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

[redacted]

APPEAL NO. 15F-02596

PETITIONER,

Vs.

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

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, a telephonic administrative hearing in the above referenced matter was convened on May 11, 2015 at 1:35 p.m.

APPEARANCES

For the Petitioner: [redacted]
Pro Se

For the Respondent: Carol King
Registered Nurse Specialist

ISSUE

At issue is whether respondent's denial of the following dental procedures was proper:

- Removal of impacted tooth – partially bony: tooth #1 and tooth #16 (Procedure D7230)
- Deep Sedation (Procedure D9220)
- Deep Sedation – each additional 15 minutes (Procedure D9221)

The burden of proof is assigned to the petitioner.

PRELIMINARY STATEMENT

The hearing was scheduled by Hearing Officer Peter Tsamis. The hearing was thereafter reassigned to this hearing officer.

Petitioner represented himself and entered no exhibits into evidence.

Ms. King appeared as both the representative and witness for the respondent. Present from DentaQuest were Dr. Frank Manteiga, Dental Consultant and Jackelyn Salcedo, Compliance and Grievance Specialist. Present from Humana was Mindy Aikman, Grievance and Appeal Specialist. Respondent's Exhibits "1" through "3" were accepted into evidence. The record was held open through May 18, 2015 for respondent to provide additional information. The requested information included respondent's position regarding the need of a prior authorization for the dental procedures at issue. Information was timely received and entered as respondent's exhibit "4".

The record was held open through May 22, 2015 for petitioner to respond to post hearing submissions. A response was not received.

Administrative Notice was taken for Florida Statutes: § 409.963; § 409.965; § 409.971; § 409.972; § 409.973; Florida Administrative Code R. 59G-1.010; 4.060; and 4.002; the Florida Medicaid Dental Services Coverage and Limitations Handbook; and the Dental General Fee Schedule.

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 19 years of age with a birth date of [redacted]

2. Petitioner was Medicaid eligible at all times relevant to this proceeding.

3. Petitioner is enrolled in respondent's Statewide Medicaid Managed Care (SMMC) Program.

4. In regard to the SMMC Program, respondent entered into a contractual relationship with certain managed care providers.

5. Since July 1, 2014, Humana is the managed care entity providing petitioner's Medicaid services.

6. On behalf of Humana, DentaQuest conducts prior authorization reviews for requested dental services.

7. On February 23, 2015 petitioner's dentist submitted a request for the following dental procedures:

Procedure:	Description:
D7230	Extraction of impacted teeth #1 and #16[1] with some bone
D9220	Deep Sedation/General Anesthesia – first 30 minutes
D9221	Deep Sedation/General Anesthesia – each additional 15 minutes

8. If medically necessary, procedure D7230 is a service provided by Humana.

9. For the review, the referring dentist provided radiographs and wrote, in part: "The patient presents with a history of pain and discomfort from the above listed teeth. These teeth are unable to erupt normally and surgical removal is indicated. The upper wisdom teeth are affecting the periodontal health of the surrounding dentition necessitating their removal."

[1] Teeth #1 and #16 are known as either third molars or wisdom teeth.

10. A DentaQuest dentist reviewed submitted information. All dental reviewers at DentaQuest have at least 15 years of experience as a practicing dentist.

11. Petitioner was thereafter notified that the request for extraction of teeth #1 and #16 and the sedation/anesthesia were denied. The notice stated the requested procedures were not medically necessary. The notice also stated, in part:

- We cannot approve this request to remove your tooth because the information that your dentist sent shows that your teeth are not bad enough to be removed and show no sign of infection or pain. We have told your dentist this also. Please talk to your dentist about your choice to treat your teeth.

- Your dentist has asked for anesthesia (a medicine to make you sleep) for a service that has been denied. Therefore, the request to make you sleep is also denied.

12. On March 12, 2015 petitioner's request for Medicaid Fair Hearing was timely received by the Office of Appeal Hearings.

13. Upon notification of the hearing request, a second dental reviewer at DentaQuest reviewed all submitted information and concurred with the initial decision. The dentist wrote, in part: "Appeal received for the denial of extractions #1 and 16. Upon review of submitted documentation (radiographs, narratives, notes, ADA form) the denial is upheld. There does not appear to be medical necessity due to infection or pathology."

14. Respondent argues the submitted radiographs do not show either tooth #1 or #16 to be impacted in bone. As such, the requested extraction process is in excess of petitioner's need. The treating dentist could consider a less extensive extraction procedure, such as procedure D7140. Had the extractions been approved, information was not provided why deep sedation was necessary as opposed to local anesthesia.

15. Petitioner states the teeth at issue cause pain; gum damage; and a clicking sound in the jaw. His other wisdom teeth were previously approved for extraction through the Medicaid Program.

16. Respondent's General Fee Schedule (January 2015) identifies dental procedures requiring a prior authorization. Procedures D7230; D9220; and D9221 do not require a prior authorization. Respondent argues the managed care organization must still determine the requested procedures are medically necessary.

Principles of Law and Analysis

17. By agreement between the Agency for Health Care Administration (AHCA) 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.

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

19. The standard of proof in an administrative hearing is by 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, 7th Ed.).

20. Fla. Admin. Code R. 59G-4.060 addresses dental services and states, in part:

> (2) All dental services providers enrolled in the Medicaid program must be in compliance with the Florida Medicaid Dental Services Coverage and Limitations Handbook, November 2011, ... and the Florida Medicaid Provider Reimbursement Handbook, ADA Dental Claim Form, July 2008, which are incorporated by reference, and the Florida Medicaid Provider Reimbursement Handbook, CMS-1500, which is incorporated by reference in Rule 59G-4.001, F.A.C.

21. The Florida Medicaid Provider General Handbook – July 2012 (Provider Handbook) provides the following relevant information:

> 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.
>
> Page 1-30:
>
> An HMO's services cannot be more restrictive than those provided under Medicaid fee-for-service.
>
> **All** [Emphasis Added] services may[2] be prior authorized by the HMO plan except for the following:
>
> - Emergency services;
> - Family planning services regardless of whether the provider is a plan provider;
> - The diagnosis and treatment of sexually transmitted diseases and other communicable diseases such as tuberculosis and human immunodeficiency rendered by county health departments;
> - OB/GYN services for one annual visit and the medically-necessary follow up care for a condition(s) detected at that visit (the recipient must use a plan provider for these services);
> - Chiropractic, podiatry, and some dermatology services (the recipient must use a plan provider for these services); and
> - Immunizations by county health departments.

[2] Page iv of the Provider Handbook states "New material will be identified by yellow highlighting."

22. The Findings of Fact establish the requested dental procedures are covered by Humana. As such, Humana's service assortment is not more restrictive than the Medicaid State Plan.

23. Neither testimony nor documentary evidence establish the requested dental procedures met any of the exceptions for a prior authorization.

24. Respondent's contract with Humana (Respondent's Exhibit 2) requires compliance with Florida Medicaid Coverage and Limitations Handbooks and the Florida Medicaid fee schedules. Regarding dental services, the contract also states: "In any instance when compliance conflicts with the terms of this Contract, the Contract prevails."

25. The Florida Medicaid Dental Services Coverage and Limitations Handbook (Dental Handbook) states, on page 2-2, "Medicaid reimburses for services that are **determined** [Emphasis Added] medically necessary ..."

26. In regard to medical necessity for Medicaid funded services, the definition is found in 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.

27. The undersigned recognizes the Dental General Fee Schedule states the requested procedures do not require a prior authorization. The Dental Handbook, however, requires a procedure be "determined" medically necessary. For a service to be "determined" medically necessary, a review of the requested procedure must first occur.

28. The undersigned has also taken note of Florida Statute § 409.913 which states, in part:

> (1)
>
> (d) 'Medical necessity' or 'medically necessary' means any goods or services necessary to palliate the effects of a terminal condition, or to prevent, diagnose, correct, cure, alleviate, or preclude deterioration of a condition that threatens life, causes pain or suffering, or results in illness or infirmity, which goods or services are provided in accordance with generally accepted standards of medical practice. **For purposes of determining Medicaid reimbursement, the agency is the final arbiter of medical necessity** [Emphasis Added] ...
>
> (5)
>
> A Medicaid provider is subject to having goods and services that are paid for by the Medicaid program reviewed by an appropriate peer-review organization designated by the agency. The written findings of the applicable peer-review organization are admissible in any court or administrative proceeding as evidence of medical necessity or the lack thereof.

29. Based on the above authorities, a medical necessity review by the respondent of the requested dental procedures was warranted.

30. As the petitioner is under 21 years of age, Early Periodic Screening, Diagnosis, and Treatment (EPSDT) requirements apply to the evaluation of the petitioner's request for dental services. Section 409.905, Fla. Stat., *Mandatory Medicaid services*, defines Medicaid services for children to include:

> (2) EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT SERVICES.--The agency shall pay for early and periodic screening and diagnosis of a recipient under age 21 to ascertain physical and mental problems and conditions and provide treatment to correct or ameliorate these problems and conditions. These services include all services determined by the agency to be medically necessary for the treatment, correction, or amelioration of these problems, ...

31. In regard to EPSDT requirements, The State Medicaid Manual, published by the Centers for Medicare and Medicaid Services states, in part:

> 5110. Basic Requirements...
> ...Services under EPSDT must be sufficient in amount, duration, or scope to reasonably achieve their purpose. The amount, duration, or scope of EPSDT services to recipients may not be denied arbitrarily or reduced solely because of the diagnosis, type of illness, or condition. **Appropriate limits may be placed on EPSDT services based on medical necessity** [Emphasis Added].

32. The Findings of Fact establish dental procedure D7230 is covered by the Medicaid Program. The Findings of Fact also establish petitioner is under the age of 21.

33. The issue before the undersigned, therefore, focuses upon whether the requested dental procedures meet medical necessity criteria.

34. The Dental Handbook states:

> Page 1-2:

> The children's dental program provides full dental services for all Medicaid eligible children age 20 and below.
>
> Page 2-3:
>
> The Medicaid children's dental services program may provide reimbursement for diagnostic services, preventive treatment, restorative, endodontic, periodontal, surgical procedures and extractions, orthodontic treatment, and full and partial dentures (fixed and removable) for recipients under age 21.
>
> Page 2-14:
>
> A simple extraction is the removal of a permanent or deciduous tooth by the closed method using the elevation and forceps removal technique in which a flap is not retracted ...
>
> A surgical extraction is the removal of any erupted or unerupted tooth by the open method that includes the retraction of a mucoperiosteal flap and the removal of alveolar bone in order to extract or section a tooth.
>
> Page 2-36:
>
> The use of general anesthesia procedure codes(s), D9220 and D9221, for either intravenous or non-intravenous sedation modalities is not reimbursable for Medicaid eligible dental services.

35. Extraction of wisdom teeth is a common dental procedure. In particular for those in the petitioner's age group. It is noted two of his wisdom teeth were previously extracted. The rational for the prior extraction method and type of anesthesia is not clear.

36. The comments of both the treating dentist and DentaQuest reviewers have been considered. The petitioner's testimony regarding pain is also noted. Information, however, was not presented as to why the simple extraction process would not be appropriate.

37. The testimony of Dr. Manteiga that neither tooth #1 or #16 is impacted in bone was compelling. As such, the greater weight of evidence does not establish the extraction process associated with procedure D7230 is medically necessary.

38. The petitioner's request for dental procedure D7230 has not satisfied the following conditions of medical necessity:

> 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

39. In regard to anesthesia, petitioner's dentist requested procedures D9220 and D9221. The Dental Handbook states neither procedure is reimbursable through the Medicaid Program. As such, it is not clear why the procedures appear on the Dental General Fee Schedule.

40. The undersigned has reviewed EPSDT policy; medical necessity requirements; and applicable rules and regulations. After considering such, the petitioner has not established in a preponderant manner that respondent's action in this matter was incorrect.

DECISION

Based upon the foregoing Findings of Fact and controlling 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 2nd day of June, 2015,

in Tallahassee, Florida.

Frank Houston
Hearing Officer
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