

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

FILED

JAN 26 2015

OFFICE OF APPEAL HEARINGS
DEPT. OF CHILDREN & FAMILIES

[REDACTED]
APPEAL NO. 14F-08646

PETITIONER,

Vs.

CASE NO. [REDACTED]

AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 17 Broward
UNIT: 88136

RESPONDENT.

FINAL ORDER

Pursuant to notice, the undersigned hearing officer convened an administrative hearing in the above-referenced matter telephonically on December 2, 2014, at 10:55 a.m.

APPEARANCES

For the Petitioner:

[REDACTED]

For the Respondent:

Carol King, R.N.
Registered Nurse Specialist/Fair Hearing Coordinator
Agency for Health Care Administration

STATEMENT OF ISSUE

The issue is whether the petitioner's Medicaid health maintenance organization correctly denied a portion of the petitioner's request for dental work, including dental crowns and moldings.

PRELIMINARY STATEMENT

[REDACTED] ("petitioner"), the petitioner, appeared on her own behalf. Carol King, R.N., Registered Nurse Specialist and Fair Hearing Coordinator for the Agency for Health Care Administration, appeared on behalf of the Agency for Health Care Administration (sometimes hereinafter referred to as "AHCA" or the "Agency"). Sharon Garrison, R.N., also a Registered Nurse Specialist and Fair Hearing Coordinator with the Agency for Health Care Administration, was present solely for observation. The following individuals appeared as witnesses on behalf of the Agency: Mindy Aikman, Grievance and Appeals Specialist with Humana; Frank Manteiga, D.M.D., Florida Dental Director of DentaQuest; and Bibi De La Cruz, Complaints and Grievance Specialist with DentaQuest. Keren Curnutt, Grievance and Appeals Specialist with Humana, was present for observation.

The respondent introduced Exhibits "1" through "7", inclusive, at the hearing, all of which were accepted into evidence and marked accordingly. The hearing record was left open until the close of business on the day of the hearing for the respondent to provide additional documents. Once received, this information was accepted into evidence and marked as respondent's Exhibit "8". The hearing record was then closed.

FINDINGS OF FACT

Based on the oral and documentary evidence presented at the final hearing and on the entire record of this proceeding, the following Findings of Fact are made:

1. The petitioner is a 47-year-old female.
2. The petitioner was eligible to receive Medicaid at all times relevant to this proceeding.

3. Petitioner is enrolled in Humana Florida Medicaid Plan. Humana is a health maintenance organization ("HMO") which is contracted by the Agency for Health Care Administration, the respondent, to provide services to certain Medicaid eligible persons in the State of Florida.

4. Petitioner was enrolled in Humana effective July 1, 2014.

5. DentaQuest is the dental provider for the Humana Florida Medicaid Plan.

6. On August 25, 2014, the DentaQuest Authorization Department received a pre-authorization request from the petitioner's dental provider.

7. DentaQuest denied the following services on August 27, 2014:

D2950 Crown buildup including any pins when required, tooth 22;
D2750 Crown, porcelain fused to high noble metal, tooth 22;
D3320 Endodontic therapy, bicuspid tooth (excluding final restoration),
Tooth 29;
D2950 Core buildup, including any pins when required, tooth 29;
D2750 Crown, porcelain fused to high noble metal, tooth 29;
D2950 Core buildup, including any pins when required, tooth 5;
D2750 Crown, porcelain fused to high noble metal, tooth 5; and
D3320 Endodontic therapy, bicuspid tooth (excluding final restoration),
Tooth 5.

The denial reason for each of the services rejected was the same: "This is not a covered service."

8. DentaQuest mailed a letter to the petitioner on August 29, 2014 advising her of its decision to deny the above services.

9. The petitioner sent a letter dated September 30, 2014 to DentaQuest asking that DentaQuest reconsider its decision to deny the requested services.

10. Petitioner's request for reconsideration was reviewed by a DentaQuest Dental Consultant. The Dental Consultant upheld the denial of services on November

11, 2014 explaining: "This type of service is not covered under the member's plan, therefore, the denial is upheld."

11. The petitioner subsequently requested a fair hearing and this proceeding ensued.

CONCLUSIONS OF LAW

12. By agreement between the Agency for Health Care Administration 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.

13. This is a final order pursuant to § 120.569 and § 120.57, Fla. Stat.

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

15. The petitioner in the instant matter is requesting a new or additional service. Therefore, in accordance with Fla. Admin. Code R. 65-2.060 (1), the burden of proof is assigned to the petitioner.

16. The standard of proof in an administrative hearing is by a preponderance of the evidence. (See Fla. Admin. Code R. 65-2060(1).) The preponderance of the evidence standard requires proof by "the greater weight of the evidence," (Black's Law Dictionary at 1201, 7th Ed.).

17. The Florida Medicaid program is authorized by Fla. Stat. ch 409 and Fla. Admin. Code R. 59G. The Medicaid program is administered by the respondent.

18. Fla. Admin. Code R. 59G-1.010(166) explains that medical or allied care, goods, or services furnished or ordered must meet the definition of medically necessary or medical necessity, and defines medical necessity as:

(a) "Medical necessary" or "medical necessity" means that medical or allied care, goods or services furnished or ordered must 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 patient'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.

19. Section 409.912, Fla. Stat. states, in relevant parts:

Cost-effective purchasing of health care.—The agency shall purchase goods and services for Medicaid recipients in the most cost-effective manner consistent with the delivery of quality medical care ...

(3) The agency may contract with health maintenance organizations certified pursuant to part I of chapter 641 for the provision of services to recipients. This subsection expires October 1, 2014.

20. The Florida Medicaid Provider General Handbook – July 2012 is

incorporated by reference in the Medicaid Services Rules found in Fla. Admin. Code

Chapter 59G-4. In accordance with the above Statute, the Handbook states on page 1-

27:

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.

21. Page 1-30 of the Florida Medicaid Provider General Handbook states: "An HMO's services cannot be more restrictive than those provided under Medicaid fee-for-service."

22. Pages 1-28 and 1-29 of the Florida Medicaid Provider General Handbook provide a list of HMO covered services. Although these services do not include adult dental services, an HMO may opt to offer dental services to its members.

23. Page 1-30 of the Florida Medicaid Provider General Handbook, Optional Services, explains: "Other services that plans may provide include dental services, transportation, nursing facility and home and community-based services. Plans may also provide services under their contracts that Medicaid does not cover, such as over-the-counter drugs."

24. If an HMO chooses to offer dental services, these services must comply with the dental policy of the Agency for Health Care Administration.

25. The Agency's dental policy is set forth in the Dental Services Coverage and Limitations Handbook – November, 2011, which is promulgated into rule by Chapter 59G, Fla. Admin Code.

26. Humana's dental policy is contained on Page 31 of the Humana Member Handbook. It states as follows:

Full dental services are covered for members age 20 and below.

All members are covered for denture and denture-related services and oral and maxillofacial surgery services for all members.

For members age 21 and older, the plan covers:

- Emergency dental services
- One (1) basic exam every six (6) months
- One (1) X-ray per year
- One (1) cleaning every six (6) months
- One (1) fluoride treatment every six (6) months
- One (1) periodontal Treatment every three (3) years

27. Humana dental policy is similar the dental policy of the Agency for Health Care Administration.

28. Page 2-8 of the Dental Services Coverage and Limitations Handbook – November, 2011 explains that endodontic services are only reimbursed for Medicaid eligible recipients under age 21.

29. Page 2-35 of the Dental Services Coverage and Limitations Handbook – November, 2011 states that Medicaid will not reimburse for crowns provided solely for aesthetic reasons.

30. Although not specifically addressed in the Dental Services Coverage and Limitations Handbook – November, 2011, a core buildup is only performed in conjunction with either a root canal or crown moldings. Since neither of these services was approved for the petitioner, a core buildup cannot be approved.

31. The respondent did not improperly deny the petitioner's pre-authorization request for crowns, moldings, core building, and endodontic therapy.

32. The petitioner has not met her burden of proof that the respondent has failed to approve any medically necessary services.

33. This Final Order does not purport to say that the petitioner is not in need of the dental services requested; only that the services requested are not covered by the petitioner's dental plan.

DECISION

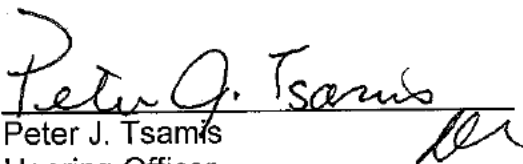
Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is DENIED.

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 26th day of January, 2015,

in Tallahassee, Florida.



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