

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

**FILED**

FEB 20 2015

OFFICE OF APPEAL HEARINGS  
DEPT OF CHILDREN & FAMILIES



APPEAL NO. 14F-09536

PETITIONER,

Vs.

CASE NO.

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

RESPONDENT.

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**AMENDED FINAL ORDER**

Pursuant to notice, the undersigned hearing officer convened an administrative hearing telephonically in the above-referenced matter on December 8, 2014, at 10:50 a.m.

**APPEARANCES**

For the Petitioner:

Petitioner

For the Respondent:


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

**STATEMENT OF ISSUE**

The petitioner is requesting reimbursement of dental expenses incurred on May 16, 2011 and June 9, 2011.

**PRELIMINARY STATEMENT**

This Amended Final Order is being entered to correct a Scrivener's error in Paragraphs 9 and 10 of the Findings of Fact found on Page 4 of the Final Order entered in this matter on February 2, 2015.

 "petitioner"), the petitioner appeared on his own behalf. Carol King, R.N., Registered Nurse Specialist and Fair Hearing Coordinator with the Agency for Health Care Administration, appeared on behalf of the Agency for Health Care Administration, which may sometimes hereinafter be 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 the purpose of observation. The following individuals appeared as witnesses on behalf of the Agency for Health Care Administration: Paula Daley, Appeals and Grievance Coordinator at Sunshine Health; Donna Laber, Appeals and Grievance Manager at Sunshine Health; and Elizabeth Douglas, Economic Self-Sufficiency Supervisor at the Florida Department of Children and Families.

The petitioner introduced Exhibits "1" through "3", inclusive, at the hearing, all of which were accepted into evidence and marked accordingly. The respondent introduced Exhibit "1", inclusive, which was also accepted into evidence and marked accordingly. The hearing record in this matter was left open until the close of business on the day of the hearing for the respondent to provide Medicaid policy regarding the time limits for submitting claims. Once received, this information was accepted into evidence and marked as respondent's Exhibit "2". 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 an adult male. He resides in Broward County, Florida.
2. The petitioner was approved for Medicaid and enrolled in the Sunshine State Health Plan through March 31, 2011. Sunshine State Health Plan was a health maintenance organization contracted by the Agency for Health Care Administration to provide services to certain Medicaid eligible individuals in Broward County. The petitioner's Medicaid ended on March 31, 2011.
3. On or about July 13, 2011, the petitioner was approved for Medicaid for the period April 1, 2011 through July 31, 2011 and enrolled in the Medicaid State Plan. The petitioner did not realize that his Medicaid coverage had been reinstated until the latter part of July 2011.
4. The petitioner incurred charges for dental services on May 16, 2011 and June 9, 2011.
5. Although petitioner was not eligible for Medicaid at the time these charges were incurred, he later became eligible for retroactive coverage during this period.
6. The petitioner testified that, after he discovered his Medicaid coverage had been reinstated in July 2011, he verbally requested reimbursement of the charges associated with his dental visits on May 16, 2011 and June 9, 2011. He also testified he received a telephone call at that time advising him that he would not be reimbursed.
7. The petitioner first submitted a copy of the bills associated with the dental services performed in 2011 to the Agency for Health Care Administration in November

2014. Petitioner's request for reimbursement was received by the Agency on December 1, 2014.

8. The petitioner is requesting that the Agency for Health Care Administration reimburse him for the dental charges he incurred in 2011.

9. The petitioner is seeking reimbursement for services he received while he was covered by the Medicaid State Plan. The respondent asserted the dental services received by the petitioner were not services that were allowable under the Medicaid State Plan.

10. The dental services the petitioner received in May and June 2011 may have been covered by the Sunshine State Health Plan (Petitioner's Exhibit 2). However, the petitioner was not enrolled in the Sunshine State Health Plan at the time the dental services were rendered.

#### **CONCLUSIONS OF LAW**

11. 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.

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

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

14. The petitioner in the present case is requesting reimbursement for a new service. Therefore, in accordance with Fla. Admin. Code R. 65-2.060(1), the burden of proof is assigned to the petitioner.

15. 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, 7<sup>th</sup> Ed.).

16. For dental services to be approved, the services requested must be determined to be medically necessary and meet any additional requirements set forth in the Dental Services Coverage and Limitations Handbook (November 2011).

17. The definition of medically necessary is found in the Fla. Admin Code. R. 59G-1.010 and states:

(166) '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 patient's needs;
3. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;
4. 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; 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 Dental Services Coverage and Limitations Handbook is promulgated into rule by Fla. Admin. Code R. 59G-4.060.

19. The Dental Services Coverage and Limitations Handbook, on Page 2-3, addresses covered services for adults ages 21 and over and states as follows:

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.

20. The dental services secured by the petitioner in 2011 do not fall within the parameters of covered services for adults ages 21 and over as set forth in the Dental Services Coverage and Limitations Handbook.

21. The Dental General Fee Schedule effective January 1, 2011 is promulgated into rule by Fla. Admin. Code. R. 59G-4.002. The Schedule was introduced and accepted into evidence as respondent's Exhibit "1".

22. The services secured by the petitioner in 2011 do not appear on the Dental General Fee Schedule as reimbursable services.

23. Pursuant to the testimony and evidence presented in this matter, the petitioner is not eligible for reimbursement of his dental services secured on May 16, 2011 and June 9, 2011. Therefore, the petitioner has not met his burden of proof that the Agency for Health Care Administration incorrectly denied his request for reimbursement.

### **DECISION**

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

### **NOTICE OF RIGHT TO APPEAL**

FINAL ORDER (Cont.)

14F-09536

PAGE - 7

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 20<sup>th</sup> day of February, 2015,

in Tallahassee, Florida.

*Peter Tsamis*

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