



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

FILED
May 28, 2024, 12:53 pm
OFFICE OF FAIR HEARINGS

[REDACTED]

PETITIONER,

AHCA Case No.: 24-FH0615

vs.

**AGENCY FOR HEALTH CARE
ADMINISTRATION,**

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned Hearing Officer convened a telephonic Fair Hearing on the instant case on April 12, 2024, at 1:11 p.m. Eastern Standard Time (“EST”).

APPEARANCES

For the Petitioner:

[REDACTED]

Petitioner’s Authorized Representative

For the Respondent:

Marielisa Amador
Medical Health Care Program Analyst
Agency for Health Care Administration

STATEMENT OF ISSUE

The issue is whether Respondent proved by a preponderance of the evidence that Respondent’s termination of Petitioner’s behavior analysis (“ABA” or “BA”) services was correct.

PRELIMINARY STATEMENT

All parties and witnesses appeared telephonically. [REDACTED] (“[REDACTED]”),
Petitioner’s Authorized Representative and [REDACTED], appeared at the Fair Hearing on behalf of

Petitioner. [REDACTED], Petitioner's Board-Certified Behavior Analyst ("BCBA"), appeared at the Fair Hearing as a witness for Petitioner.

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

The following translators appeared at the Fair Hearing to provide translation services: Tania, ID Number 386890.

Petitioner did not introduce any exhibits at the Fair Hearing.

Respondent sent to the Office of Fair Hearings and Petitioner a one hundred and thirty-seven (137)-page evidence packet and a forty-nine (49)-page evidence packet. The one hundred and thirty-seven (137)-page packet appears in the Office of Fair Hearings' document management system as file titled "[REDACTED] FH 04.12.2024.pdf." The forty-nine (49)-page packet appears in the Office of Fair Hearings' document management system as the file titled "24-FH0615 AHCA Evidence (Pages 1-49 of 49). pdf". Absent any objections from Petitioner, the undersigned admitted the one hundred and thirty-seven (137)-page evidence packet as Respondent's Composite Exhibit 1 ("RCE 1") and the forty-nine (49)-page evidence packet as Respondent's Composite Exhibit 2 ("RCE 2").

FINDINGS OF FACT

1. Petitioner receives Medicaid services on a fee-for-service basis through the Agency. See RCE 1 at page 22. eQHealth is a Quality Improvement Organization contracted by the Agency to review prior authorization requests for services. See RCE 2 at page 2.

2. As of the date of the Fair Hearing, Petitioner is [REDACTED]. See RCE 1 at page 22. Petitioner is diagnosed with [REDACTED] [REDACTED] *Id.* at 22, 97.

3. As provided in the provider’s Functional Behavioral Assessment (FBA) and Behavior Intervention Plan (BIP) Assessment & Behavior Analysis Support Plan (“treatment plan” or “behavior plan”) dated February 12, 2024, as reported by the provider, Petitioner is engaging in the following maladaptive behaviors: [REDACTED], [REDACTED], [REDACTED], [REDACTED], [REDACTED], [REDACTED], and [REDACTED]. *Id.* at 97. The data graphs for Petitioner’s maladaptive behaviors in the treatment plan show the following between February 2024 and May 2024: for [REDACTED], Petitioner’s incidents decreased from approximately [REDACTED]; for [REDACTED], Petitioner’s incidents remained consistent at [REDACTED]; for [REDACTED], Petitioner’s incidents decreased from approximately [REDACTED]; for [REDACTED], Petitioner’s incidents remained consistent at [REDACTED]; for [REDACTED], Petitioner’s incidents decreased from approximately [REDACTED]; for [REDACTED], Petitioner’s incidents decreased from approximately [REDACTED]; for [REDACTED], Petitioner’s incidents decreased from approximately [REDACTED]. *Id.* at 118 – 122.

4. The treatment plan includes four graphs for the replacement behaviors of [REDACTED] [REDACTED], [REDACTED], [REDACTED], [REDACTED]

[REDACTED], and [REDACTED]. *Id.* at 123 – 126. [REDACTED]

[REDACTED]

5. On February 14, 2024, Petitioner requested continuation of BA services; specifically, 3,120 units of code 97153; 104 units of code 97155; 208 units of code 97155 HN; 104 units of code 97156; and 208 units of code 97156 HN. *See* RCE 1 at 29. In a Notice of Outcome – Denial (“NOO”), dated February 23, 2024, Respondent terminated Petitioner’s BA services. *Id.* at 29 – 33. The NOO explained the basis for the partial denial as follows:

The request for services is denied in whole or in part because they are not medically necessary as defined in Rule 59G-1.010, Florida Administrative Code. Specifically, the requested services are not medically necessary under the following standard(s):

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

Furnished in a manner not primarily intended for the convenience of the recipient, the recipient’s caregiver, or the provider.

The NOO further provided:

The rationale for our decision is as follows:

PR Principal Reason – Denial:

Submitted information does not support the medical necessity for requested frequency and/or duration.

PR Clinical Rationale – Denial: The request for assessment is denied. The previous BA services with this provider for this recipient were denied due to a lack of progress and held up at reconsideration. The interventions and data submitted by the provider for this request for services do not meet medical necessity criteria.

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RCE 1 at 29 – 30.

6. Petitioner requested reconsideration of the Respondent’s decision. In a Notice of Reconsideration Determination (“NRD”), dated March 19, 2024, Respondent upheld its decision.

Id. at 41 – 44. 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:

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: This request for behavior Analysis Services is denied. The previous BA services with this provider for this recipient were denied due to a lack of progress and held up at reconsideration. The interventions and data submitted by the provider for this request for services do not meet medical necessity criteria.

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RCE 1 at 42.

7. On February 23, 2024, Petitioner requested a Fair Hearing to challenge the termination of BA services. On March 19, 2024, the undersigned issued an Order Scheduling Fair Hearing and Prehearing Instructions, setting the hearing for April 12, 2024, at 1:00 p.m. EST.

8. Dr. Conway, BCBA-D, testified to the following:

- a. eQHealth is the quality improvement organization contracted by Florida Medicaid to review requests for BA services for medical necessity. Medical necessity means that the medical or allied care, goods, or services must meet the medical necessity criteria. Dr. Conway read the five (5) medical necessity criteria into the record. See

RCE 2 at 7.

- b. Petitioner's treatment plan was reviewed by three (3) different BCBA's at both the master's and doctoral levels to determine if the treatment meets medical necessity criteria.
- c. Petitioner has been in ABA services since [REDACTED], and with this provider since [REDACTED].
- d. The requested services were denied and upheld at reconsideration due to lack of sufficient progress and lack of modifications to the plan. The treatment does not meet criterion three, in that the treatment plans were not consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational.
- e. Petitioner may qualify for ABA services based on the maladaptive behaviors and skill deficits but does not meet medical necessity criteria with the current provider.
- f. The most recent treatment plan only includes baseline data and does not include progress data from previously authorized services. The provider did not note any modifications to the treatment plan to address the previous issue, which was the lack of progress.
- g. The data graph for [REDACTED] is not clear if the data point is from an observation or a weekly frequency. See RCE 1 at 118.
- h. There are four (4) replacement skills or acquisition goals listed. See RCE 1 at 123 – 126.

- i. Each of the data graphs for caregiver training goals show parent performance is [REDACTED] [REDACTED] See RCE 1 at 127 – 130. This indicates the caregiver made no progress over the year of service.
 - j. Overall, the treatment plan does not include modifications to address the lack of progress noted by Respondent and the provider. The treatment plan does not meet the standards of care in the field of applied behavior analysis.
 - k. Without the appropriate modifications and with the limited replacement goals, Petitioner will continue to have lack of progress.
9. [REDACTED], Petitioner’s Authorized Representative and [REDACTED], testified to the following:
- a. Petitioner has not received ABA services since [REDACTED].
 - b. Petitioner’s behaviors have become worse.
10. [REDACTED], BCBA, testified to the following:
- a. Petitioner was not making progress in [REDACTED] [REDACTED].
 - b. Petitioner’s behaviors increased in [REDACTED].

CONCLUSIONS OF LAW

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

13. Because Respondent terminated a previously approved service, Fla. Admin. Code R. 59G-1.100(17)(b) 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.).

14. 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.

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1.4.6 Medically Necessary/Medical Necessity

As defined in Rule 59G-1.010, F.A.C.

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2.0 Eligible Recipient

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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.

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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.)

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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.

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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.

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RCE 2 at 41 – 43, 46 – 47

15. 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.

RCE 2 at 4 – 5.

16. 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.

RCE 2 at 13.

17. Section 2.83 of the 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.

RCE 2 at 23.

18. The Florida Medicaid Authorization Requirements Policy (“Authorization Requirements 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 errors or omissions in prior certifications.
- There is a documented improvement in the recipient’s medical condition.
- There is a documented change in the recipient’s circumstances.
- The reviewing physician determines the recipient will not gain any additional benefit by continuing services at the current level.

RCE 2 at 34.

19. In the instant case, Respondent terminated Petitioner’s ABA services. *See* ¶ 5. In the NOO dated February 23, 2024, Respondent explained that continuing services with the current provider were not medically necessary, specifically, that the services did not meet the requirement that services must be “[c]onsistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational” and “furnished in a manner not primarily intended for the convenience of the recipient, the recipient’s caregiver, or the provider.” *See* ¶ 5. Respondent further explained that the “[s]ubmitted information does not support the medical necessity for requested frequency and/or duration” and that the “the previous BA services with this provider for this recipient were denied due to a lack of progress and held up at reconsideration.” *See* ¶ 5. In the NRD dated March 19, 2024, Respondent rationalized that the reason for the denial of services was also because services were not “[c]onsistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational.” *See* ¶ 6. Finally, Respondent reasoned that the “interventions and data submitted by the provider for this request for services do not meet medical necessity criteria.” *See* ¶ 6.

20. 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* ¶ 16. As provided in section 2.83 of 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* ¶ 17. This criterion was identified as not being met in the NOO and NRD. *See* ¶ 5 – 6. [REDACTED] testified that Petitioner’s behaviors have become

worse, *see* ¶ 9, and [REDACTED] testified that Petitioner’s behaviors increased in [REDACTED]. *See* ¶ 10. However, as shown by the record, Petitioner’s submitted treatment plan is not consistent with generally accepted professional medical standards and the submitted information does not support the medical necessity for requested frequency and/or duration. *See* ¶ 3 – 4, 5. Dr. Conway established that Petitioner has been in ABA services since [REDACTED], and with this provider since [REDACTED], and that the requested services were denied and upheld at reconsideration due to lack of progress and lack of modification. *See* ¶ 8. Further, Dr. Conway opined that [REDACTED] may qualify for ABA services based on the maladaptive behaviors and skill deficits but does not meet medical necessity criteria with the current provider. *See* ¶ 8. Although Petitioner may need ABA services, the current treatment plan does not appear to be consistent with generally accepted professional medical standards. *See* ¶ 5. In all, based on the credible and convincing testimony of Dr. Conway, and the lack of progress in the treatment plan, Respondent demonstrated that the provider’s treatment is not “consistent with generally accepted professional medical standards as determined by the Medicaid program”.

21. 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* ¶ 18. As discussed, *supra* ¶ 20 – 21, the current treatment plan indicates a lack of progress and a lack of modifications.

22. Upon consideration of the testimony provided, Respondent’s Composite Exhibit 1, Respondent’s Composite Exhibit 2, and the applicable polices and laws, the undersigned concludes that Respondent proved by a preponderance of the evidence that the ABA services at issue do not meet medical necessity criteria. 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 BA services was correct.

IT IS HEREBY ORDERED AND ADJUDGED THAT:

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

Respondent's denial of Petitioner's request for additional behavior analysis services is **AFFIRMED**. Petitioner's appeal based on Respondent's denial is **DENIED**.

DONE and **ORDERED** this 28th day of May, 2024, in Tallahassee, Leon County, Florida.

 Kameisha Presley
24-FH0615
2024.05.28
10:42:50 -04'00'

KAMEISHA PRESLEY, 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
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