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

FILED
Mar 27, 2024, 11:40 am
OFFICE OF FAIR HEARINGS

[redacted],

PETITIONER, **AHCA Case No.: 23-FH3219**

vs.

AGENCY FOR HEALTH CARE ADMINISTRATION,

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic Fair Hearing on the instant case on February 14, 2024, at 1:04 p.m. Eastern Standard Time ("EST").

APPEARANCES

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

For the Respondent: Diana Hearod
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 Behavior Analysis ("BA" or "ABA") services was correct.

The second issue is whether Petitioner proved by a preponderance of the evidence that Respondent's decision to deny Petitioner's request for additional ABA services was incorrect.

PRELIMINARY STATEMENT

All parties and witnesses appeared telephonically. Petitioner's Authorized Representative and [redacted], [redacted] ("[redacted]"), appeared on behalf of Petitioner.

Diana Hearod ("Ms. Hearod"), 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"), Board Certified Behavior Analyst and Director of Clinical Operations for eQHealth Solutions Inc. ("eQHealth"), appeared as a witness for Respondent.

Alejandra, interpreter number 383204, appeared to offer Spanish translation services for the Petitioner.

Petitioner did not introduce any exhibits at the Fair Hearing. Prior to the hearing, Respondent sent to the Office of Fair Hearings and Petitioner a two-hundred and five (205)-page evidence packet and a fifty (50)-page evidence packet. The two-hundred and five (205)-page evidence packet appears in the Office of Fair Hearings' document management system as the file titles: "[redacted] FH 02.14.2024 1-68.pdf"; "[redacted] FH 02.14.2024 69-103.pdf"; "[redacted] FH 02.14.2024 104-167.pdf"; "[redacted] FH 02.14.2024 168-201.pdf"; and "[redacted] FH 02.14.2024 202-205.pdf". The fifty (50)-page evidence packet appears in the Office of Fair Hearings' document management system as the file title "23-FH3219_Behavior Analysis AHCA Evidence_50 PG_[PETITIONER].pdf". Absent an objection from the Petitioner, the undersigned admitted the two-hundred and five (205)-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").

FINDINGS OF FACT

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

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

3. According to Petitioner's Treatment Plan, Petitioner is engaging in the following maladaptive behaviors: [redacted]; [redacted]; [redacted]; [redacted]; [redacted]; [redacted]; [redacted]; [redacted]; and [redacted]. *Id*. at 60-68. Petitioner's Treatment Plan shows the following progress: for [redacted], Petitioner reduced [redacted] incidents from approximately [redacted]; for [redacted], Petitioner reduced [redacted] incidents from approximately [redacted]; for [redacted], Petitioner reduced [redacted] incidents from approximately [redacted]; for [redacted], Petitioner reduced [redacted] incidents from approximately [redacted] for [redacted], Petitioner reduced [redacted] incidents from approximately [redacted]; for [redacted], Petitioner reduced [redacted] incidents from approximately [redacted]; for [redacted], Petitioner reduced [redacted] incidents from approximately [redacted]; for [redacted], Petitioner reduced [redacted] incidents from approximately [redacted]; and for [redacted], Petitioner reduced [redacted] incidents from approximately [redacted] *Id*.

4. As testified to by Dr. Bicard, in the previous authorization, Petitioner requested and was approved for 2,496 units of code 97153, representing a difference of 624 units of service.

5. Petitioner requested continuation of BA services; specifically, 3,120 units of code 97153; 416 units of code 97155; and 208 units of code 97156. In a Notice of Outcome ("NOO"), dated

November 1, 2023, Respondent terminated Petitioner's ABA services. *Id*. at 22. The NOO explained the basis for the termination as follows:

> [T]he requested services are not medically necessary under the following standard(s):
>
> Consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational.
> 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:

> PR Clinical Rationale – Denial: The definitions of behaviors under treatment must be written according to generally accepted practice within the field of ABA and according to AHCA standards set in Florida Behavior Analysis Services Coverage Policy (page 7, 6.2.2) The behavioral definitions must be clear, complete, objective and free of unobservable intentional states ([redacted]- describes intent). The behaviors should have clear boundaries, definite on-sets and off-sets, should not overlap with other target behaviors definitions, and not be a listing of behaviors that the recipient does not engaging in. The behavior definitions in this treatment plan do not conform to generally accepted standards of care within the field of applied behavior analysis.
>
> The provider submitted documents including data in graphs that are not consistent with data that are typically reported in behavior analytic treatment. Many of the graphs for maladaptive behavior and skill acquisition show the same general pattern, level, and trend in the data. These data do not appear to have been accurately reported or observed and measured according to standards of care within the field of behavior analysis. 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 22 – 23.

6. Petitioner requested reconsideration of the Respondent's decision. In a Notice of Reconsideration Determination ("NRD"), dated December 28, 2023, Respondent upheld its decision. *Id.* at 34. 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 34 –35.

7. On December 27, 2023, Petitioner requested a Fair Hearing to challenge the termination and denial of additional ABA services. On February 1, 2024, the undersigned issued an Order Scheduling Fair Hearing by Telephone and Prehearing Instructions, setting the hearing for February 14, 2024, at 1:00 p.m. EST.

8. Dr. Bicard is a Board -Certified Behavior Analyst at the doctoral level. Dr. Bicard testified to the following at the Fair Hearing:

a. Petitioner has participated in ABA services since [redacted], and has been with this provider since [redacted]. Petitioner is still engaging in the same behaviors as [redacted] was [redacted], and behavior levels have shown no overall improvement. The provider's Treatment Plan shows that skill acquisition goals are still mostly prompt dependent, meaning the provider has not taught Petitioner to independently engage in replacement behaviors. This is below ABA standards. There are no diagnoses other than [redacted] identified by the provider, but the initial request for services in [redacted] states that Petitioner has [redacted]. It is not clear if this is accurate.

b. All maladaptive behavior data appear identical. Dr. Bicard stated [redacted] has never seen data like these in [redacted] years of experience, as multiple problem behaviors do not show the same trends and levels at the same time. These data do not reflect what occurs in therapy, as there is usually a slow decrease at the beginning of the authorization and a rapid decrease at the end of the authorization. The Treatment Plan's data move unusually. *Id. at* 60. The occurrence of [redacted] incidents between [redacted] times per week is indicative of ineffective therapy after [redacted]. *Id*. at 61. This behavior shows the same general level and trend in the data as does [redacted] behavior. *Id*. [redacted] still occurs between [redacted] times per week after [redacted] total years of therapy. *Id*. at 62. The graph for [redacted] looks the same as the graphs for the other behaviors.

Id. at 63. The provider indicated that Petitioner can speak in complete sentences and use sophisticated language. *Id*. at 63. [redacted] still occurs between [redacted] times, indicating ineffective treatment. *Id*. at 64. [redacted] is an easy behavior to treat in ABA, so Petitioner's engagement in this behavior after [redacted] total years of therapy indicates therapy below the standards of ABA. *Id*. at 65. The same trend as in all other behaviors is shown in this behavior. *Id*. Overall, these levels of maladaptive behavior after [redacted] with this provider indicate ineffective treatment, and the behaviors exhibit the same levels and trends.

c. The provider's interventions are not individualized for Petitioner, and some cannot be implemented simultaneously and are not truly ABA treatments. *Id*. at 68-70.

d. According to the provider, Petitioner is not able to wait for one minute for a tangible reward without prompt after [redacted] of BA therapy. *Id*. at 72. Petitioner is [redacted] with a [redacted], and should [redacted]. The data are not believable. *Id*. at 73. Petitioner is not [redacted] after [redacted] of therapy. *Id*. at 73. According to the provider, Petitioner is [redacted] although Petitioner has a [redacted]. *Id*. at 74-75. [redacted] is an inappropriate skill for a [redacted], and Petitioner is [redacted] after [redacted] of treatment. *Id*. at 76. [redacted] decreased dramatically with a change in prompts, which does not usually occur with prompt fading and indicates improper prompt fading. *Id*. at 77.

9. [redacted] is the [redacted] of Petitioner. [redacted] testified to the following at the Fair Hearing:

a. [redacted] testified that Petitioner has been with the current provider since [redacted]. Petitioner has been with this provider for fewer than [redacted]. [redacted] stated [redacted] has seen progress in these [redacted] and sees progress every day. When the provider took baseline in [redacted], baseline for [redacted] was between [redacted] occurrences, but it is now between [redacted] occurrences. This is an improvement of [redacted]. The graph for [redacted] indicates [redacted], and baseline was [redacted], so there is [redacted] progress. The denial was due to lack of progress. Petitioner needs therapy, and the provider has done good work.

CONCLUSIONS OF LAW

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

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

12. Because Respondent terminated a previously approved service, Fla. Admin. Code R. 59G-1.100(17)(g) assigns the burden of proof to the Respondent pertaining to issue one. Furthermore, because Petitioner is requesting a new service, Fla. Admin. Code R. 59G-1.100(17)(g) assigns the burden of proof to the Petitioner pertaining to issue two. The standard of proof in an

administrative hearing is a preponderance of the evidence. The preponderance of the evidence standard requires proof by "the greater weight of the evidence" (Black's Law Dictionary at 1201, 7th Ed.)

13. The Florida Medicaid Behavior Analysis Services Coverage Policy (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.

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

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

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

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

16. The 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.
Page 7 of the Definitions Policy.

17. The Florida Medicaid Authorization Requirements Policy (June 2016) ("Authorization Policy"), incorporated by reference in Fla. Admin. Code R. 59G-1.053, provides as follows:

3.2.1 Continued Authorization Requests
The QIO shall not deny or reduce the amount, frequency, or duration of a service that is already being provided, unless:

- The reduction is to correct for factual error or omissions in prior certifications.
- There is a documented improvement in the recipient's medical condition.
- There is a documented change in the recipient's circumstances.
- The reviewing physician determines the recipient will not gain any additional benefit by continuing services at the current level.

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Page 3 of the Authorization Policy.

Respondent's Termination of ABA Services

18. In the instant case, Respondent terminated Petitioner's ABA services. *See* ¶ 5. In the NOO of November 1, 2023, Respondent explained that continuing services at the prior level was not

medically necessary, specifically, that it did not meet the requirements that services must be "individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness under treatment, and not in excess of the patient's needs," as well as "consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational." *Id.* Respondent further explained that "the information submitted does not meet standards of care within the field of behavior analysis." *Id.*

19. As provided by the EPSDT requirements, the recipient must meet the medical necessity criteria as outlined in Fla. Admin. Code R. 59G-1.010. As provided in section 2.83 of the Definitions Policy, two components of medical necessity are that services must be "individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness under treatment, and not in excess of the patient's needs," as well as "consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational." As shown by the record, the provider's Treatment Plan exhibits highly unusual data within the field of ABA, and the data do not reflect what typically occurs in therapy. *See* ¶ 7. Dr. Bicard provided credible testimony that the maladaptive behavior graphs all show very similar levels and trends in the data, which Dr. Bicard stated is highly unusual. *Id*. Dr. Bicard also testified that the provider's treatment has been ineffective due to the high levels of maladaptive behavior after years of treatment, and due to the prompt dependency of Petitioner's replacement behaviors. *Id*. Dr. Bicard testified that Petitioner is still working on the same treatment goals as [redacted] was [redacted]. *Id*. Furthermore, Dr. Bicard noted that the provider's interventions are not individualized for Petitioner, and some interventions cannot be implemented simultaneously or are not truly ABA treatments. *Id*. As the Treatment Plan contains

general procedures which are not individualized, which cannot be implemented simultaneously, and which are outside of the field of ABA, the Treatment Plan is not "individualized, specific, and consistent" with Petitioner's treatment needs. As the plan contains graphs with nearly identical data, and as the maladaptive behaviors occur at such high levels after [redacted] years of therapy, the Treatment Plan is not "consistent with generally accepted professional medical standards as determined by the Medicaid program," nor is it consistent with the standards of care within the field of ABA. As such, Respondent has demonstrated that it is not medically necessary to continue services with the current provider.

20. As QIO for the Agency, eQHealth is authorized to terminate services when "the reviewing physician determines the recipient will not gain any additional benefit by continuing services at the current level." *See* ¶ 17. The provider's Treatment Plan does not meet ABA standards, as it contains nearly identical graphs and non-individualized procedures. Here, the insufficiencies of the Treatment Plan are well documented.

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

Respondent's Denial of Additional ABA Services

22. In the instant case, Respondent denied Petitioner's request for additional ABA services. *See* ¶ 4, 5. In the NOO of November 1, 2023, Respondent explained that continuing services at the prior level was not medically necessary, specifically, that it did not meet the requirements that services must be "individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness under treatment, and not in excess of the patient's needs," as well as "consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational." *Id.* Respondent further explained that "the information submitted does not meet standards of care within the field of behavior analysis." *Id.*

23. As provided by the EPSDT requirements, the Recipient must meet the medical necessity criteria as outlined in Fla. Admin. Code R. 59G-1.010. As provided in section 2.83 of the Definitions Policy, two components of medical necessity are that services must be "individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness under treatment, and not in excess of the patient's needs," as well as "consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational." As shown by the record, the provider's Treatment Plan indicates ineffective therapy. *See* ¶ 7. Dr. Bicard provided credible testimony that effective treatment would not have resulted in such high levels of maladaptive behaviors after years of treatment. *Id*. Dr. Bicard also testified that all of Petitioner's replacement skills are prompt dependent, as well as that Petitioner has been working on the same treatment goals for [redacted] years. *Id*. Furthermore, Dr. Bicard identified non-individualized procedures outside of the field of ABA within the plan, further indicating ineffective treatment. *Id*. As the Treatment Plan contains high levels of

maladaptive behavior after years of treatment, is still targeting the same goals as were targeted [redacted], and maintains the prompt dependency of the replacement skills, the Treatment Plan is not "individualized, specific, and consistent" with Petitioner's treatment needs, nor is it "consistent with generally accepted professional medical standards as determined by the Medicaid program." As such, Petitioner has not demonstrated that the requested services are medically necessary.

24. As QIO for the Agency, eQHealth is authorized to deny services when "the reviewing physician determines the recipient will not gain any additional benefit by continuing services at the current level." *See* ¶ 17. The provider's Treatment Plan does not indicate effective ABA therapy. Here, the insufficiencies of the Treatment Plan are well documented.

25. Upon consideration of the testimony provided, evidence submitted, and applicable polices, the undersigned concludes that Petitioner did not prove by a preponderance of the evidence that the additional ABA services are medically necessary. Looking at all the evidence relevant to the particular needs of Petitioner, Petitioner has not demonstrated that the previously authorized 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 ABA services is **AFFIRMED**. Petitioner's appeal based on Respondent's termination is **DENIED**.

Respondent's denial of additional ABA services is **AFFIRMED**. Petitioner's appeal based on Respondent's denial of **DENIED**.

DONE and **ORDERED** this 27th day of March, 2024, in Tallahassee, Leon County, Florida.

LYNNE RINGERS, 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