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

FILED
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OFFICE OF APPEAL HEARINGS
DEPT OF CHILDREN & FAMILIES

[redacted]

PETITIONER,

vs.

AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 06 PINELLAS
UNIT: AHCA

RESPONDENT.
_____/

APPEAL NO. 15F-00817

FINAL ORDER

Pursuant to Notice of Rescheduling, this matter convened for hearing before Hearing Officer Patricia C. Antonucci on April 1, 2015 at approximately 10:00 a.m. All parties and witnesses appeared via teleconference.

APPEARANCES

For the Petitioner: [redacted] Petitioner

For the Respondent: Stephanie Lang, Registered Nurse Specialist, Agency for Health Care Administration

ISSUE ON APPEAL

At issue is whether it was proper for Respondent, the Agency for Health Care Administration (AHCA), through its contracted health maintenance organization (HMO), Molina Healthcare, to deny Petitioner's requests for services and, subsequently, for reimbursement. Petitioner bears the burden of proof, by a preponderance of the evidence. She seeks reimbursement of out-of-pocket expenses for a dental biopsy procedure, which she underwent after Molina denied prior authorization of same.

PRELIMINARY STATEMENT

Petitioner was present at hearing, and acted as her own representative. The Respondent was represented by Stephanie Lang, Registered Nurse Specialist with AHCA. Respondent presented one witness from Petitioner's former HMO, Molina Healthcare of Florida (Molina): Natalie Fernandez, Government Contract Specialist. Jacquelyn Salcedo and Dr. Daniel Dorrego, both from Molina's subcontracted dental plan, DentaQuest, appeared but did not provide testimony. Lou Esposito, AHCA Medical Health Care Analyst, observed the proceedings.

Petitioner's Exhibit 1 and Respondent's Exhibits 1 through 7, inclusive, were entered into evidence. All parties were advised that, although convening to obtain the facts of the case, the undersigned would have to review all testimony and documentation to determine whether she held jurisdiction over the issue(s) on appeal.

FINDING OF FACTS

1. The Petitioner was a member of Molina from January 1, 2012 through May 31, 2014.

2. On or about July 17, 2013, Petitioner's provider submitted a request to Molina/DentaQuest for procedure code D7286: biopsy of soft tissue.

3. Via letter dated July 19, 2013, Molina notified Petitioner that this request was denied because "This is not a covered service. Upon review by the DentaQuest Dental Director, there is no evidence to support the medical necessity of this service."

4. On August 13, 2013, Petitioner underwent the soft tissue biopsy. On the date of surgery, Petitioner signed an "Acknowledge of Disclosure and Acceptance of Member" form, provided by the treating dentist. Said form notes, in pertinent part:

> The Member or the Member's legal representative *hereby acknowledges that he or she has been informed that the following health care services to be provided to the Member have not been approved for payment under the Member's health benefit program.*
> Accordingly, *the undersigned agrees that the Member or Member's legal representative and not the applicable health benefit program will bear full financial responsibility for payment of all charges for these services.*
> (emphasis original)

Under the 'Financial Agreement Terms' portion of the form, the provider hand-wrote: "Pt knows responsible but will help her send to medical benefits. Minimum of $25.00 1st of month." The total cost of the procedure was $255.00.

5. At hearing, Petitioner testified that she realized she had made a mistake in agreeing to pay for the procedure when she had difficulty paying for other obligations, such as her utility bill, as a result of her payment agreement with the dental provider.

6. On or about October 20, 2014, Petitioner submitted to Molina a request for reimbursement of the biopsy expense, including an invoice reflecting her out-of-pocket payments.

7. By letter dated November 18, 2014, Molina notified Petitioner, in part:

> We are done reviewing your grievance we got on 10/20/2014. Your request was for reimbursement of dental services. It was reviewed and the decision was made by the Molina Healthcare of Florida Grievance and Appeals Coordinator. Our decision is to deny your request.
>
> The reason for our decision was based on the Molina Healthcare of Florida Member Handbook, which states under section *Services Not Covered By Molina:* "If you get services that are not covered or do not follow the rules in this Member Handbook, you may have to pay. Molina will not pay for things that are not covered by Medicaid."

8. On January 22, 2014, Petitioner requested a hearing to challenge Respondent's denials.

9. At hearing, Molina referenced its Adult Medicaid Benefit Schedule, which was in place at time Petitioner's request for the biopsy was denied. Said schedule does not include code D7286. Molina contends that if the procedure is not included on its benefit schedule, it is not a covered service.

10. Respondent, AHCA, confirmed that the service is also not covered under fee-for-service Medicaid.

PRINCIPLES OF LAW AND ANALYSIS

11. In order to determine jurisdiction over the various issues raised at hearing, the undersigned has reviewed the following legal authority.

12. Fla. Admin. Code 65-2.046, Time Limits in Which to Request a Hearing, states:

> (1) The appellant or authorized representative must exercise the right to appeal within 90 calendar days in all programs....The time period begins with the date following:
> ...
> (c) The date of the Department's written notification of denial or a request or other action which aggrieves the petitioner when that denial or action is other than an application decision or a decision to reduce or terminate program benefits.

13. Review of Petitioner's request for services reflects that Molina denied procedure D7286 on July 19, 2013. Petitioner did not appeal this denial, nor did she file a grievance with Molina to contest denial of the procedure, itself.

14. Petitioner's hearing request was received by the Office of Appeal Hearings on January 22, 2014. While this appeal is timely with regard to Molina's November 18,

2014 denial of reimbursement, it is *not* within the timeframe permitted for appealing the service denial.

15. The undersigned concludes that she does not have jurisdiction to review Molina's denial of service, but, pursuant to Florida Statues § 409.285, does retain jurisdiction to review denial of reimbursement.

16. 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.

21. 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. Dental Code D7286 does not appear on the Fee Schedule, and AHCA confirms that this procedure is not covered by Molina or by fee-for-service Medicaid.

22. The Florida Medicaid Provider General Handbook (July 2012) is incorporated by reference in Fla. Admin. Code R. 59G-5.020, and provides certain protections for Medicaid recipients. Page 1-7 of the Florida Medicaid Provider General Handbook states, in relevant part:

> Other than Medicaid copayments and Medicaid coinsurance, the provider cannot seek payment from a recipient for a compensable service for which a claim has been submitted, regardless of whether the claim has been approved, partially approved or denied except under the following circumstances:
>
> - The recipient is not eligible to receive Medicaid services on the date of service;
> - The service the recipient receives is not covered by Medicaid;
> - The provider has verified that the recipient has exceeded the Medicaid coverage limitations or frequency cap. The provider must inform the recipient that he has exceeded the frequency cap for the specific service to be rendered. (An exception is for prenatal visits. Payment for prenatal care is based on a total amount for complete care. Reimbursement for the 10 or 14 visits is the maximum reimbursement for the full course of prenatal care. If additional visits are provided, payment is considered already made in full. The provider may not bill the additional visits to Medicaid or the recipient.);
> - The recipient is enrolled in a Medicaid managed care program or Medipass and has been informed that the particular service has not been authorized by the recipient's managed care plan or primary care provider;
> - The recipient is enrolled in managed care program and has been informed that the treating provider is not a member of the recipient's managed care network; and

- The provider has informed the recipient in advance that he does not accept Medicaid payment for the specific service to be rendered. The provider must document in the recipient's medical record that the recipient was informed and agrees to the service.
(emphasis added)

23. With regard to reimbursement, Section 409.902, Florida Statutes (2014), 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, subject to any limitations or directions provided for in the General Appropriations Act, only for services included in the program, 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 [emphasis added]. This program of medical assistance is designated the "Medicaid program."...
>
> (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 [emphasis added] 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)

24. Florida Administrative Code Rule 59G-5.110 addresses direct payment to Medicaid recipients, as follows:

> 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. All payments shall be made at the Medicaid established payment rate in effect at the time the services were rendered. 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.

25. Petitioner has presented no evidence that the biopsy was a medical emergency. Indeed, that the procedure was performed nearly one month after it was originally requested and denied suggests that it did not constitute an emergency treatment.

26. The undersigned concludes that, in combination, Fla. Stat. § 409.902(2) and Fla. Admin. Code R 59G-5.020 and 59G-5.110 do not provide for reimbursement of out-of-pocket expenses incurred for non-covered services, rendered without authorization. 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 for a non-covered service during a period of Medicaid eligibility, particularly when the recipient has been informed that the service is denied and has not timely appealed the service denial.

27. Petitioner was a Medicaid recipient at the time she obtained the services, and was cautioned by her provider regarding the risk of refused reimbursement, if Petitioner chose to have the procedure completed. She is not entitled to reimbursement.

DECISION

Petitioner's appeal is DISMISSED as non-jurisdictional with regard to the denial of services and DENIED with regard to reimbursement of services performed.

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 6th day of May, 2015,

in Tallahassee, Florida.

Patricia C. Antonucci

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Copies Furnished To: [redacted] Petitioner
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