceeding and the parties pursuant to section 409.285(2), Florida Statutes (2019). This order is the final administrative decision of AHCA under section 409.285(2)(a).

10. This hearing was held as a *de novo* proceeding pursuant to Rule 59G-1.100(17)(b), Florida Administrative Code ("F.A.C.").

11. Because Respondent terminated a previously approved service, Rule 59-1.100(17)(g), F.A.C. assigns the burden of proof to the Respondent in regards to the termination of ABA 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.).

12. Because Petitioner is requesting a new service, Rule 59-1.100(17)(g), F.A.C. assigns the burden of proof to the Petitioner in regards to the request for additional ABA 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. 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).

14. According to 42 U.S.C. § 1396d(r)(5), EPSDT services mean, in relevant part, the following items and services:

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

15. A state may place medical necessity limitations on EPSDT services. *See* 42 C.F.R. §§ 440.230(a), (b), (d).

16. 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.

17. The Florida Medicaid 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.

Respondent's Composite Exhibit 2 at page 23.

18. The Florida Medicaid Behavior Analysis Services Coverage Policy (September 2023) ("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.
. . .
1.4.6 Medically Necessary/Medical Necessity
As defined in Rule 59G-1.010, F.A.C.
. . .
2.0 Eligible Recipient
. . .
2.2 Who Can Receive
Florida Medicaid recipients under the age of 21 years requiring BA services that are medically necessary to address behavior that impairs a recipient's ability to perform a major life activity. Such functional impairment is expressed through the following behaviors:
- Safety – aggression, self-injury, property destruction, elopement
- Communication – problems with expressive/receptive language, poor understanding or use of non-verbal communications, stereotyped, repetitive language

- Self-stimulating – abnormal, inflexible, or intense preoccupations
- Self-care – difficulty recognizing risks or danger, grooming, eating, or toileting
- Other behaviors not identified above but not limited to complexity of treatment, programming, or environmental variables

The recipient must be referred by an independent physician or practitioner qualified to assess and diagnose disorders related to functional impairment, including:

- Primary care physician with family practice, internal medicine, or pediatric specialty
- Board certified or board eligible physician with specialty in developmental behavioral pediatrics, neurodevelopmental pediatrics, pediatric neurology, adult or child psychiatry
- Child psychologist

The referral must include a comprehensive diagnostic evaluation (CDE) performed according to national evidence-based practice standards. CDEs may be performed by a multidisciplinary team or individual practitioner. In either case, the CDE must be led by a licensed practitioner working within their scope of practice. The CDE must include assessment findings and treatment recommendations appropriate to the recipient. For example, the CDE may include data from behavioral reports by parents, guardians, and/or teachers; diagnostic testing related to recipients' development, behavior, hearing, and/or vision; genetic testing; and/or other neurological and/or medical testing.

Some services may be subject to additional coverage criteria as specified in section 4.0.

. . .

4.0 Coverage Information

4.1 General Criteria

Florida Medicaid covers services that meet all of the following:

- Are determined medically necessary
- Do no 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 and Behavior Plan

A behavior assessment must be conducted prior to the initiation of behavior analysis interventions. The assessment must identify behavioral deficits that interfere with a major life activity including the events and subsequent interactions that elicit and sustain targeted behavior.

The initial assessment must include the administration, scoring, and reporting of two core standardized behavior instruments, as follows:

- Vineland-3 Comprehensive Parent Interview Form Including Maladaptive Behavior Domain, for all recipients
- Behavior Assessment System for Children, Third Edition, Parenting Relationship Questionnaire (BASC-3 PRQ), for all recipients 2 years old and less than 19 years old

The complete scoring report, including outcome measure scores, must be submitted with service prior authorization requests. Additional assessment tools may be used at the Lead Analyst's discretion.

The behavior plan identifies intervention strategies that are likely to eliminate, mitigate or replace the behavior to produce change sufficient to reengage the recipient in the major life activity. The plan must include specific behavior goal(s), intervention strategies for each goal, anticipated timeframes that are of sufficient duration to address the targeted behavior, and how the ongoing progress of intervention strategies will be reported.

The behavior plan must reflect the requested authorization period (up to six months).

A reassessment and updated behavior plan to renew prior authorization for continued services must be completed at least every six months. The core instruments must be included with reassessments every 12 months.

More frequent assessments must be conducted when:

- New behavior emerges that interferes with a recipient's participation in a major life activity
- Additional BA services are medically necessary and are likely to address the emergent behavior

A full reassessment may be requested if there is a change in provider; however, a change of a practitioner status (e.g., an RBT becoming certified as a BCaBA) is not grounds for conducting a reassessment or updating a behavior plan.

4.2.2 Behavior Analysis Interventions

Florida Medicaid covers up to 40 hours per week of BA intervention services as indicated in the recipient's prior-authorized behavior plan. These services much be delivered to reduce maladaptive behaviors and assist the recipient reach the best possible function level for that individual. Services include:

- Adaptive behavior treatment by protocol - behavior analysis services provided according to the authorized treatment protocol
    - Services may be provided by Lead Analyst, BCaBA, or RBT

- Adaptive behavior treatment with protocol modification – behavior analysis services provided with modifications to the authorized treatment protocol to address behavior and/or response changes or progress
    - Services may be provided by Lead Analyst or BCaBA
- Group adaptive behavior treatment by protocol – behavior analysis services provided in a group setting according to the authorized treatment protocol
    - Maximum group size is six recipients
    - Services may be provided by Lead Analyst, BCaBA, or RBT
- Group adaptive behavior treatment with protocol modification – behavior analysis services provided in a group setting with modifications to the authorized treatment protocol to address behavior and/or response changes or progress
    - Maximum group size is six recipients
    - Services may be provided by Lead Analyst or BCaBA
- Family adaptive behavior treatment guidance – parent, guardian, and/or caregiver training on the implementation of the behavior plan and intervention strategies
    - The recipient may or may not be present depending upon clinical appropriateness.
    - Services may be provided by Lead Analyst or BCaBA
    - The Lead Analyst may provide up to two hours per week of training to parents or guardians via telemedicine in accordance with Rule 59G-1.057, Florida Administrative Code (F.A.C.)

. . .

4.2.4 Discharge

Recipients receiving Florida Medicaid BA services who meet one or more of the following will be considered for discharge from services:

- The recipient is no longer eligible for BA services as outlined in the Florida Medicaid Behavior Analysis Services Coverage Policy, incorporated by reference in Rule 59G-4.125, F.A.C.
- The recipient no longer meets medical necessity criteria as defined in Rule 59G-1.010, F.A.C.
- The recipient no longer engages in maladaptive behaviors.
- Data indicates the frequency and severity of maladaptive behavior(s) or level functional impairment no longer poses a barrier to the recipient's ability to function in his/her environment.
- The level of functional impairment as expressed through behaviors no longer justifies continued BA services.
- Parent or guardian withdraws consent for treatment

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 Authorization Requirements Policy.

. . .

5.0 Exclusion

5.1 General Non-Covered Criteria

Services related to this policy are not covered when any of the following apply:

- The service does not meet the medical necessity criteria listed in section 1.0
- The recipient does not meet the eligibility requirements listed in section 2.0
- The service unnecessarily duplicates another provider's service

5.2 Specific Non-Covered Criteria

Florida Medicaid does not cover the following as part of this service benefit:

- Any procedure or physical crisis management technique that involves the use of seclusion or manual, technical, or chemical restraint utilized to control behaviors
- Services for the delivery of recipient supervision, personal care assistance (e.g., acting as a 1:1 aid), companion, chaperone, or shadow regardless of activity or setting. This may include supports and services that are reimbursed through a different Florida Medicaid service benefit or are able to be provided by individuals without professional skills or training.
- Caregiver or childcare services
- Psychological testing, neuropsychology, psychotherapy, cognitive therapy, sex therapy, psychoanalysis, hypnotherapy, or long-term counseling
- Services funded under section 110 of the Rehabilitation Act of 1973
- Services not listed on the fee schedule
- Services on the same day as behavioral health overlay services*
- Services on the same day as therapeutic behavioral on-site services*
- Services on the same day as therapeutic group care services*
- Services provided simultaneously by more than one BA provider, unless determined to be medically necessary, prior authorized, and indicated in the approved behavior plan
- Travel Time

* These services include behavior analysis treatment.

Florida Medicaid may cover some services listed in this section through a different service benefit.

6.0 Documentation

6.2 Specific Criteria

Providers must maintain the following documentation in the recipient's file:

6.2.1 Referral Information

Original referral documentation must be maintained in the recipient's medical record.

6.2.2 Behavior Assessment and Behavior Plan

The behavior assessment and behavior plan must be signed by the Lead Analyst and the recipient's parent or guardian. Each behavior assessment and behavior plan must include:

- Patient information
- Reason for referral
- Medical and developmental history, including medications prescribed to ameliorate behaviors
- Relevant family history
- Clinical interview
- Review of recent assessments/reports (file review)
- Assessment procedures and results
- Behavior plan
    - Treatment setting(s)
    - Proposed treatment targets, goals, and objectives related to medically necessary behavioral interventions
    - For each:
        - Definition in observable, measurable terms
        - Direct observation and measurement procedures
        - Current level (baseline)
        - Behavior reduction or acquisition procedures
        - Condition(s) under which behavior is to be demonstrated and mastery criteria
        - Date of introduction
        - Estimated date of mastery
        - Plan for generalization
        - Timely reporting of progress, including statements as to whether goal or objective is met; not met; or, modified (with explanation)
- Parent/guardian/caregiver training
    - Proposed targets, goals, and objectives (as above)
    - Training procedures
    - Date of introduction
    - Estimated date of mastery
- Number of units requested
    - Number of units for each billing code
    - Medical necessity for units requested
- Supervision plan, including name(s) of authorized supervisor(s)

- Care coordination with parents/caregivers, schools, state disability programs, and others as applicable
- Transition (fading) plan
- Crisis management plan
- Discharge plan

6.2.3 Assessment and Behavior Plan for Reauthorization and Continuation of Services

In addition to the documentation requirements indicated in 6.2.2, subsequent assessments and behavior plans for reauthorization and continuation of services must include:

- Data reflecting progress of all behaviors targeted for improvement. Each behavior under treatment must have its own data table and corresponding graph.
- A narrative discussion of progress and a statement of justification for continuation of care at the intensity level requested

If significant clinical progress is not made over the course of an authorized period, the provider must explain why clinically significant progress was not made and treatment changes to promote progress.

. . .

Pages 1 – 8 of BA Policy.

19. The Florida Medicaid Authorization Requirements Policy ("Authorization Requirements Policy") (June 2016), incorporated by reference in Rule 59G-1.053, F.A.C., 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.

Respondent's Composite Exhibit 2 at pages 32-34.

A. Termination of ABA Services

21. In the NOO, dated December 4, 2023, Respondent terminated Petitioner's ABA services. *See* ¶ 4. In the NRD, dated December 8, 2023, Respondent explained that continuing ABA services with Petitioner's current provider was not medically necessary, specifically that continuation was not "consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational" and that services were not "individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment" and were "in excess of the patient's needs". *See* ¶ 5. Further, Respondent explained that "services were denied due to a lack of progress and held up at reconsideration." *Id.*

22. As Respondent bears the burden of proof, Respondent must show that ABA services are no longer medically necessary for Petitioner. Two (2) components of medical necessity are that services must be "individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment and not in excess of the patient's needs" and services must be "consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational". At the Fair Hearing, Dr. Conway provided credible testimony that the treatment plan at issue was not consistent with generally

accepted professional medical standards. *See* ¶ 7. Dr. Conway explained that the graphs of the maladaptive behaviors show minimal progress, and there was no modification to the treatment plan. *Id.* For example, behaviors such as [redacted], [redacted] and [redacted], Petitioner's behaviors largely remained unchanged. *See* ¶ 3. As testified by Dr. Conway, no modifications were made during the authorization period. *See* ¶ 7. Here, [redacted] agreed that progress was slow, but asserted that progress had been exhibited. *See* ¶ 8. However, as Dr. Conway is a BCBA at the doctoral level, her testimony on the adequacy of progress is persuasive. In all, the record shows that the treatment plan at issue is not "consistent with generally accepted professional medical standards as determined by the Medicaid program. Accordingly, Respondent demonstrated that it is not medically necessary for Petitioner to continue receiving ABA services through this provider.

23. As QIO for the Agency, eQHealth is authorized to termination services when the reviewing physician determines the recipient will not gain any additional benefit by continuing services at the current level." *See* ¶ 19. Here, based on Dr. Conway's testimony, the record shows that Petitioner will not receive sufficient benefit continuing services with the current provider. *See* ¶ 22.

24. Upon consideration of the testimony provided, evidence submitted, and applicable policies, the undersigned concludes that Respondent proved by a preponderance of the evidence that the termination of ABA services with this provider was necessary. Looking at all the evidence relevant to the particular needs of Petitioner, Respondent has demonstrated that the previously authorized services, based on the treatment plan at issue in this case, are not necessary to correct or ameliorate a defect or a physical and mental illness or condition. Accordingly, Respondent

provided by a preponderance of the evidence that Respondent's termination of ABA services was correct.

B. Denial of Additional ABA Services

25. Petitioner requested an increase in services. *See* ¶ 4. Respondent denied Petitioner's request for additional services and terminated Petitioner's previously approved services. *Id*. Respondent explained that additional services were not "consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational" and were not "individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment" and were "in excess of the patient's needs". *Id.*

26. As Petitioner bears the burden of proof, Petitioner must show that additional ABA services are medically necessary for Petitioner. Two (2) components of medical necessity are that services must be "individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment and not in excess of the patient's needs" and services must be "consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational". At the Fair Hearing, [redacted] explained that additional services were requested due to new behaviors. *See* ¶ 9. Ultimately, as Respondent demonstrated that continuing services with the current provider was not medically necessary, an increase in services is similarly not medically necessary. As such, Petitioner did not demonstrate that additional services were medically necessary for Petitioner.

27. 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 request for additional ABA services with this provider was necessary. Looking at all the evidence relevant to the particular needs of Petitioner, Petitioner has not demonstrated that additional 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.

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**.

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

DONE and **ORDERED** this 25th day of March 2024, in Tallahassee, Leon County, Florida.

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]

AHCA Medicaid Hearing Unit
MedicaidHearingUnit@ahca.myflorida.com