FILED

Aug 26, 2024, 10:18 am

OFFICE OF FAIR HEARINGS

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

______________,

PETITIONER, **AHCA Case No.: 24-FH1288**

vs.

AGENCY FOR HEALTH CARE ADMINISTRATION,

RESPONDENT.
________________________________/

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic Fair Hearing on the instant case on June 13, 2024, at 10:08 a.m. Eastern Standard Time ("EST").

APPEARANCES

For the Petitioner: ______________
Petitioner's Authorized Representative

For the Respondent: Diana Hearod
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 decision to terminate Petitioner's behavior analysis ("BA" or "ABA") services was correct.

PRELIMINARY STATEMENT

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

Diana Hearod, Medical Health Care Program Analyst for the Agency for Health Care Administration ("Agency" or "AHCA"), appeared for the Fair Hearing as representative for Respondent. Dr. Joseph Darling ("Dr. Darling"), BCBA at the Doctoral level and Second Level Reviewer for eQHealth Solutions Florida ("eQHealth"), appeared for the Fair Hearing as a witness for Respondent.

The following individuals appeared for Fair Hearing to provide translation services for Petitioner: Mensaina, interpreter number 412663 of Language Line Solutions; Bilman, interpreter number 435524 of Language Line Solutions.

Petitioner did not introduce any exhibits at the hearing.

Prior to the hearing, the Office of Fair Hearings received a three hundred and seventy-seven (377)-page evidence packet and a forty-nine (49)-page evidence packet from Respondent. The three hundred and seventy-seven (377)-page packet appears in the Office of Fair Hearings document management system as file titles "[redacted] FH 06.13.2024 1-162.pdf" "[redacted] FH 06.13.2024 163-223.pdf" "[redacted] FH 06.13.2024 224-282.pdf" "[redacted] FH 06.13.2024 283-338.pdf" and "[redacted] FH 06.13.2024 339-377.pdf." The forty-nine (49)-page evidence packet appears in the Office of Fair Hearings document management system as the file title "24-FH1288_Behavior Analysis_AHCA EVIDENCE_49 PGS_[Petitioner].pdf." Absent an objection from the Petitioner, the undersigned admitted the three hundred and seventy-seven (377)-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 ("QIO") contracted by the Agency to review prior authorization requests for services. *See* RCE 2 at page 2.

2. Petitioner is . *See* RCE 1 at page 21. Petitioner is diagnosed with . *Id.*

3. Petitioner receives ABA therapy at . *Id*. As provided in the Behavior Analysis Assessment ("Treatment Plan"), Petitioner is engaging in the following maladaptive behaviors: , , , and . *Id*. at 308-309. As provided in the Treatment Plan, Petitioner's incidents of maladaptive behaviors, for the period of to March 2024, are as follows: for , Petitioner's incidents were "measured occurrences per week in , and it is currently occurrences per week"; for , Petitioner's incidents were "measured occurrences per week in , and it is currently occurrences per week"; for , Petitioner's incidents were "measured occurrences per week in , and it is currently occurrences per week"; and for , Petitioner's incidents were "measured occurrences per week in , and it is currently occurrences per week". *Id*. It should be noted that each of the maladaptive behavior graphs show gaps for missing data points across various dates throughout this period. *Id*.

4. Petitioner engages in [redacted] replacement behaviors, for the period of October 2023 to March 2024, at the following rates: for [redacted], Petitioner increased from about [redacted]; for [redacted], Petitioner increased from about [redacted]; and [redacted], Petitioner increased from about [redacted]. *Id*. at 310-311.

5. Petitioner requested ABA services for the certification period of March 26, 2024, to September 21, 2024; specifically, 2,600 units of code 97153; 208 units of code 97155; and 104 units of code 97156. *Id*. at 25, 29. On March 29, 2024, eQHealth requested additional information from the BA provider concerning the Treatment Plan. *Id*. at 24, 52.

6. In a Notice of Outcome ("NOO"), dated April 9, 2024, Respondent terminated Petitioner's requested ABA services. *Id.* at 29-31. The NOO explained the basis for the termination as follows:

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

The NOO further provided:

> Requested services are denied because documentation is neither showing improvement nor support for maintenance.
>
> PR Clinical Rationale - Denial: the provider submitted documents including data in graphs that are not consistent with data that are typically reported in behavior analytic treatment. The plan indicates caregiver collected treatment data, which does not conform to standards of care within the field of behavior analysis. The supporting documentation does not meet generally accepted practices within the field of applied behavior analysis and standards set forth in the Florida Behavior Analysis Services Coverage Policy (Pages 8, 6.2.3). The provider was approved to provide behavior analysis services. The provider has not submitted all graphed for skill acquisition goals and maladaptive behaviors that were to be completed during the authorized hours. According to the Florida Medicaid State Plan (page 8, 6.2.3), the data provided must show evidence that the frequency of the

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

Id. at 29-30.

7. Petitioner requested reconsideration of the Respondent's decision. In a Notice of Reconsideration Determination ("NRD"), dated April 22, 2024, Respondent upheld its decision. *Id.* at 41-42. The NRD explained the basis for the decision as follows:

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

Id.

8. On April 19, 2024, Petitioner requested a Fair Hearing to challenge the termination of ABA services. On May 10, 2024, the undersigned issued an Order Scheduling Fair Hearing and Prehearing Instructions, setting the hearing for June 13, 2024, at 10:00 a.m. EST. *Id*. at 8-19.

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

a. EQHealth reviews requests for ABA services using a multi-level peer review process to determine if the requested ABA services meet the medically necessary criteria. *See* ¶ 18.

b. Three eQHealth reviewers agreed that the data submitted in the treatment plan did not show effective treatment was provided to Petitioner. *See* RCE 1 at 25-28.

c. Petitioner's provider submitted four (4) treatment plans for review but none addressed the issues that led to the denial or made the changes necessary to approve ABA services. *Id*. at 95-159, 160-231, 232-303, 305-374.

d. The BCBA did not make any modifications to reduce the frequency of [redacted] after [redacted] where [redacted] were still occurring about [redacted] [redacted]. *Id*. at 308.

e. Regarding [redacted], Dr. Darling contended that the provider was authorized for protocol modifications throughout the prior authorization period, but the provider made changes only after the initial denial. *Id*.

f. Performance of replacement skills of "[redacted]," "[redacted] [redacted]," and "[redacted]" show not [redacted] of opportunities were successful after years of treatment. *Id*. at 310-311.

g. Dr. Darling opined that in the field of ABA, a BCBA might remove treatment from one behavior to test its effectiveness, but from not all behaviors. Dr. Darling argued that the provider's proposal to begin at baseline and remove any intervention for every behavior is inappropriate or possibly unethical. *Id*. at 331-336. The status reported by the lead analyst shows each behavior graph baseline [redacted] showing Petitioner learned nothing from the prior authorization. *Id*. at 348.

h. Further, the provider stated they experienced issues related to Petitioner's plan during the prior authorization period, particularly a high turnover rate of Registered Behavior Technicians ("RBT"). Dr. Darling argued that this showed the provider does not have the staff to provide therapy and the Treatment Plan did not show progress or oversight by a supervising professional. *Id*. at 305-306.

10. [redacted] is Petitioner's [redacted]. [redacted] testified that [redacted] needs ABA therapy due to [redacted], but [redacted] did not otherwise have any testimony to present.

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 (2022). 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 Rule 59G-1.100(17)(b), Florida Administrative Code ("Fla. Admin. Code R.").

13. 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.)

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

> **1.0 Introduction**
> Behavior analysis (BA) services are highly structured interventions, strategies, and approaches provided to decrease maladaptive behaviors and increase or reinforce appropriate behaviors.
>
> . . .
>
> **1.4.6 Medically Necessary/Medical Necessity**
> As defined in Rule 59G-1.010, F.A.C.
>
> . . .
>
> **4.0 Coverage Information**
>
> **4.1 General Criteria**
> Florida Medicaid covers services that meet all of the following:
>
> - Are determined medically necessary
> - Do no duplicate another service
> - Meet the criteria as specified in this policy
>
> **4.2 Specific Criteria**
> Florida Medicaid covers the following BA services in accordance with the applicable Florida Medicaid fee schedule(s), or as specified in this policy:
>
> **4.2.1 Behavior Assessment and Behavior Plan**
> A behavior assessment must be conducted prior to the initiation of behavior analysis interventions. The assessment must identify behavioral deficits that interfere with a major life activity including the events and subsequent interactions that elicit and sustain targeted behavior.
>
> The initial assessment must include the administration, scoring, and reporting of two core standardized behavior instruments, as follows:
>
> - Vineland-3 Comprehensive Parent Interview Form Including Maladaptive Behavior Domain, for all recipients
> - Behavior Assessment System for Children, Third Edition, Parenting Relationship Questionnaire (BASC-3 PRQ), for all recipients 2 years old and less than 19 years old

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

The behavior plan identifies intervention strategies that are likely to eliminate, mitigate or replace the behavior to produce change sufficient to reengage the recipient in the major life activity. The plan must include specific behavior goal(s), intervention strategies for each goal, anticipated timeframes that are of sufficient duration to address the targeted behavior, and how the ongoing progress of intervention strategies will be reported.

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

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

More frequent assessments must be conducted when:

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

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

4.2.2 Behavior Analysis Interventions

Florida Medicaid covers up to 40 hours per week of BA intervention services as indicated in the recipient's prior-authorized behavior plan. These services must be delivered to reduce maladaptive behaviors and assist the recipient reach the best possible functional level for that individual. The recipient's parent or guardian should participate in treatment when possible and clinically appropriate. The provider must make every effort to accommodate parental participation and must document those efforts in treatment plan updates. If parent or guardian participation is not possible, the treatment plan and session notes must document the reasons for nonparticipation. Documentation should also explain potential impacts of nonparticipation and how potential impacts are being mitigated.

Services include:

- Adaptive behavior treatment by protocol – behavior analysis services provided according to the authorized treatment protocol
  - Services may be provided by Lead Analyst, BCaBA, or RBT
- Adaptive behavior treatment with protocol modification – behavior analysis services provided with modifications to the authorized treatment protocol to address behavior and/or response changes or progress
  - Services may be provided by Lead Analyst or BCaBA
- Group adaptive behavior treatment by protocol – behavior analysis services provided in a group setting according to the authorized treatment protocol
  - Maximum group size is six recipients
  - Services may be provided by Lead Analyst, BCaBA, or RBT
- Group adaptive behavior treatment with protocol modification – behavior analysis services provided in a group setting with modifications to the authorized treatment protocol to address behavior and/or response changes or progress
  - Maximum group size is six recipients
  - Services may be provided by Lead Analyst or BCaBA
- Family adaptive behavior treatment guidance – parent, guardian, and/or caregiver training on the implementation of the behavior plan and intervention strategies
  - The recipient may or may not be present depending upon clinical appropriateness
  - Services may be provided by Lead Analyst or BCaBA
  - The Lead Analyst may provide up to two hours per week of training to parents or guardians via telemedicine in accordance with Rule 59G-1.057, Florida Administrative Code (F.A.C.)

4.2.3 Supervision

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

4.3 Early and Periodic Screening, Diagnosis, and Treatment

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

schedule may be approved, if medically necessary. For more information, please refer to Florida Medicaid's Authorization Requirements Policy.

. . .

6.2.2 Behavior Assessment and Behavior Plan

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

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

– Discharge plan

6.2.3 Assessment and Behavior Plan for Reauthorization and Continuation of Services

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

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

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

See RCE 2 at 41, 43-47.

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.

16. Petitioner is under age 21, and therefore EPSDT applies to [redacted] request for services. However, a state may place medical necessity limitations on EPSDT services. *See* 42 C.F.R. §§ 440.230(a), (b), (d). Section 409.905(2), Florida Statutes, limits EPSDT services with a medical necessity standard:

> The [Agency] shall pay for early and periodic screening and diagnosis of a recipient under age 21 to ascertain physical and mental problems and conditions and all services determined by the agency to be medically necessary for the treatment, correction, or amelioration of these problems and conditions, including personal

care, private duty nursing, durable medical equipment, physical therapy, occupational therapy, speech therapy, respiratory therapy, and immunizations.

17. The Florida Medicaid Definitions Policy (August 2017) ("Definitions Policy"), incorporated by reference in Fla. Admin. Code R. 59G-1.010, defines "Medically Necessary" or "Medical Necessity" as follows:

> The medical or allied care, goods, or services furnished or ordered must meet the following conditions:
>
> - Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate pain
> - Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs
> - Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational
> - Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available statewide
> - Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider
>
> The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services does not, in itself, make such care, goods or services medically necessary or a medical necessity or a covered service.

See RCE 2 at 23.

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

> **3.0 Determination Process**
> **3.1 Review Criteria**

The QIO may use a national standardized set of criteria, or other set of criteria, approved by AHCA, as a guide for authorizations performed at the first review level. If services cannot be approved at the first level review, the QIO's physician peer reviewer will determine medical necessity using his or her clinical judgment, acceptable standards of care, state and federal laws, and AHCA's medical necessity definition.

3.2 Review Process
The QIO will review each authorization request and will approve, deny, or request additional information. The QIO may deny a portion of the requested units of service if it cannot substantiate medical necessity based upon the information submitted.

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

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

See RCE 2 at 34.

19. In the instant case, Petitioner is under 21 years of age and is diagnosed with [redacted]. *See* ¶ 2. Petitioner requested recertification of ABA services. *See* ¶ 5. In a NOO, dated April 9, 2024, Respondent terminated the services. *See* ¶ 6. Respondent cited to the medical necessity criteria as the basis for their decision, specifically that the services were not "consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational." *See* ¶ 6-7. In addition, Respondent determined that the requested services were not "individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness under treatment, and not in excess of the patient's needs." *See* ¶ 6-7. Respondent has the burden of proof to show by a preponderance of evidence that the Respondent's determination was correct. *See* ¶ 13.

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* ¶ 15-16. In the Definitions Policy, a component of medical necessity is that services must be "consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational." *See* ¶ 17.

21. The BA Policy requires that for continuation of services a behavior plan must include data reflecting progress of all behaviors targeted for improvement. *See* ¶ 14. The BA Policy outlines that "if significant clinical progress is not made over the course of an authorization period, the provider must explain why clinically significant progress was not made and treatment changes to promote progress." *See* ¶ 14.

22. Through a multi-level peer review process, three eQHealth reviewers agreed that effective treatment was not provided to Petitioner based on the information submitted in the treatment plan. *See* ¶ 6-7, 9, 18. Dr. Darling established at Fair Hearing that Petitioner's provider had multiple opportunities to submit an effective Treatment Plan but none of the four (4) submitted treatment plans showed effective treatment or met generally accepted professional standards. *See* ¶ 9. When the frequency of a behavior is not improving, the BCBA must make modifications to the treatment and reflect them on each graph. *See* ¶ 9, 14. Dr. Darling argued that each of the maladaptive behavior graphs show a similar pattern of a lack of progress throughout the Treatment Plan without appropriate modifications. *See* ¶ 9. As an example, no modifications were made to reduce the frequency of [redacted] after [redacted] where [redacted] were still occurring about [redacted]. *See* ¶ 3, 9. Additionally, the provider failed to make changes regarding [redacted] until after the

initial denial. *See* ¶ 9. The same lack of progress was shown with Petitioner's performance of replacement skills of "," "," and "" as of successful opportunities. *See* ¶ 4, 9. Most notably, Dr. Darling opined that in the field of ABA, a BCBA might remove treatment from one behavior to test its effectiveness, but from not all behaviors. *See* ¶ 9. Dr. Darling argued that the provider's proposal to begin at baseline and remove any intervention for every behavior is inappropriate or possibly unethical. *See* ¶ 3, 9. Further, Dr. Darling established that the provider does not have the staff to provide therapy, and the Treatment Plan did not show progress or oversight by a supervising professional. *See* ¶ 9. Based on these demonstrations, Dr. Darling described the lack of progress and lack of interventions as ineffective treatment in the field of ABA. *See* ¶ 9. As shown by the record, the provider's Treatment Plan did not conform to standards of care within the field of behavior analysis. *See* ¶ 3-4, 6-7, 9, 14-17.

23. 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 previously discussed, the Treatment Plan does not include appropriate interventions or modifications to provide adequate explanations "why clinically significant progress was not made and treatment changes to promote progress." *See* ¶ 14, 21-22. Where Petitioner needs qualified and trained professionals to deliver ABA services, the Treatment Plan submitted by this provider did not demonstrate effective treatment to satisfy the medical necessity criteria to recertify Petitioner's ABA services. *See* ¶ 14, 21-22. The ABA provider had numerous opportunities to make the necessary revisions to Petitioner's therapy and failed

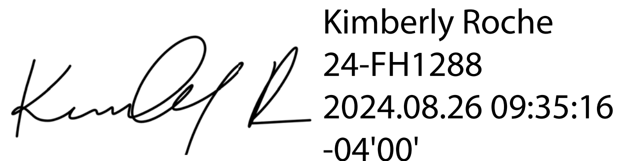
to do so. *See* ¶ 5-7, 9. All in all, Respondent has demonstrated that the requested ABA services are not "consistent with generally accepted professional medical standards." *See* ¶ 9, 17, 21-22.

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

IT IS HEREBY ORDERED AND ADJUDGED THAT:

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

DONE AND ORDERED this 26th day of August, 2024 in Tallahassee, Leon County, Florida.



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

NOTICE OF A RIGHT TO JUDICIAL REVIEW

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

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