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

FILED
MAY 05 2015
OFFICE OF APPEAL HEARINGS
DEPT OF CHILDREN & FAMILIES

[redacted]

APPEAL NO. 15F-00633

PETITIONER,

vs.

AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 13 Hillsborough
UNIT: AHCA

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, Hearing Officer Patricia Antonucci convened this matter for administrative hearing in Tampa, Florida on March 6, 2015 at approximately 2:30 p.m.

APPEARANCES

For the Petitioner: [redacted] Petitioner's Guardian Advocate

For the Respondent: David Beaven, Medical Health Care Program Analyst
Agency for Health Care Administration

STATEMENT OF ISSUE

At issue is whether it was proper for Respondent, the Agency for Health Care Administration, to deny Petitioner's request for reimbursement of dental expenses, which she paid to an out of network provider. Petitioner bears the burden of proving, by a preponderance of the evidence, that her out-of-pocket payment should be reimbursed.

PRELIMINARY STATEMENT

The Office of Appeal Hearings received Petitioner's hearing request on or about January 14, 2015. On March 6, 2015, hearing convened in Tampa, Florida, with Petitioner represented by her Guardian Advocate (GA), [redacted] Mr. [redacted] did not present any additional witnesses on Petitioner's behalf. Respondent, the Agency for Health Care Administration (AHCA) was represented by AHCA Medical Health Care Program Analyst, David Beaven. Mr. Beaven presented one additional witness, from AHCA's contracted managed care plan, Humana Florida Medicaid: Mindy Aikman, Humana Grievance and Appeals Specialist. Donna Cheeks, Front Line Lead with Humana, appeared as an observer.

Petitioner's Exhibits 1 and 2 and Respondent's Exhibits 1 through 9, inclusive, were accepted into evidence. Following testimony, the record was held open so that both parties could supplement the record with additional documentation. Said documentation was timely received and copied to the opposing party, and has been entered as follows:

- Petitioner's Exhibit 3: E-mail correspondence between Mr. [redacted] and Beth Kidder at AHCA, dated August 5, 2014 (3 pages);
- Petitioner's Exhibit 4: E-mail from Mr. [redacted] to Ms. Kidder, dated August 5, 2014 (1 page);
- Petitioner's Exhibit 5: March 13, 2015 e-mail response to Respondent's supplemental evidence (1 page);
- Petitioners Exhibit 6: March 16, 2015 e-mail response to Respondent's second packet of supplemental evidence (1 page);

- Petitioner's Exhibit 7: March 16, 2015 e-mail confirmation that Petitioner's responses were copied to Respondent (1 page).

Also entered into evidence was:

- Respondent's Exhibit 10: March 10, 2015 cover letter from David Beaven (p. 2);

- Respondent's Exhibit 11: Screen shot of Petitioner's health maintenance organization (HMO) eligibility (p. 3);

- Respondent's Exhibit 12: Portions of AHCA's model contract agreement, effective January 1, 2015 (p. 6-13);

- Respondent's Exhibit 13: Humana's phone call history, pertaining to Petitioner's account, August 6, 2014 through September 4, 2014 (p. 2-8);

- Respondent's Exhibit 14: Internal correspondence regarding Humana's Critical Inquiry review, dated September 8, 2014 (p. 9-11);

- Respondent's Exhibit 15: Office notes from Dr. Renato Aves, DDS, office visits July 1, 2014 and August 26, 2014 (p. 12);

- Respondent's Exhibit 16: January 6, 2015 DentaQuest letter of determination claim, including appeal rights (p. 13-16).

No further documentation was received from either party, and the record in this matter closed on March 24, 2015.

FINDINGS OF FACT

1. Petitioner is a 33-year-old female, born [redacted] who resides in Tampa, Florida. She has a developmental disability, and is assisted with health care matters by her Guardian Advocate (GA).

2. Petitioner is enrolled in Medicaid under a managed care/health maintenance organization (HMO) plan, contracted by AHCA. She was previously enrolled with

AmeriGroup, but became a member of Humana's Florida Medicaid Plan (Humana), effective August 1, 2014. Both AmeriGroup and Humana subcontract with DentaQuest to provide their members with enhanced adult dental services, in excess of the dental care formerly provided under fee-for-service Medicaid.

3. While still with AmeriGroup, Petitioner encountered difficulty in obtaining services from some DentaQuest providers. Per her GA, some dentists did not want to accept Medicaid patients, some would not see adults, and one provider did not want to treat a patient with developmental disabilities.

4. On August 5, 2015, Petitioners GA contacted Beth Kidder, Assistant Deputy Secretary for Medication Operations with AHCA, stating that he made an appointment with an out-of-network (OON) dentist to have Petitioner's cavities filled. In a series of e-mails that same date (August 5th), the GA told Ms. Kidder that AHCA was supposed to schedule Petitioner to have her teeth pulled August 4th or 5th, and if AHCA did not have a provider selected for her by August 6th, he would take Petitioner to a dentist of his choosing. The GA stated Petitioner "has been waiting for 3 months to have her cavities drilled out. She cannot wait any longer." He further noted that AHCA had "dropped the ball" by not asking Humana to approve an OON dentist.

5. In response to this correspondence, Ms. Kidder informed the GA:

> My understanding was that you were asking us to assist in getting you a Humana contact so that you could get her into a Humana network dentist or a Humana-approved out of network dentist for extractions prior to the appointment with Dr. Moreham. (You indicated Dr. Moreham would not do filings until the needed extractions were complete.)
>
> ...
>
> As always, if you use a provider that is out of network without the authorization of your managed care plan, the managed care plan is not obligated to pay the

provider, and Medicaid will not reimburse you for any payments you make to the provider.

Ms. Kidder also provided the GA with a direct contact at Humana, to assist in finding an in-network dentist.

6. Case notes from Humana document correspondence between Petitioner's Humana caseworkers and Petitioner's GA. On August 6, 2014, Humana provided to the GA the name of one dentist within Petitioner's residential zip code, and an additional dentist in the Tampa area. Later that same date, Humana contacted Petitioner's GA with names of two other in-network providers.

7. The GA informed Humana that Petitioner had previously attempted to see these dentists while enrolled with AmeriGroup, but had been told she required extractions before cavities could be filled, had been turned away for various reasons and/or had been told not to return after the dental offices got into arguments with the GA. He noted that he was with Petitioner at a no-participating dentist's office that date (August 6th) to have fillings completed. He also stated Petitioner would be returning for additional fillings, and that he would send the bill to AmeriGroup and/or Humana for reimbursement. Petitioner's case manager noted that she was not sure how this would work with an OON provider, but that she would follow up on the matter once the bills were received.

8. On August 27, 2014, the GA submitted an ADA Dental Claim Form and receipts for Petitioner's (paid) bills from August 6 and 12, 2014. Services rendered on these dates include 8 fillings and one pulp-cap/deep medicated filling (D3120) plus final

restoration filling (D2392) of tooth 29, at a total cost of $2,005.00. No separate exam/evaluation fee is noted.

9. Humana forwarded the receipts and Claim Form to its dental plan, DentaQuest. Via internal e-mails, Katrina Knight-Vera, Director of Medicaid Provider Relations with DentaQuest, informed Humana of Petitioner's history, including DentaQuest's attempts to schedule appointments with "at least 10 participating dentists in the member's area." In conclusion, DentaQuest noted that Petitioner's GA "is requesting reimbursement for services rendered on 08/06/14 at a non-par office which he had no authorization from AMGP, Humana nor DQ to [see]. Therefore, DQ has denied the request. [GA] took the member on his own when DQ clearly had participating providers who were willing to treat the member."

10. On September 8, 2014, an internal e-mail from Humana's Critical Inquiry Unit noted, in part:

> I contacted [GA] on September 8, 2014 and provided the above resolution... I provided [the GA] with his appeal rights and apologized for any inconvenience this may have caused.

11. By letter dated January 6, 2015, DentaQuest provided Petitioner with written notification of its decision. Under 'Reason for Denial' and "Clinical Guidelines/Criteria,' DentaQuest noted, "Services provided by an Out-of-Network or Non-contracted provider are not provided under this benefit program."

12. At hearing, Humana testified that OON providers can only be used during a continuation of care period (Humana Member Handbook page 14 & 15), in an emergency (Humana Member Handbook page 14), or by prior authorization when the

plan cannot find an in-network provider. Humana contends that it *was* able to find Petitioner in-network providers, but that her GA did not want to utilize same. Since Petitioner became a Humana member on August 1, 2014 and first saw the dentist for fillings on August 6, 2014, Humana contends that continuation of care does not apply.

13. With regard to emergencies, Humana contacted DentaQuest's Dental Director, Daniel Dorrego, DDS, to conduct a pre-hearing review of Petitioner's reimbursement request. Humana testified that DentaQuest reviewed the submitted ADA Dental Claim Form and the receipts, before notifying Humana in writing:

> Appeal denied, services were provided by an out of network provider. There is no indication that these services were an emergency situation. Due to the length of time involved in getting treatment for the member by her guardian, could have lead [*sic*] to an emergency in one or two teeth, but not all at the same time as indicated by the claim submitted by the treating dentist. DentaQuest providers were available to the member but were not used.

14. No one from DentaQuest appeared at hearing to provide testimony or to corroborate this denial, and Humana was not able to explain whether the plan utilized a specific definition of "emergency" in conducting its review.

15. It is Petitioner's contention that, regardless of emergency, Humana is required to authorize reimbursement for an OON provider if it is unable to find an in-network provider to meet Petitioner's needs. Petitioner's GA states that he had been speaking to Humana about finding a provider since July of 2014, but that Humana omitted these case notes of their original correspondence. He does not dispute that the August 6 and August 12, 2014 do not fall under continuity of care, but he contends that without the pulp cap, Petitioner was in jeopardy of losing her tooth (tooth 29), and thus, the

procedure constitutes an emergency. He requests reimbursement equal to what AHCA/Humana would have paid, had Petitioner visited a participating dentist.

PRINCIPLES OF LAW AND ANALYSIS

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

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

18. In accordance with Fla. Admin. Code R. 65-2.060 (1), the burden of proof is assigned to Petitioner, who seeks reimbursement for a paid medical bill.

19. With regard to the administration of Medicaid services, Fla. Stat. § 409.902, states, in part:

> (1) The Agency for Health Care Administration is designated as the single state agency authorized to make payments for medical assistance and related services under Title XIX of the Social Security Act. These payments shall be made...only on behalf of eligible individuals, and shall be made only to qualified providers in accordance with federal requirements for Title XIX of the Social Security Act and the provisions of state law.
>
> (2)(b) State funds may not be used to provide medical services to individuals who do not meet the requirements of this subsection unless the services are necessary to treat an emergency medical condition or are for pregnant women. Such services are authorized only to the extent provided under federal law and in accordance with federal regulations as provided in 42 C.F.R. s. 440.255. (emphasis added)

20. Fla. Stat. § 409.973(1)(e) requires that managed care Medicaid plans provide dental services to their members.

Out-of-Network Providers for Non-Emergency Services

21. With regard to "qualified providers," per page 15 of Humana's Member Handbook, members are informed:

> • You must get your care from providers or facilities in network except in an emergency or during the Continuity of Care period…
> • If you use doctors or hospitals that are not in the Humana Family Network, or have not been approved by your PCP, you may have to pay the bill unless you are in a Continuity of Care.

22. The model contract between managed care plans and AHCA specifies, at Section 3(a & b), Attachment II, Exhibit II-A, page 83, that the plan:

> …shall enter into provider contracts with a sufficient number of Primary Dental Providers (PDPs) providing dental services to ensure adequate accessibility for enrollees of all ages… [defined as] At least one (1) FTE PDP per service area including, but not limited to…[a] general dentist."

23. At page 84, Section 3(c), the contract sets out time periods within which the plan must ensure provision to members of PDP services and referrals:

> Urgent Care – within one (1) day;
> Routine Sick Patient Care – within one (1) week;
> Well Care Visit – within one (1) month; and
> Follow-up dental services – within one (1) month after assessment.

24. Page 85, Section 4(d) notes, "The Managed Care Plan shall determine when exceptional referrals to non-participating specialty-qualified providers are needed to address any unique dental needs of an enrollee… Financial arrangements for the provision of such services shall be agreed prior to the provision of services."

25. The undersigned concludes that Humana, through DentaQuest, has secured sufficient providers within Petitioner's geographic location, and referred at least four of them to Petitioner. While it is noted that some providers did not want to treat Petitioner,

Petitioner has not shown that she exhausted all local providers within Humana/DentaQuest's network.

26. Humana documented its attempts to secure an in-network provider, beginning with the case manager's contact to Petitioner's GA on August 5, 2014. While Petitioner had previously received coverage under DentaQuest, she only became a member of Humana on August 1, 2014. The record reflects that Humana began diligent attempts to find a provider for Petitioner within one week of enrollment, but that these attempts were rejected by Petitioner and/or her GA. Only the time period for securing urgent care (i.e., one day) is definitively outside the time frame within which a plan must facilitate provider care.

Out-of-Network Provider for Emergency Services

27. Emergency services are defined under 42 U.S.C. 1396u–2 § 1932(b), which also sets forth the requirement that Medicaid cover same:

> (2) Assuring coverage to emergency services.—
> (C) Emergency medical condition defined.—In subparagraph (B)(ii), the term "emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in—
>
> (i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,
>
> (ii) serious impairment to bodily functions, or
>
> (iii) serious dysfunction of any bodily organ or part.

28. Petitioner contends that provision of a pulp cap/deep medicated filling was an emergency procedure, insofar as it was needed to prevent loss of Petitioner's tooth.

Absent evidence to the contrary, the undersigned finds that a "prudent layperson" would correctly conclude loss of the tooth to constitute "serious dysfunction" of that tooth, thus warranting immediate, emergency treatment. However, there is insufficient evidence to conclude that the remaining 9 fillings (including final restoration of tooth 29) were emergency procedures.

Reimbursement

29. In terms of emergency or urgent care, Fla. Stat § 409.967(2)(b) provides:

> Emergency services.—Managed care plans shall pay for services required by ss. 395.1041 and 401.45 and rendered by a noncontracted provider. The plans must comply with s. 641.3155. Reimbursement for services under this paragraph is the lesser of:
> 1. The provider's charges;
> 2. The usual and customary provider charges for similar services in the community where the services were provided;
> 3. The charge mutually agreed to by the entity and the provider within 60 days after submittal of the claim; or
> 4. The rate the agency would have paid on the most recent October 1st.

30. Per Fla. Admin. Code R. 59G-5.110(1)(a):

> The agency provides eligible individuals with access to Medicaid services and goods by direct payment to the Medicaid provider upon submission of a payable claim to the fiscal agent contractor....Direct payment may be made to a recipient who paid for medically necessary, Medicaid-covered services received from the beginning date of eligibility (including the three-month retroactive period) and paid for during the period of time between an erroneous denial or termination of Medicaid eligibility and a successful appeal or an agency determination in the recipient's favor. The services must have been covered by Medicaid at the time they were provided. Medicaid will send payment directly to the recipient upon submission of valid receipts to the Agency for Health Care Administration.... Any services or goods the recipient paid before receiving an erroneous determination or services for which reimbursement from a third party is available are not eligible for reimbursement to the recipient.
> (emphasis added)

31. The undersigned concludes that, in combination, Fla. Stat. § 409.902(2), Fla. Admin. Code R 59G-5.110, AHCA's Managed Care Contract, and Humana's Member

Handbook, do not provide for reimbursement of out-of-pocket expenses incurred for non-emergency services (9 fillings) rendered by a non-Medicaid provider. These authorities only provide for direct reimbursement based either on an emergency need or an incorrect denial/delay. As such, they do *not* expressly permit direct reimbursement where a Medicaid recipient incurs an out-of-pocket medical expense from a non-Medicaid provider during a period of Medicaid eligibility, particularly when the plan was making diligent efforts to find an in-network provider. Petitioner was a Medicaid recipient at the time she obtained the services, and was eligible for coverage, had she chosen a participating provider. Additionally, the record reflects that Petitioner's GA was cautioned on multiple occasions regarding the risk of refused reimbursement, if Petitioner chose to see an OON dentist.

32. As the pulp cap/deep medicated filling reasonably constitutes an emergency, the cost of that service should be reimbursed to Petitioner/Petitioner's GA. Petitioner has agreed to accept Medicaid's standard fee for services.

33. The Florida Medicaid Provider Reimbursement Schedule for dental procedures, specifically, the Dental General Fee Schedule, has been promulgated into law and incorporated by reference at Fla. Admin. Code R. 59G-4.002. Per the Fee Schedule, code D3120 for patients of any age is reimbursed to providers at the rate of $16.35. Humana has not provided a copy of its fee schedule. As such, to the extent that Humana and/or DentaQuest may have negotiated a higher rate for D3120, Petitioner must be reimbursed at that higher rate.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, Petitioner's appeal is DENIED with regard to reimbursement for 9 fillings and GRANTED with regard to the pulp cap/medicated filling. Respondent is instructed to reimburse Petitioner at no less than $16.35, in accordance with the appropriate fee schedule.

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 5th day of May, 2014, in Tallahassee, Florida.

Patricia C. Antonucci

Patricia C. Antonucci
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
Lorraine Campanaro, Area 6, AHCA Field Office Manager