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

FILED
JUN 29 2015
OFFICE OF APPEAL HEARINGS
DEPT OF CHILDREN & FAMILIES

[redacted]

APPEAL NO. 15F-03595
15F-04106

PETITIONER,

Vs.

CASE NO.

AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 12 Manatee
UNIT: AHCA

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on June 3, 2015, at approximately 3:07 p.m.

APPEARANCES

For Petitioner: [redacted] Petitioner's mother

For Respondent: Stephanie Lang, RN Specialist/Fair Hearing Coordinator
Agency for Healthcare Administration

STATEMENT OF ISSUE

Whether the Agency was correct in denying Petitioner's request for braces and 24 treatment visits. The burden of proof on this issue was assigned to Petitioner.

PRELIMINARY STATEMENT

Appearing as witnesses for Respondent were Lissette Lopez (Grievance & Appeals Supervisor with Better Health), Dr. Barbara Cowley (Medical Director of Better Health), Heidi Penaranda (Grievance & Appeals and Compliance Specialist with

DentaQuest) and Dr. Frank Mantega (Dental Consultant, DentaQuest). Dr. Mantega also served as Spanish translator for Petitioner's representative when necessary, and did take the translator's oath.

Respondent admitted seven exhibits into evidence, which were marked and entered as Respondent's Exhibits 1 through 7. Petitioner submitted one exhibit into evidence, marked and entered as Petitioner's Exhibit 1. Administrative notice was taken of the Florida Statutes sections 409.910, 409.962 through 409.965, 409.973 and Florida Administrative Code Rules 59G-1.001 and 59G-1.010, and the cases contained in the August 2014 EPSDT Memorandum.

FINDINGS OF FACT

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

1. Petitioner is a Medicaid recipient under 21 years of age. She has a tooth on top of her gum which is visible when she talks. Her upper arch hasn't come down yet and it is a food trap. As her teeth grow, she is having a lot of pressure and discomfort. Her dentist saw an occlusion and recommended orthodontic treatment.

2. On November 24, 2014, Petitioner's orthodontist submitted a prior authorization request to Petitioner's managed care plan, Better Health. DentaQuest handles the prior authorization reviews for Better Health members. Better Health requires prior authorization for orthodontic treatment for children under 21.

3. As part of the prior authorization request, Petitioner's orthodontist filled out a Medicaid Orthodontic Initial Assessment form. On this form, he noted Petitioner had a deep impinging overbite, 1 mm overjet, 12 mm overbite, scored 6 points for ectopic

eruptions, and scored 5 points on anterior crowding. The total score was 24 points, but the orthodontist wrote a note and the number 26. It is unclear how he reached this number. Petitioner's Exhibit 1.

4. Better Health, by notice dated March 16, 2015, denied Petitioner's request for braces and the treatment visits. The reason given is DentaQuest's dental director used the Medicaid Orthodontic Initial Assessment form and Petitioner scored 19 points. Petitioner needs to score 26 points on the initial assessment to get braces. DentaQuest used the dental records Petitioner's dentist submitted in order to score her teeth.

5. Petitioner requested an appeal through Better Health, received on March 25, 2015. A second dental director scored Petitioner's teeth again on March 27, 2015, and Petitioner only scored 19. DentaQuest reviewed all of Petitioner's documentation and notes, and recommended denial on April 10, 2015. Respondent's Exhibit 4. Better Health denied the request by notice on April 27, 2015.

6. DentaQuest's medical director disagrees with the Petitioner's orthodontist's assessment scoring. Petitioner's orthodontist scored 12 points for overbite when DentaQuest reviewed the records and only scored 3 points on the same criteria. The numbers for overbite are determined by millimeter measurements, so should be similar between scorers.

CONCLUSIONS OF LAW

7. 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 Chapter 120.80, Florida Statutes.

8. This is a final order pursuant to Sections 120.569 and 120.57, Florida Statutes.

9. This hearing was held as a de novo proceeding pursuant to Florida Administrative Code Rule 65-2.056.

10. In accordance with Florida Administrative Code Rule 65-2.060(1), the burden of proof was assigned to the Petitioner. The standard of proof needed to be met for an administrative hearing is by a preponderance of the evidence, as provided by Florida Administrative Code Rule 65-2.060(1).

11. Section 409.912, Florida Statutes, notes that AHCA shall purchase goods and services for Medicaid recipients in the most cost-effective manner possible, consistent with the delivery of quality medical care. The statutes further provide that AHCA shall contract on a prepaid or fixed-sum basis with appropriately licensed prepaid dental health plans to provide dental services.

12. The Florida Medicaid Provider General Handbook (Provider Handbook) – July 2012 is incorporated by reference in Florida Administrative Code Rule 59G-4. In accordance with the Florida law, the Provider Handbook discusses managed care coverage, stating on 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.

13. Page 1-30 of the Provider Handbook states: "An HMO's services cannot be more restrictive than those provided under Medicaid fee-for-service."

14. All Medicaid services must be medically necessary. Florida Administrative Code, 59G-1.010(166), defines medical necessity, as follows:

> "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.

15. The Medicaid Dental Services Coverage and Limitations Handbook (Dental Handbook) is promulgated into law by Rule 59G-4.060(2), Florida Administrative Code.

16. Rule 59G-4.060, Florida Administrative Code, 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.

> (3) The following forms that are included in the Florida Medicaid Dental Services Coverage and Limitations Handbook are incorporated by reference: Medicaid Orthodontic Initial Assessment Form (IAF), ...

17. As the petitioner is under 21, a broader definition of medically necessary applies to include the Early and Periodic Screening, Diagnosis, and Treatment Services (EPSDT) requirements. 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...

18. The Dental Handbook states on page 1-2: "The children's dental program provides full dental services for all Medicaid eligible children age 20 and below."

19. The Dental Handbook states on page 2-2: "Medicaid reimburses for services that are determined medically necessary..."

20. The Dental Handbook states on page 2-3:

> Covered Child Services (Ages under 21):
>
> 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.
> Note: See the Florida Medicaid Provider Reimbursement Schedule for information on which dental procedure codes apply to recipients under age 21.

21. Orthodontic treatment is covered under the above authorities for a child under 21 if it is a medically necessary service. According to page 2-15 of the Dental

Handbook, prior authorization is required for all orthodontic services. At page 2-16 of the Dental Handbook, the relevant criteria for orthodontic treatment is specifically discussed:

> Orthodontic procedures are limited to recipients under age 21 whose handicapping malocclusion creates a disability and impairment to their physical development.
>
> Criteria for approval is limited to one of the following conditions:
>
> • Correction of severe handicapping malocclusion as measured in the Medicaid Orthodontic Initial Assessment Form (IAF) AHCA-Med Serv Form 013...

22. The Agency relies on the Medicaid initial assessment form to assist with the medical necessity determination. The assessment and instructions to complete it are included in Appendix A of the Dental Handbook. On those instructions, there is information on how to score the assessment for each criterion.

23. Even assuming all numbers are correct, Petitioner only scored a 24 on her orthodontist's assessment. It is unclear from its face why Petitioner's orthodontist suggested Petitioner scored a 26 without the numbers adding up. Moreover, Petitioner's records were reviewed and she was reassessed by DentaQuest's dental directors, who are familiar with the assessment tool and criteria. Their interpretation of her dental records are given great weight in the absence of contrary information.

24. As Petitioner's corrected score on the assessment was 19, not 26, she did not meet Medicaid criteria for severe handicapping malocclusion and medical need for orthodontic treatment.

25. After careful review of the relevant authorities, the testimony and the evidence in this matter, the hearing officer concludes that the Agency properly denied Petitioner's request for orthodontic treatment.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, Petitioner's appeal is DENIED, and the Agency's action is 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 29th day of June, 2015, in Tallahassee, Florida.

Danielle Murray
Hearing Officer
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Copies Furnished To: [redacted] Petitioner
Don Fuller, Area 6, AHCA Field Office Manager