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

[redacted]

APPEAL NO. 14F-10495

PETITIONER,

Vs.

CASE NO.

AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 11 Dade
UNIT: AHCA

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on January 29, 2015, at 1:00 p.m.

APPEARANCES

For the Petitioner: [redacted] Pro se.

For the Respondent: Dianna Chirino, Senior Program Specialist, Agency for Health Care Administration (AHCA).

STATEMENT OF ISSUE

At issue is the Agency action through United Health Care to deny the petitioner's request for crowns and/or dentures, as dental procedures.

PRELIMINARY STATEMENT

Present as witnesses for the respondent were Susan Frischman, Senior Compliance Analyst and Debra Bond, Director of Client Operations for Government Dental Programs, both from United Health Care.

The respondent submitted into evidence, Respondent Exhibit 1.

FINDINGS OF FACT

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

1. The petitioner lives in Miami-Dade County, Florida and is a Medicaid recipient. She is enrolled in the Medicaid MMA (Managed Medical Assistance) Program with United Health Care (UHC or Plan). United Health Care is a Managed Care Organization that has been authorized by AHCA to make prior service authorization decisions for individuals enrolled in Medicaid MMA Programs, including requests for dental care.

2. In November 2014, the petitioner was seen by a United Health Care authorized dentist in the Miami area. This dentist had taken X-rays of the petitioner's teeth and submitted a prior authorization request to United Health Care for dental procedures. In the meantime, the petitioner switched to another United Health Care authorized dentist based on the distance she had to travel, the fact that this dentist made her wait all day to get information about the prior authorization request, and the fact that staff at the dental office spoke little English.. She went to her appointment with the new dentist.

3. She indicated that she also had problems with this next dentist as they wanted to take their own X-rays, charge her for services, and this dental location was also too far a distance for her to travel. She indicated that she changed to another United Health Care authorized dentist (the third dentist) whose office is closer to her residence. She indicated that she has an appointment with the new dentist in early February 2015.

4. The petitioner has requested, from what she understands she needs as dental procedures from the dentist, both crowns and dentures. The respondent witness indicated no medical necessity decision for the dental requests were made by United Health Care because the X-rays sent to United Health Care were poorly made and unable to be read; the petitioner has changed dentists; and the first dentist sent in requests for crowns that were not covered under the Plan. As a result, a denial letter was sent by United Health Care to the petitioner for the various dental procedures and items.

5. This notice was mailed to the petitioner on November 20, 2014 indicating:

Upper false teeth; reason code 178

Lower false teeth; reason code 179

Code 178 and 179; The request is denied for incomplete information. All request must be accompanied by full mouth or panorex x-rays...

Crown; reason code 115

Code 115; This service is not covered under the members benefit package.

The petitioner requested this hearing based on the above.

6. The respondent witness, Debra Bond, indicated and requested that since the petitioner was going to see the new dentist for the February 2015 appointment, she should provide the name and address of this dentist to her. She indicated that the Plan will contact this dentist and advise him of the petitioner's situation, advise him to take new X-rays of the petitioner's teeth and advise him of the correct "codes" to make the appropriate request for the procedures. After this is done, then United Health Care will make a medical necessity decision for the dental requests. This witness indicated that United Health Care had attempted and is attempting to resolve this matter with the petitioner.

7. The petitioner provided on record, the name and address of the "new" dentist. However, she argued that she is very upset about having to go through all of these situations and processes in order to receive her needed dental items.

CONCLUSIONS OF LAW

8. The Department of Children and Families, Office of Appeal Hearings has jurisdiction over the subject matter of this proceeding and the parties, pursuant to § 409.285, Fla. Stat. This order is the final administrative decision of the Department of Children and Families under § 409.285, Fla. Stat.

9. This proceeding is a de novo proceeding pursuant to Fla. Admin. Code R. 65-2.056.

10. In accordance with Fla. Admin. Code R. 65-2.060 (1), the burden of proof was assigned to the petitioner.

11. The Dental Services Coverage and Limitation Handbook, which has been incorporated by reference into Chapter 59G-4, Fla. Admin. Code, page 1-2 (November 2011) states:

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.

12. Fla. Admin. Code 59G-1.010 states in part:

> (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;
> 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...

13. For the case at hand, United Health Care properly denied the dental procedures requested based on receiving unreadable X-rays of the petitioner's teeth and the dentist entering codes for dental items not covered under the Plan,. The witness from United Health Care indicated they would work with the petitioner's new dentist in order to receive all of the necessary dental information and then make a medical necessity decision. After this is done, the Plan would send another notice to the petitioner. If the petitioner disagrees with this new decision, she could request another hearing.

14. After considering the evidence and all of the appropriate authorities set forth in the findings above, the hearing officer concludes that the petitioner has not met her burden of proof and the Agency action to deny the petitioner's request for the dental procedures is correct.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, this appeal is denied and the Agency action affirmed.

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 4th day of March, 2015,

in Tallahassee, Florida.

Robert Akel

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Copies Furnished To: [redacted] Petitioner
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