



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

FILED

Apr 09, 2024, 11:59 am
OFFICE OF FAIR HEARINGS

[REDACTED]

PETITIONER,

AHCA Case No.: 24-FH0051

vs.

AGENCY FOR HEALTH CARE
ADMINISTRATION,

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic Fair Hearing on the instant case on March 1, 2024, at 9:06 a.m. Eastern Standard Time (“EST”).

APPEARANCES

For the Petitioner:

[REDACTED]

Petitioner’s Authorized Representative

For the Respondent:

Sandra Durden
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.

Sandra Durden ("Ms. Durden"), Medical/Health Care Program Analyst for the Agency for Health Care Administration ("Agency" or "AHCA"), appeared on behalf of Respondent. Dr. Alissa Conway ("Dr. Conway"), Board Certified Behavior Analyst at the doctoral level for eQHealth Solutions Inc. ("eQHealth"), appeared as a witness for Respondent.

Angel, interpreter number 222451, and Anderoh, interpreter number 428007, from Language Line solutions 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 one hundred and sixty-four (164)-page evidence packet and a fifty (50)-page evidence packet. The one hundred and sixty-four (164)-page evidence packet appears in the Office of Fair Hearings' document management system as the file titles: "[REDACTED] FH 03.01.2024 1-106.pdf"; "[REDACTED] FH 03.01.2024 107-140.pdf" and "[REDACTED] FH 03.01.2024 1401-164.pdf." The fifty (50)-page evidence packet appears in the Office of Fair Hearings' document management system as the file title "24-FH0051 AHCA Evidence.pkt.pdf". Absent an objection from the Petitioner, the undersigned admitted the one hundred and sixty-four (164)-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 22 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 109-111.

Petitioner's Treatment Plan shows the following progress: for [REDACTED], Petitioner reduced [REDACTED] frequency from [REDACTED] incidents per week; for [REDACTED], Petitioner reduced [REDACTED] frequency from [REDACTED]; for [REDACTED], Petitioner reduced [REDACTED] frequency from [REDACTED]; For [REDACTED], Petitioner reduced [REDACTED] frequency from [REDACTED]; For [REDACTED], Petitioner reduced [REDACTED] frequency from [REDACTED] per week to an average of [REDACTED] per week for [REDACTED], Petitioner reduced [REDACTED] frequency from [REDACTED] incident per week, for [REDACTED] petition or reduced [REDACTED] frequency from [REDACTED] per week; For [REDACTED] Petitioner reduced [REDACTED] frequency from [REDACTED] incidents per week. *Id.*

4. As testified to by Dr. Conway regarding the issues for the Fair Hearing, Petitioner had requested an of increase thirty (30) hours per week of BA services.

5. Petitioner requested continuation of BA services; specifically, 2,600 units of code 97153; 312 units of code 97155; and 208 units of code 97156. In a Notice of Outcome (“NOO”), dated December 8, 2023, Respondent terminated Petitioner’s ABA services. *Id.* at 29-30. 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 Principal Reason-Denial: Requested services are denied because documentation is neither showing improvement nor support for maintenance.

PR Clinical Rationale: Denial: According to the Florida Medicaid State Plan (page 8, 6.2.2), 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 January 4, 2024, Respondent upheld its decision.

Id. at 41-42. The NRD explained the basis for the decision as follows:

The reason for the denial is that the services are not medically necessary as defined in 59G-1.010, Florida Administrative Code. 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.

The rationale for our decision is as follows:

PR Recon Determination: 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. Please submit information regarding lack of progress and modifications to address lack of progress.

...

Id.

7. On January 4, 2024, Petitioner requested a Fair Hearing to challenge the termination and denial of additional ABA services. On February 12, 2024, the undersigned issued an Order Scheduling Fair Hearing by Telephone and Prehearing Instructions, setting the hearing for March 1, 2024, at 9:00 a.m. EST.

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

- a. Petitioner has shown no progress and no modifications have been made to the treatment plan.
- b. The request for an increase in services is in excess of medical necessity. Petitioner may qualify for applied behavior analysis services but not with the current provider.
- c. At reconsideration, it was requested that the providers submit information regarding lack of progress and modifications to address lack of progress. The provider did not do this.
- d. There has been no progress in incidents of [REDACTED]. The plan indicates that the behavior was mastered however the long-term objective indicates that mastery is shown when there are [REDACTED] for six weeks.
- e. Incidents of [REDACTED] and [REDACTED] has been below [REDACTED] [REDACTED] and has not improved. The behavior should have been removed from the treatment plan because the data has stayed the same without progress for [REDACTED].

- f. Petitioner has made minimal progress in reducing [REDACTED] and [REDACTED]. *Id.* at 120-121.
- g. Incidents of [REDACTED] has increased from May of 2023 to September of 2023. No modifications are noted and the petitioner is still at baseline with over [REDACTED] per week. This behavior does overlap with [REDACTED] which was described as being mastered.
- h. For [REDACTED], the graph showed the same pattern as [REDACTED] with no progress since [REDACTED]. *Id.* at 123. For [REDACTED] there has been no progress throughout the authorization; this behavior has been targeted since [REDACTED]. *Id.* at 124.
- i. Similarly, [REDACTED] and [REDACTED] have been targeted since [REDACTED] and has shown minimal progress. *Id.* 125 -126.
- j. Regarding replacement behaviors the data collection and recording distorts the visual analysis and is not within the standards of care behavior analysis
- k. Multiple replacement behaviors have been targeted since [REDACTED] and there has been minimal progress with each goal. *Id.* 132 -135
- l. There is data shown for [REDACTED] and [REDACTED]. These behaviors are the same thing, however, the graph showed different data performance despite targeting the skill for a lengthy period of time.
- m. The petitioner cannot [REDACTED] after [REDACTED] of services.

- n. The Petitioner [REDACTED] desires independently after [REDACTED] of services. *Id.* 141. Petitioner does not have [REDACTED] [REDACTED] after [REDACTED] of services.
- o. There is minimal variability across the graphs and it may be due to data collection. There is no fidelity data to analyze the variability issue.
- p. There is no medical necessity to increase the behavior analysis services for this petitioner to 30 hours per week.

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

- a. They are requesting additional hours because ever since the hours have been reduced the behavior bad behavior has increased.
- b. The behavior has worsened since the [REDACTED] left the home and the Petitioner has been [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 (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 (increased hours), 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 not duplicate another service
- Meet the criteria as specified in this policy

4.2 Specific Criteria

Florida Medicaid covers the following BA services in accordance with the applicable Florida Medicaid fee schedule(s), or as specified in this policy:

4.2.1 Behavior Assessment 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 must 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
 - o Treatment setting(s)
 - o Proposed treatment targets, goals, and objectives related to medically necessary behavioral interventions
 - o 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
 - o Proposed targets, goals, and objectives (as above)
 - o Training procedures
 - o Date of introduction
 - o Estimated date of mastery
- Number of units requested
 - o Number of units for each billing code
 - o 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.

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 December 8, 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. *See* ¶ 14-15. 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." *See* ¶ 16. Dr. Conway provided credible testimony that the maladaptive behavior graphs show a lack of progress after [REDACTED] of treatment. *Id.* Dr. Conway 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. Conway testified that Petitioner is still working on the same treatment goals as [REDACTED] was [REDACTED] ago. *Id.* Furthermore, Dr. Conway 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 data graphs show a lack of progress in the maladaptive behaviors without appropriate intervention, 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 a lack of modification in the treatment plan to address the lack of progress 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 policies, 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 an additional 30 hours per week of ABA services. See ¶ 4. 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. Conway provided credible testimony that effective treatment would not have resulted in such high levels of maladaptive behaviors after years of treatment. *Id.* Dr. Conway 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]. *Id.* Furthermore, Dr. Conway 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] ago, 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 9th day of April, 2024, in Tallahassee, Leon County, Florida.



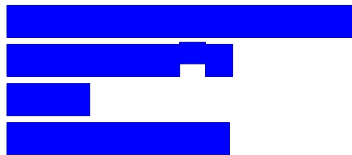
Lynne Ringers
24-FH0051
2024.04.09 08:21:44
-04'00'

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:



AHCA Medicaid Hearing Unit
MedicaidHearingUnit@ahca.myflorida.com