FILED
APR 02 2014
OFFICE OF APPEAL HEARINGS
DEPT OF CHILDREN & FAMILIES

STATE OF FLORIDA
DEPARTMENT OF CHILDREN AND FAMILIES
OFFICE OF APPEAL HEARINGS

APPEAL NO. 14F-00232

PETITIONER,

Vs.

AGENCY FOR HEALTH
CARE ADMINISTRATION
CIRCUIT: 04 Duval
UNIT: AHCA

RESPONDENT.
_______________________________/

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing telephonically in the above-referenced matter on February 21, 2014 at approximately 10:10 a.m.

APPEARANCES

For the Petitioner: petitioner represented herself

For the Respondent: Jackie Allison, human services program specialist

STATEMENT OF ISSUE

At issue is the respondent's partial denial of dental services requested by the petitioner.

PRELIMINARY STATEMENT

AHCA administers the Florida Medicaid Program. Sunshine Health is a health maintenance organization (HMO) contracted to provide medical services to Medicaid recipients. Sunshine Health subcontracts its dental services to MCNA Dental.

By notice dated December 11, 2013, MCNA dental informed the petitioner that her request for several dental procedures were approved in part and denied in part.

On January 6, 2014, the petitioner timely requested a hearing to challenge the partial denial decision.

There were no additional witnesses for the petitioner. The petitioner did not submit exhibits.

Present as witnesses for the respondent were Latasha Hammton, medical analyst with AHCA; Carolyn Janvier, grievance coordinator with Sunshine Health; Marianna Aceveo, appeals manager with MCNA Dental; and Jessica Cruz, grievance and appeals administrator with MCNA Dental. Present as an observer was India Smith, appeals coordinator with Sunshine Health. Respondent Composite Exhibits 1 and 2 were admitted into evidence.

The record was held open until close of business on February 24, 2014 for submission of additional evidence. Evidence was received from the respondent and admitted as Respondent's Composite Exhibit 3.

FINDINGS OF FACT

1. The petitioner (age 51) is a Florida Medicaid recipient. She is enrolled with Sunshine Health HMO.

2. In late 2013, the petitioner's dentist, Dr. Jon Baumbauer, requested prior authorization from MCNA to remove all of her remaining teeth, several dental procedures, and a full set of dentures.

3. In notices dated December 13, 2013, MCNA informed the petitioner that her request was approved in part and denied in part. The notice reads in relevant part:

After review of the information received, the request was partially approved for the dental services listed below:

Tooth	Code	Description
	5120	COMPLETE DENTURE- MANDIBULAR
11	7140	EXTRACTION, ERUPTED TOOTH OR EXPOSED ROOT (ELEVATION AND/OR FORCEPTS REMOVAL)
27	7140	EXTRACTION, ERUPTED TOOTH OR EXPOSED ROOT (ELEVATION AND/OR FORCEPTS REMOVAL)
29	7140	EXTRACTION, ERUPTED TOOTH OR EXPOSED ROOT (ELEVATION AND/OR FORCEPTS REMOVAL)
30	7140	EXTRACTION, ERUPTED TOOTH OR EXPOSED ROOT (ELEVATION AND/OR FORCEPTS REMOVAL)

MCNA has not approved coverage for the following dental service(s)/treatment(s) that you or your dental provider requested:

Tooth	Code	Description
20	7310	ALVEOLOPLASTY IN CONJUNCTION WITH EXTRACTIONS – PER QUADRANT
10	7310	ALVEOLOPLASTY IN CONJUNCTION WITH EXTRACTIONS – PER QUADRANT
40	7310	ALVEOLOPLASTY IN CONJUNCTION WITH EXTRACTIONS – PER QUADRANT
30	7310	ALVEOLOPLASTY IN CONJUNCTION WITH EXTRACTIONS – PER QUADRANT

22	7210	SURGICAL REMOVAL OF ERUPTED TOOTH REQUIRING ELEVATION OF MUCOPERIOSTEAL FLAP AND REMOVAL OF BONE AND/OR SECTION OF TOOTH
	5110	COMPLETE DENTURE MAXILLARY

The dental service(s)/treatment(s) requested [above] are not approved because you have already reached your $300 limit for the year. Please see your member Handbook for a list of covered benefits.

...

Tooth	Code	Description
30	7210	SURGICAL REMOVAL OF ERUPTED TOOTH REQUIRING ELEVATION OF MUCOPERIOSTEAL FLAP AND REMOVAL OF CBONE AND/OR SECTION OF TOOTH
29	7250	SURGICAL REMOVAL OF RESIDUAL TOOTH ROOTS (CUTTING PROCEDURE)
27	7210	SURGICAL REMOVAL OF ERUPTED TOOTH REQUIRING ELEVATION OF MUCOPERIOSTEAL FLAP AND REMOVAL OF CBONE AND/OR SECTION OF TOOTH
11	7210	SURGICAL REMOVAL OF ERUPTED TOOTH REQUIRING ELEVATION OF MUCOPERIOSTEAL FLAP AND REMOVAL OF CBONE AND/OR SECTION OF TOOTH

The dental service(s)/treatment(s) requested [above] are not approved because the Clinical Reviewer has determined that another treatment will be as effective as the one your dentist asked for. The decision was based on the General Criteria as stated in MCNA's Utilization Review Guidelines.

4. The petitioner requested a hearing on January 6, 2014 to challenge the partial denial decision. The request for hearing reads in pertinent part: "I have gum disease. I am currently on antibiotics for the infectious gums. Heart disease runs in my family. I have been told by the dentist it does effect my heart..."

5. The respondent re-reviewed its decision in this matter, while preparing for the hearing, and partially overturned the previous denial. Respondent's Medicaid Fair Hearing Summary dated January 29, 2014 reads in pertinent part:

> After review by Sunshine Health's dental vendor Managed Care of North America (MCNA), the Clinical Dental Reviewer has partially overturned the denial per MCNA's Criteria for Oral and Maxillofacial Surgery and MCNA's Removable Prosthodontics Criteria...
>
> The Clinical Dental Reviewer states the following:
>
> All treatment medically necessary as recoded and approved on 12/3/2013 with the following exception: All D7310s are denied as I have determined that the treatment is in excess of the member's needs. The overturned services are approved beyond the yearly maximum.

6. The respondent reviewed its decision in this matter a second time and determined that the original December 2013 determination should be upheld. Respondent's Addendum to Medicaid Fair Hearing Summary dated February 17, 2014 reads in pertinent part:

> A second review was conducted 2/3/14 by Sunshine Health's dental vendor MCNA's Clinical Dental Reviewer and the decision to partially overturn the denial per MCNA's Criteria for Oral and Maxillofacial Surgery and MCNA's Removable Prosthodonitics Criteria is corrected. The service exceeds the yearly maximum and will not be approved. In addition, the member has also reached the $300.00 maximum allowed dental benefits. Therefore, the services requested are denied.

7. The reviewing clinician did not appear as a witness during the hearing. None of the respondent witnesses present could explain the medically necessary clinical review process. In the end, the respondent argued that the denied services were in excess of plan limitations. The respondent did not provide evidence of expenditures made on the petitioner's behalf.

8. Sunshine Health submitted an excerpt from its member Handbook; page 17 of the handbook addresses covered services and reads in pertinent part:

Benefits	Coverage	Area 4 Plan Limits/Copay
Dental Services	For ages 21 and older, includes diagnostic services and preventative care, surgical procedures and/or extractions, complete and partial dentures. Evaluations for adults are limited to determining the need for dentures and denture related procedures or for acute emergency services to alleviate pain and infection (AREA 4 ONLY)	$300/year $ copay

9. The petitioner has fewer than half her original teeth. There is a risk of the infection spreading to other parts of her body; a history of heart disease "runs" in the petitioner's family. Without the requested dental procedures, the petitioner fears her health is at risk

10. The petitioner did not have the approved dental procedures completed because she could not afford to pay out of pocket for the remaining procedures. All of the mouth preparation work must be completed before she is fitted for dentures.

CONCLUSIONS OF LAW

11. By agreement between the Agency for Health Care Administration (AHCA) and the Department of Children and Families, AHCA has conveyed jurisdiction to the Office of Appeal Hearings to conduct this hearing pursuant to §120.80 Fla. Stat.

12. Florida Medicaid State Plan is authorized by Chapter 409, Florida Statutes, and Chapter 59G, Florida Administrative Code. The program is administered by the Agency for Health Care Administration.

13. This hearing was held as a de novo proceeding pursuant to Fla. Admin. Code R. 65-2.056.

14. The burden of proof was assigned to the petitioner, per Fla. Admin. Code R. 65-2.060(1).

15. The standard of proof in this administrative hearing is "preponderance of the evidence," as provided by Fla. Admin. Code R. 65-2.060(1).

16. Fla. Admin. Code R. 59G-1.010 (155) states, "'Medicaid services' or 'Medicaid care' means medically necessary medical or allied institutional or noninstitutional care, goods, services, or procedures covered, and eligible for payment, by the Medicaid program. Also see 'Medically necessary.'"

17. This rule continues at paragraph (166) and defines Medically necessary as:

> 'Medically necessary' or 'medical necessity' means that the medical or allied care, goods, or services furnished or ordered must:
> (a) Meet the following conditions:
> 1. Be necessary to protect life, to prevent significant illness or significant disability or to alleviate severe pain;
> 2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patent's needs;
> 3. Be consistent with generally accepted professional medical standards as defined by the Medicaid program and not be experimental or investigational;
> 4. Be reflective of the level of service that can safely be furnished, for which no equally effective and more conservative or less costly treatment is available statewide; and,
> 5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider. . .

> (c) 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.

18. The Florida Medicaid Provider General Handbook (Provider Handbook) – July 2008 is incorporated by reference in the Medicaid Services Rules found in Fla. Admin. Code R. 59G-4. In accordance with the Florida law, the Handbook discusses HMO Coverage, stating on page 1-28:

> Medicaid contracts with Health Maintenance Organizations (HMOs) to provide prepaid, comprehensive, cost-effective medical services to enrolled Medicaid recipients.
>
> Medicaid pays each HMO a monthly capitation fee for managing and providing care to each enrolled recipient. In accordance with certain contractual agreements with Medicaid, the HMO provides a specified, comprehensive package of medical services for this monthly Medicaid fee.
>
> Medicaid HMOs are also required to provide quality and benefit enhancements and can provide other expanded benefits as described in this section.

19. Page 1-31 of the Provider Handbook states: "An HMO's services <u>cannot be more restrictive</u> than those provided under Medicaid fee-for-service," (emphasis added).

20. The Florida Medicaid Dental Services Coverage and Limitations Handbook (Dental Handbook) – November 2011 is incorporated by reference into Fla. Admin. Code R. 59G-4.060.

21. The Dental Handbook addresses adult dental services on page 1-2:

> The adult Medicaid dental services program provides medically-necessary, emergency dental procedures to alleviate pain or infection to

eligible Medicaid recipients age 21 and older. Emergency dental care for recipients 21 years of age and older is limited to a problem focused oral evaluation, necessary radiographs in order to make a diagnosis, extractions, and incision and drainage of an abscess. Full and removable partial dentures and denture-related services are also covered services of the adult dental program.

22. The Dental Handbook states on page 2-3:

Covered Child Services (Ages 21 and over)
The adult dental program provides for the reimbursement of full and removable partial dentures. Extractions and other surgical procedures essential to the preparation of the mouth for dentures are reimbursable if the patient is to receive dentures. Procedures relating to dentures such as repairs, relines and adjustments are reimbursable.

Medicaid will reimburse for medically-necessary emergency dental procedures to alleviate pain and or infection for eligible adult Medicaid recipients 21 years of age or older. Emergency dental care shall be limited to emergency problem-focused evaluations, necessary radiographs to make a diagnosis, extraction, and incision and drainage of abscess.

23. The petitioner suffers from gum disease and has fewer than half of her original teeth remaining. A history of heart disease runs in her family. The petitioner is concerned about infection spreading to her heart and causing serious medical complications. The petitioner's dentist has ordered that her remaining teeth be removed, surgical procedures are required, and she be fitted with a full set of dentures.

24. The respondent denied the petitioner's request in part. The respondent concluded that the petitioner had exceeded Sunshine Health's $300 yearly dental service limit and that some of the requested services were not medically necessary. However, the respondent did not provide evidence of the dental service expenditures or explanation of the medical necessity determination.

25. The Medicaid adult dental program provides for reimbursement of full dentures and removable partials. The program also provides for extractions and other surgical procedures necessary for the preparation of the mouth for dentures. The HMO dental plan can be no more restrictive, in service provision or service fee capitation, than fee-for-service Medicaid.

26. After carefully reviewing the evidence and controlling legal authorities, the undersigned concludes that the petitioner met her burden of proof in this matter. The respondent erred in its partial denial decision.

DECISION

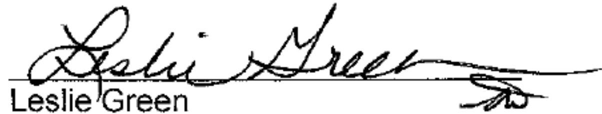
Petitioner's appeal is GRANTED. The respondent is hereby ORDERED to approve all extractions and procedures essential to the preparation of the petitioner's mouth for dentures.

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the agency. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Agency Clerk, Agency for Health Care Administration, 2727 Mahan Drive, Tallahassee, FL 32308-5403. The petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The petitioner is responsible for any financial obligations incurred as the agency has no funds to assist in this review.

DONE and ORDERED this 2nd day of April, 2014,

in Tallahassee, Florida.



Leslie Green
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
Fax: 850-487-0662
Email: Appeal_Hearings@dcf.state.fl.us

Copies Furnished To: [redacted], Petitioner
Lisa Broward, Area 4, AHCA Field Office Manager