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

FILED

Apr 09, 2024, 9:48 am

OFFICE OF FAIR HEARINGS

[redacted],

PETITIONER,

AHCA Case No.: 24-FH0009

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 9:57 a.m. Eastern Standard Time ("EST").

APPEARANCES

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

For the Respondent: Linda Latson
Registered Nurse Specialist
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 behavior analysis ("BA" or "ABA") services was correct.

PRELIMINARY STATEMENT

All parties and witnesses appeared telephonically. [redacted] ("[redacted]"), Petitioner's Authorized Representative and [redacted], appeared for the Fair Hearing to provide testimony on behalf of Petitioner.

Linda Latson, Registered Nurse Specialist for the Agency for Health Care Administration ("Agency" or "AHCA"), appeared for the Fair Hearing as representative for Respondent. Dr. Jospeh Darling ("Dr. Darling"), Board Certified Behavior Analyst at the doctoral level and Second Level Reviewer for eQHealth Solutions Florida ("eQHealth"), appeared for the Fair Hearing as a witness for Respondent.

Petitioner did not introduce any exhibits at the hearing.

Prior to the hearing, the Office of Fair Hearings received a three hundred sixty-one (361)-page evidence packet and a fifty (50)-page evidence packet from Respondent. The three hundred sixty-one (361)-page packet appears in the Office of Fair Hearings document management system as the file titles "[redacted] FH 02.14.2024 1-155.pdf," "[redacted] FH 02.14.2024 156 -302.pdf," and "[redacted] FH 02.14.2024 303 -361.pdf." The fifty (50)-page evidence packet appears in the Office of Fair Hearings document management system as the file title "24-FH0009 AHCA Evidence BA Svcs 50 Pages.pdf." Absent an objection from the Petitioner, the undersigned admitted the three hundred sixty-one (361)-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 ("QIO") contracted by the Agency to review prior authorization requests for services. *See* RCE 2 at page 2.

2. Petitioner is [redacted]. *See* RCE 1 at page 22. Petitioner is diagnosed with [redacted] *Id.* Petitioner receives ABA therapy at [redacted]. *Id*. As provided in the Behavior Analysis Reassessment ("Treatment Plan"), Petitioner is engaging in the following maladaptive behaviors: [redacted] and [redacted]. *Id*. at 262-263. As provided in the Treatment Plan, Petitioner's incidents of maladaptive behaviors, for the period of March 2023 to August 2023, are as follows: for [redacted], Petitioner's incidents decreased from about [redacted] per week; for [redacted], Petitioner's incidents decreased from about [redacted] per week; for [redacted], Petitioner's incidents decreased from about [redacted] per week; for [redacted], Petitioner's incidents decreased from about [redacted] per week; for [redacted], Petitioner's incidents decreased from about [redacted] per week; for [redacted], Petitioner's incidents decreased from about [redacted] per week; for [redacted], Petitioner's incidents decreased from about [redacted] per week; for [redacted] Petitioner's incidents decreased from about [redacted] per week; and for [redacted], Petitioner's incidents decreased from about [redacted] per week. *Id*. at 271-279.

3. Petitioner engages in [redacted] replacement behaviors, for the period of March 2023 to August 2023, at the following rates: for [redacted], Petitioner increased from approximately [redacted]

[redacted] for [redacted], Petitioner increased from approximately [redacted] for [redacted], Petitioner increased from approximately [redacted] for [redacted], Petitioner increased from [redacted] for [redacted], Petitioner increased from approximately [redacted] for [redacted], Petitioner remained at [redacted]; for [redacted], Petitioner increased from approximately [redacted] for [redacted], Petitioner increased from approximately [redacted] for [redacted], Petitioner remained at [redacted] for [redacted], Petitioner increased from approximately [redacted] for [redacted], Petitioner increased from approximately [redacted] for [redacted], Petitioner increased from approximately [redacted]; for [redacted] Petitioner increased from approximately [redacted] for [redacted], Petitioner increased from approximately [redacted] for [redacted], Petitioner increased from [redacted] for [redacted], Petitioner increased from approximately [redacted]; for [redacted], Petitioner increased from approximately [redacted] for [redacted], Petitioner increased from approximately [redacted] and for [redacted], Petitioner increased from approximately [redacted] *Id*. at 280-303.

4. Petitioner requested recertification of ABA services for the period of October 31, 2023, to April 27, 2024; specifically, 2,080 units of code 97153; 156 units of code 97155; and 156 units of code 97156. *Id*. at 29. On November 3, 2023, Respondent requested additional information ("PEND") from the ABA provider concerning the Treatment Plan. *Id*. at 24-25, 52.

5. In a Notice of Outcome ("NOO"), dated November 16, 2023, Respondent terminated Petitioner's requested ABA services. *Id.* at 29-31. 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:

> Submitted information does not support the medical necessity for requested frequency and\or duration.
> Requested services are denied because documentation is neither showing improvement nor support for maintenance.
>
> PR Clinical Rationale - Denial: Calming/coping/relaxation strategies ([redacted] are not empirically supported procedures within the conceptual system of behavior analysis for treating the functions of maladaptive behavior. According to Behavior Analysis Services Coverage Policy (page 2, 1.1), treatment that does not meet generally accepted standards of care within the field of applied behavior analysis are not covered under the behavior analysis service coverage policy.
> Provider, multiple behaviors show lack of progress across the authorization. Additionally, the graph for [redacted] states toward people and the other graph does not indicate the type of [redacted]. 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.

6. Petitioner requested reconsideration of the Respondent's decision. In a Notice of Reconsideration Determination ("NRD"), dated December 12, 2023, Respondent upheld its decision. *Id.* at 41-42. The NRD explained the basis for the decision as follows:

> PR Recon Determination: At reconsideration all documents were carefully reviewed. According to the Florida Medicaid State Plan (page 8, 6.2.3), the data provided must show evidence that the frequency of the maladaptive behavior(s) has decreased since the last review and, if not, that there is a modification of the behavior plan. The recommendations for procedural modifications include: additions/changes to treatment plan to impact behaviors targeted for reduction. Procedural modifications should include one or more of the following: antecedent manipulation modifications, modifications of prompting procedures used in acquisition, modifications in consequence-based strategies-- ones that either reduce maladaptive behavior or reinforce replacement behavior (e.g., manipulation of reinforcement schedules, switch to a different decelerative procedure), or if lack of progress was due to therapist error (e.g., poor data collection or poor training on intervention methods), how you will address human error. The provider has not addressed the lack of progress during the last observation period and did not amend the treatment plan in relation to the lack of progress or the proposed changes have little chance at improving behavior. The information submitted does not meet standards of care within the field of behavior analysis. This denial is upheld.

Id.

7. On December 28, 2023, Petitioner requested a Fair Hearing to challenge the termination of ABA services. On January 23, 2024, the undersigned issued an Order Scheduling Fair Hearing and Prehearing Instructions, setting the hearing for February 14, 2024, at 10:00 a.m. EST.

8. Dr. Darling is a BCBA at the doctoral level and Second Level Reviewer at eQHealth. Dr. Darling established the following at Fair Hearing:

a. EQHealth reviews requests for services based on medical necessity. *See* RCE 2 at 7. eQHealth reviews behavior analysis cases to ensure ABA services are consistent with the standards enumerated in the Behavior Analysis Coverage Policy as well as professional medical standards of behavior analysis. *Id*. at 28.

b. Three eQHealth reviewers found that the Treatment Plan submitted did not meet the third criteria for medical necessity. *See* ¶ 4-6.

c. Visual interpretation of graphs is used to determine effectiveness of treatment with the frequency of maladaptive behaviors decreasing and the opportunities of replacement skills increasing. *See* ¶ 13.

d. Dr. Darling argued that the final Treatment Plan showed very minimal progress in Petitioner's behaviors during the previous authorization period with a lack of modifications that is inconsistent with ABA standards.

e. Each of the graphs for maladaptive behaviors show a pattern of a lack of progress throughout the Treatment Plan. *See* ¶ 2. Dr. Darling highlighted the [redacted] behavior as an example of these minimal changes in high frequency throughout the prior authorization period and no modifications to help reduce them. *See* ¶ 2.

f. Dr. Darling also argued that the pattern of Petitioner's replacement skills shows no clinically significant progress or mastery and no indication the proposed interventions would be effective. *See* ¶ 3.

g. Dr. Darling opined that "[redacted]" is a fundamental replacement skill, which is usually learned very early in treatment to build on other skills later in treatment; however, the short-term objective ("STO") planned for 10% improvement after

three months. *See* RCE 1 at 280. This skill was initiated [redacted] ago but shows no mastery. *Id*.

h. The provider stated "new function analysis was conducted on behaviors targeted for reduction to work on prevalent functions that are maintaining maladaptive behaviors" in an updated Treatment Plan. *Id*. at 256. Dr. Darling argued that the provider was authorized to conduct a new assessment every six (6) months prior to submitting for recertification but no functional assessment was completed.

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

a. [redacted] asserted that the graphs do show a reduction in maladaptive behaviors.

b. [redacted] argued that the intensity and frequency in Petitioner's behaviors improved in the course of [redacted] daily life with ABA therapy.

c. [redacted] argued that since the termination within the last three (3) months Petitioner's behaviors have increased and [redacted] engages in new behaviors now.

d. Petitioner engages in [redacted] towards [redacted], [redacted] [redacted].

CONCLUSIONS OF LAW

10. The Agency's Office of Fair Hearings has jurisdiction over the subject matter of this proceeding and the parties pursuant to section 409.285(2), Florida Statutes (2022). This order is the final administrative decision of AHCA under section 409.285(2)(a).

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

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. 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 ABA services available under Florida Medicaid. The BA Policy provides as follows:

> **1.0 Introduction**
> Behavior analysis (BA) services are highly structured interventions, strategies, and approaches provided to decrease maladaptive behaviors and increase or reinforce appropriate behaviors.
>
> . . .
>
> **1.4.6 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 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 assessment 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 must be delivered to reduce maladaptive behaviors and assist the recipient reach the best possible functional level for that individual. The recipient's parent or guardian should participate in treatment when possible and clinically appropriate. The provider must make every effort to accommodate parental participation and must document those efforts in treatment plan updates. If parent or guardian participation is not possible, the treatment plan and session notes must document the reasons for nonparticipation. Documentation should also

explain potential impacts of nonparticipation and how potential impacts are being mitigated.
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.)

4.2.3 Supervision

Florida Medicaid requires supervision of BCaBAs and RBTs in accordance with certification board requirements and specified in the supervision plan of the approved behavior plan.

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 of 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 section 1905(a) of the Social Security Act, codified in Title 42 of the United States Code 1396d(a). As such, services for recipients under the age of 21 years exceeding the coverage described within this policy or the associated fee schedule may be approved, if medically necessary. For more information, please refer to Florida Medicaid's Authorization Requirements Policy.

. . .

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 authorization period, the provider must explain why clinically significant progress was not made and treatment changes to promote progress.

See RCE 2 at 41, 43-47.

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

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

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.

See RCE 2 at 23.

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

> **3.0 Determination Process**
> **3.1 Review Criteria**
> The QIO may use a national standardized set of criteria, or other set of criteria, approved by AHCA, as a guide for authorizations performed at the first review level. If services cannot be approved at the first level review, the QIO's physician peer reviewer will determine medical necessity using his or her clinical judgment, acceptable standards of care, state and federal laws, and AHCA's medical necessity definition.
>
> **3.2 Review Process**
> The QIO will review each authorization request and will approve, deny, or request additional information. The QIO may deny a portion of the requested units of service if it cannot substantiate medical necessity based upon the information submitted.
>
> **3.2.1 Continued Authorization Requests**
> The QIO shall not deny or reduce the amount, frequency, or duration of a service that is already being provided, unless:
> - The reduction is to correct for factual error or omissions in prior certifications.
> - There is a documented improvement in the recipient's medical condition.
> - There is a documented change in the recipient's circumstances.
> - The reviewing physician determines the recipient will not gain any additional benefit by continuing services at the current level.

See RCE 2 at 34.

18. In the instant case, Petitioner is under 21 years of age and is diagnosed with ADHD. *See* ¶ 2. Petitioner requested recertification of ABA services. *See* ¶ 4. In a NOO, dated November 16, 2023, Respondent terminated the services. *See* ¶ 5. Respondent cited to the medical necessity criteria as the basis for their decision, specifically that the services were not "consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational." *See* ¶ 5-6. Respondent has the burden of proof to show by a preponderance of evidence that the Respondent's determination was correct. *See* ¶ 12.

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. *See* ¶ 14-15. In the Definitions Policy, a component of medical necessity is that services must be "consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational." *See* ¶ 16.

20. The BA Policy maintains that 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." *See* ¶ 13. Additionally, behavior analysis services require that 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." *See* ¶ 13.

21. Three eQHealth reviewers agreed that no effective treatment was provided based on the data submitted. *See* ¶ 5-6, 8. Dr. Darling established at Fair Hearing that Petitioner's provider submitted a Treatment Plan that did not meet generally accepted professional standards. *See* ¶ 8. Visual interpretation of graphs is used to determine effectiveness of treatment with the

frequency of maladaptive behaviors decreasing and the opportunities of replacement skills increasing. *See* ¶ 8. As shown by the record, each of the maladaptive behavior graphs show a pattern of a lack of progress for the period of March 2023 to August 2023 with a lack of modifications to help reduce them. *See* ¶ 2-3, 8. Dr. Darling highlighted the [redacted] behavior as an example of these minimal changes in high frequency throughout the prior authorization period and no modifications to address this lack of progress. *See* ¶ 8. Further, Dr. Darling described a similar pattern with Petitioner's replacement skills graphs and procedures as showing no clinically significant progress and no indication the proposed interventions would be effective. *See* ¶ 8. Dr. Darling opined that "[redacted]" is a fundamental replacement skill, which is usually learned very early in treatment to build on other skills later in treatment; however, the short-term objective ("STO") planned for 10% improvement after three months. *See* ¶ 8. The record shows this same pattern for Petitioner's other replacement skill goals with no mastery. *See* ¶ 3, 8. Finally, Dr. Darling pointed out in the provider's updated Treatment Plan that stated, "new function analysis was conducted on behaviors targeted for reduction to work on prevalent functions that are maintaining maladaptive behaviors." *See* ¶ 8. As testified by Dr. Darling, the provider was authorized to conduct a new assessment every six (6) months prior to submitting a plan for recertification but no functional assessment was completed. *See* ¶ 8. Petitioner has not shown a mastery since the last authorization period nor did the Treatment Plan include the necessary modifications to address the lack of progress during the course of treatment. *See* ¶ 2-3, 8.

22. [redacted] testified that that the intensity and frequency in Petitioner's behaviors improved with ABA therapy and argued that the graphs show a reduction in Petitioner's

maladaptive behaviors. *See* ¶ 9. 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. Petitioner's lack of progress in reducing [redacted] maladaptive behaviors and improving [redacted] replacement behaviors is well documented. S*ee* ¶ 2-3, 8, 21. The record shows the targeted behaviors were revised only after denial. S*ee* ¶ 4, 8. As Dr. Darling testified, the provider failed for indication that the proposed interventions would be effective. *See* ¶ 8. As previously discussed, the Treatment Plan did not include information to satisfy the medical necessity criteria to recertify Petitioner's ABA services. *See* ¶ 2-6, 8, 13-17. Dr. Darling established that these discrepancies are not consistent with accepted standards of care in the field of behavior analysis. *See* ¶ 8, 13, 17.

23. 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 ABA services at issue are not medically 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 proved by a preponderance of the evidence that Respondent's termination of ABA services was correct.

IT IS HEREBY ORDERED AND ADJUDGED THAT:

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

DONE AND ORDERED this 9th day of April, 2024 in Tallahassee, Leon County, Florida.

KIMBERLY ROCHE, 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]

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