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

FILED

Jul 01, 2024, 8:38 am

OFFICE OF FAIR HEARINGS

[redacted],

PETITIONER, **AHCA Case No.: 24-FH0729**

vs.

AGENCY FOR HEALTH CARE ADMINISTRATION,

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic Fair Hearing on the instant case on April 15, 2024, at 9:04 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. Petitioner's Authorized Representative and [redacted], [redacted] ("[redacted]") appeared on behalf of Petitioner. [redacted]

[redacted], Petitioner's Board Certified Behavior Analyst ("BCBA"), attended as a witness for Petitioner.

Linda Latson, Registered Nurse Specialist for the Agency for Health Care Administration ("Agency" or "AHCA"), appeared on behalf of Respondent. Dr. David Bicard ("Dr. Bicard"), Board Certified Behavior Analyst at the doctoral level ("BCBA-D") and Director of Clinical Operations for eQHealth Solutions Inc. ("eQHealth") appeared as a witness for Respondent.

Daniel, interpreter number 374464, and Carlos, interpreter number 365962, of Language Line Solutions, appeared to offer translation services for the Petitioner.

Prior to the hearing, Petitioner sent to the Office of Fair Hearings and Respondent a fourteen (14)-page evidence packet. The evidence packet appears in the Office of Fair Hearings' document management system as the file title "24-FH0729 – DAR Supporting Documents.pdf". Absent an objection from the Respondent, the undersigned admitted the fourteen (14)-page evidence packet into evidence as Petitioner's Composite Exhibit 1 ("PCE 1").

Prior to the hearing, Respondent sent to the Office of Fair Hearings and Petitioner a 150 -page evidence packet and a forty-nine (49)-page evidence packet. The 150-page packet appears in the Office of Fair Hearings' document management system as the file title "[redacted] FH 04.15.2024 1-142.pdf" and "[redacted] FH 04.15.2024 143-150.pdf". The forty-nine (49)-page evidence packet appears in the Office of Fair Hearings' document management system as the file title "24-FH0729 AHCA Evidence BA Services 49 Pages.pdf". Absent an objection from the Petitioner, the undersigned admitted 150-page evidence packet into evidence as Respondent's Composite Exhibit 1 ("RCE 1") and the forty-nine (49)-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. As provided in Petitioner's Behavior Analysis Re-Assessment ("treatment plan" or "behavior plan"), Petitioner is engaging in the following maladaptive behaviors: [redacted]; [redacted]; [redacted]; [redacted]; [redacted]; [redacted]; [redacted]; [redacted]; [redacted]; [redacted]; and [redacted]. *Id.* at 57.

4. Petitioner requested continuation of BA services; specifically, 2,912 units of code 97153; 312 units of code 97155; and 104 units of code 97156. In a Notice of Outcome ("NOO"), dated February 5, 2024, Respondent terminated Petitioner's ABA services. *Id.* at 28 – 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.

The NOO further provided:

> PR Clinical Rationale – Denial: 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. The request for services is denied.
>
> . . .

Pages 28 – 29 of RCE 1.

5. Petitioner requested reconsideration of the Respondent's decision. In a Notice of Reconsideration Determination ("NRD"), dated March 5, 2024, Respondent upheld its decision. *Id.* at 40 – 42. The NRD explained the basis for the decision as follows:

> [T]he requested services are not medically necessary under the following standard(s):
>
> Individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness under treatment, and not in excess of the patient's needs.
> Consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational.
> . . .
> PR Recon Determination: At reconsideration all documents were carefully reviewed. 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

. . .

Pages 40 – 41 of RCE 1.

6. On March 7, 2024, Petitioner requested a Fair Hearing to challenge the termination of ABA services. On March 25, 2024, the undersigned issued an Order Scheduling Fair Hearing and Prehearing Instructions, setting the hearing for April 15, 2024, at 9:00 a.m. EST.

7. Dr. Bicard is a BCBA-D. Dr. Bicard testified to the following:

a. Petitioner has participated in services with this provider for [redacted] and has not made adequate progress in reducing maladaptive behaviors and increasing the replacement behaviors. Provider's services are not individualized for the recipient nor are they consistent with generally accepted standards of care within the field of ABA.

b. eQHealth uses a two (2) level review process. When a request for services is made it is reviewed by a BCBA. If the treatment plan meets the medical necessity criteria the request is approved. If it does not meet the medical necessity criteria the case is referred to Second Level review. Here, the case was referred to Second Level Review due to lack of progress in reducing maladaptive behaviors and increasing replacement behaviors. At Second Level Review, the case was reviewed by a BCBA-D. The Second Level Reviewer upheld the termination of services based on the lack of progress and corresponding lack of interventions.

c. Dr. Bicard believes that the changes that were proposed have little chance of being successful.

d. There are portions of the treatment plan that do not appear to be individualized for the Petitioner. eQHealth reviews thousands of treatment plans per week, which makes it easy to spot when plans are cut and pasted from other plans. Here, the interventions have been cut and pasted from other treatment plans.

e. The efficacy of treatment is assessed by reviewing graphs. The standards of care require a BCBA to make changes when there is no improvement. In this treatment plan there does not appear to be any changes to treatment in response to Petitioner's lack of response to treatment. All changes to treatment must be reflected on the graphs – this is a standard of care of ABA.

f. The graph shows no change in the behavior. *See* page 68 of RCE 1. This same general pattern shows in all of the graphs. The graph for [redacted] shows variability, which is a sign that the provider's treatment is not the same every day. It is the responsibility of the BCBA to determine why and make adjustments. This same pattern is shown in [redacted], [redacted], [redacted], [redacted], [redacted], [redacted], [redacted], and [redacted]. Petitioner has been working on those behaviors since the onset of treatment.

g. [redacted] does not meet medical necessity criteria.

h. Replacement behaviors are intended to replace maladaptive behaviors. Many of the replacement behaviors have been worked on for more than [redacted], and Petitioner should be much further along in the treatment. For example, [redacted] is still working on [redacted]. *See* page 80 of RCE 1.

i. Petitioner cannot [redacted]. *See* page 81 of RCE 1.

j. [redacted] is not an ABA intervention, it is used in other therapies. This is not covered under the ABA Policy.

k. "[redacted]" has been taught for [redacted], Petitioner still requires for [redacted] – which does not meet standards of care within the field of ABA. *See* page 82 of RCE 1.

l. [redacted] is still being prompted. *See* page 83 of RCE 1.

m. Prompt dependency is a major problem with children diagnosed with [redacted]. The reason for prompt dependency is because the provider has not appropriately faded out prompts. Standards of care dictate that prompts should be faded quickly so the individual can respond independently as possible.

n. The interventions found on pages 107 – 110 are not individualized for Petitioner. It appears to have been cut and pasted from other plans. There are interventions listed that cannot be implemented together at the same time.

o. [redacted] is misnamed – it should be "[redacted]". *See* page 108 of RCE 1. [redacted] is also on page 109 of RCE 1. This suggests that this provider has not individualized treatment for Petitioner.

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

a. [redacted] has only recently been providing services for Petitioner.

b. [redacted] There have been environmental changes that have contributed to the

lack of progress. [redacted].

c. There are interventions to fade out the prompts

d. [redacted] does not agree that the plan is not individualized. There are overlapping interventions, but they overall responded to Petitioner's needs. The new BCBA team has had a positive impact and have decreased many of the incidents of maladaptive behaviors.

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

a. [redacted] believes Petitioner needs to continue with ABA therapy.

b. Petitioner is [redacted].

c. Petitioner's behavior has improved with the therapy.

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. The standard of proof in an administrative hearing is a preponderance of the evidence. The preponderance of the evidence

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

13. The Florida Medicaid Behavior Analysis Services Coverage Policy (September 2023) ("BA Policy"), incorporated by reference in Fla. Admin. Code. R. 59G-4.125, governs BA services available under Florida Medicaid. The BA Policy provides as follows:

> **1.0 Introduction**
> Behavior analysis (BA) services are highly structured interventions, strategies, and approaches provided to decrease maladaptive behaviors and increase or reinforce appropriate behaviors.
> . . .
> **1.4.6 Medically Necessary/Medical Necessity**
> As defined in Rule 59G-1.010, F.A.C.
> . . .
> **2.0 Eligible Recipient**
> **. . .**
> **2.2 Who Can Receive**
> Florida Medicaid recipients under the age of 21 years requiring BA services that are medically necessary to address behavior that impairs a recipient's ability to perform a major life activity. Such functional impairment is expressed through the following behaviors:
>
> - Safety – aggression, self-injury, property destruction, elopement
> - Communication – problems with expressive/receptive language, poor understanding or use of non-verbal communications, stereotyped, repetitive language
> - Self-stimulating – abnormal, inflexible, or intense preoccupations
> - Self-care – difficulty recognizing risks or danger, grooming, eating, or toileting
> - Other behaviors not identified above but not limited to complexity of treatment, programming, or environmental variables
>
> The recipient must be referred by an independent physician or practitioner qualified to assess and diagnose disorders related to functional impairment, including:
>
> - Primary care physician with family practice, internal medicine, or pediatric specialty
> - Board certified or board eligible physician with specialty in developmental behavioral pediatrics, neurodevelopmental pediatrics, pediatric neurology, adult or child psychiatry

- Child psychologist

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

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

. . .

4.0 Coverage Information

4.1 General Criteria

Florida Medicaid covers services that meet all of the following:

- Are determined medically necessary
- Do no duplicate another service
- Meet the criteria as specified in this policy

4.2 Specific Criteria

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

4.2.1 Behavior Assessment and Behavior Plan

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

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

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

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

The behavior plan identifies intervention strategies that are likely to eliminate, mitigate or replace the behavior to produce change sufficient to reengage the recipient in the major life activity. The plan must include specific behavior goal(s),

intervention strategies for each goal, anticipated timeframes that are of sufficient duration to address the targeted behavior, and how the ongoing progress of intervention strategies will be reported.

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

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

More frequent assessments must be conducted when:

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

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

4.2.2 Behavior Analysis Interventions

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

- Adaptive behavior treatment by protocol - behavior analysis services provided according to the authorized treatment protocol
    - Services may be provided by Lead Analyst, BCaBA, or RBT
- Adaptive behavior treatment with protocol modification – behavior analysis services provided with modifications to the authorized treatment protocol to address behavior and/or response changes or progress
    - Services may be provided by Lead Analyst or BCaBA
- Group adaptive behavior treatment by protocol – behavior analysis services provided in a group setting according to the authorized treatment protocol
    - Maximum group size is six recipients
    - Services may be provided by Lead Analyst, BCaBA, or RBT
- Group adaptive behavior treatment with protocol modification – behavior analysis services provided in a group setting with modifications to the authorized treatment protocol to address behavior and/or response changes or progress
    - Maximum group size is six recipients
    - Services may be provided by Lead Analyst or BCaBA

- Family adaptive behavior treatment guidance – parent, guardian, and/or caregiver training on the implementation of the behavior plan and intervention strategies
    - The recipient may or may not be present depending upon clinical appropriateness.
    - Services may be provided by Lead Analyst or BCaBA
    - The Lead Analyst may provide up to two hours per week of training to parents or guardians via telemedicine in accordance with Rule 59G-1.057, Florida Administrative Code (F.A.C.)

. . .

4.2.4 Discharge

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

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

4.3 Early and Periodic Screening, Diagnosis, and Treatment

As required by federal law, Florida Medicaid provides services to eligible recipients under the age of 21 years, if such services are medically necessary to correct or ameliorate a defect, a condition, or a physical or mental illness. Included are diagnostic services, treatment, equipment, supplies, and other measures described in sectioned 1905(a) of the Social Security Act, codified in Title 42 of the United States Code 1396d(a). As such, services for recipients under the age of 21 years exceeding the coverage described within this policy or the associated fee schedule may be approved, if medically necessary. For more information, please refer to Florida Medicaid's Authorization Requirements Policy.

. . .

5.0 Exclusion

5.1 General Non-Covered Criteria

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

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

5.2 Specific Non-Covered Criteria

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

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

* These services include behavior analysis treatment.

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

6.0 Documentation

6.2 Specific Criteria

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

6.2.1 Referral Information

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

6.2.2 Behavior Assessment and Behavior Plan

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

- Patient information
- Reason for referral
- Medical and developmental history, including medications prescribed to ameliorate behaviors
- Relevant family history
- Clinical interview

- Review of recent assessments/reports (file review)
- Assessment procedures and results
- Behavior plan
    - Treatment setting(s)
    - Proposed treatment targets, goals, and objectives related to medically necessary behavioral interventions
    - For each:
        - Definition in observable, measurable terms
        - Direct observation and measurement procedures
        - Current level (baseline)
        - Behavior reduction or acquisition procedures
        - Condition(s) under which behavior is to be demonstrated and mastery criteria
        - Date of introduction
        - Estimated date of mastery
        - Plan for generalization
        - Timely reporting of progress, including statements as to whether goal or objective is met; not met; or, modified (with explanation)
- Parent/guardian/caregiver training
    - Proposed targets, goals, and objectives (as above)
    - Training procedures
    - Date of introduction
    - Estimated date of mastery
- Number of units requested
    - Number of units for each billing code
    - Medical necessity for units requested
- Supervision plan, including name(s) of authorized supervisor(s)
- Care coordination with parents/caregivers, schools, state disability programs, and others as applicable
- Transition (fading) plan
- Crisis management plan
- Discharge plan

6.2.3 Assessment and Behavior Plan for Reauthorization and Continuation of Services

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

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

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

Pages 1 – 8 of BA Policy.

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

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

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

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

16. The 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.

17. The Florida Medicaid Authorization Requirements Policy ("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 Authorization Policy.

18. In the instant case, Respondent terminated Petitioner's ABA services. *See* ¶ 4. In the NOO dated February 5, 2024, Respondent explained that continuing services with the current provider was not medically necessary, specifically, that it did not meet the requirement that services must be "consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational." *Id.* In the NRD, dated March 5, 2024,

the Respondent also explained that the requirement that services be "individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness under treatment, and not in excess of the patient's needs" was not met. Respondent further explained that "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." *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. "consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational", as well as "individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness under treatment, and not in excess of the patient's needs." As shown by the record, Petitioner's treatment plan demonstrates a pattern of high variability and a lack of overall progress. *See* ¶ 7. Dr. Bicard provided credible testimony that Petitioner's should have greater improvement in [redacted] replacement behaviors and that the interventions are not individualized for Petitioner. *Id.* Dr. Bicard also noted that modifications should be made to the treatment plan when there is not consistent progress, and that the provider has not included significant modifications to address the high variability and lack of progress. *Id.* While the Petitioner testified to environmental changes, the treatment plan submitted for review does not show adequate progress, nor adequate modification to the plan. As the treatment plan lacks progress regarding behavior goals and lacks sufficient modification to address the lack of progress, the treatment plan is not "consistent with generally accepted professional medical standards" within the field of ABA. Furthermore, as there have not been adequate modifications

to facilitate Petitioner's progress, the treatment plan is not "individualized, specific, and consistent" with Petitioner's treatment needs. 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* ¶ 16. As discussed, *supra* ¶ 19, Petitioner's behaviors exhibit high variability and a lack of progress, and the provider has not included sufficient modifications in the treatment plan. Here, Petitioner's lack of progress and the insufficiencies of the treatment plan are well documented.

21. Upon consideration of the testimony provided, evidence submitted, and applicable polices, the undersigned concludes that Respondent proved by a preponderance of the evidence that the termination of ABA services was 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 1st day of July 2024, in Tallahassee, Leon County, Florida.

Joseph Mabry
24-FH0729
2024.07.01
07:41:50 -04'00'

JOSEPH MABRY, Hearing Officer
Agency for Health Care Administration
Office of Fair Hearings
2727 Mahan Drive, Mail Stop # 11
Tallahassee, FL 32308-5407

NOTICE OF A RIGHT TO JUDICIAL REVIEW

A PARTY WHO IS ADVERSELY AFFECTED BY THIS FINAL ORDER IS ENTITLED TO JUDICIAL REVIEW, WHICH SHALL BE INSTITUTED BY FILING THE ORIGINAL NOTICE OF APPEAL WITH THE AGENCY CLERK OF AHCA, AND A COPY, ALONG WITH THE FILING FEE PRESCRIBED BY LAW, WITH THE DISTRICT COURT OF APPEAL IN THE APPELLATE DISTRICT WHERE THE AGENCY MAINTAINS ITS HEADQUARTERS OR WHERE A PARTY RESIDES. REVIEW PROCEEDINGS SHALL BE CONDUCTED IN ACCORDANCE WITH THE FLORIDA APPELLATE RULES. THE NOTICE OF APPEAL MUST BE FILED WITHIN 30 DAYS OF THE RENDITION OF THE ORDER TO BE REVIEWED.

Copies Furnished To:

[redacted]

AHCA Medicaid Hearing Unit
MedicaidHearingUnit@ahca.myflorida.com