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

[redacted]

APPEAL NO. 15F-07811

PETITIONER,

Vs.

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

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in this matter on October 21, 2015 at 8:39 a.m. and reconvened on November 17, 2015 at 8:30 a.m.

APPEARANCES

For the Petitioner: [redacted] Mother

For the Respondent: Dianna Chirino,
Senior Human Services Program Specialist,
Agency for Health Care Administration

STATEMENT OF ISSUE

The Petitioner is appealing the Agency for Health Care Administration's (AHCA's) decision to deny the Petitioner's request for dental procedure D8660, pre-orthodontic treatment examination to monitor growth and development (braces).

Because the issue under appeal involves a request for service, the Petitioner carries the burden of proof.

PRELIMINARY STATEMENT

Appearing as Respondent's witness from the Petitioner's managed care plan Humana Healthcare was Wendy Aikman, Grievance and Appeals Coordinator. Appearing as Respondent's witnesses from DentaQuest were Jackelyn Salcedo, Grievance and Compliance Specialist and Dr. Frank Mantega, Dental Consultant.

Respondent entered a 29-page exhibit into evidence, which was marked Respondent Exhibit 1.

The record was held open to November 2, 2015 to allow the agency representative time to provide a copy of page 155 of DentaQuest's explanation of dental benefits related to procedure code D8660, as well as clarification from the contract manager on the appropriateness of the prior authorization request for this procedure. Respondent provided this information by the deadline.

Respondent's contract/policy memo was marked Respondent Exhibit 2; Page 155 of the plan's benefits covered for Children's Medicaid was marked as Respondent Exhibit 3; and Respondent's EPSDT memo of August 5, 2014 was marked as Respondent Exhibit 4. Petitioner also submitted additional information that was sent to the Respondent and forwarded to the undersigned by the November 2, 2015 deadline. Petitioner's documents related to medical necessity for the procedure.

At the November 17, 2015 proceeding, Petitioner's documents were entered into evidence and marked Petitioner Exhibit 1. Respondent also submitted a 3-page document that was entered as Respondent Exhibit 5.

FINDINGS OF FACTS

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 a ten year-old Medicaid recipient enrolled with Humana Healthcare, a Florida Health Managed Care provider.

2. Humana Healthcare requires prior authorization for services related to dental care. The plan's dental vendor, DentaQuest, is responsible for making dental prior authorizations decisions.

3. The Petitioner's dentist submitted a request for prior authorization for procedure code D8660: pre-orthodontic treatment examination to monitor growth and development (braces). This request was received by DentaQuest on August 11, 2015.

4. A Notice of Action was sent to the Petitioner on August 12, 2015 stating the pretreatment visit for braces was denied. The reason provided in relevant part was:

> Your dentist has asked for services that are part of a request for braces. We have not received a request for braces from your dentist for you. We have asked your dentist to tell us if this request should be part of a request for braces for you. Please talk to your dentist.

5. Petitioner's mother explained that her daughter is in pain and is having difficulty eating due to the sensitivity her mouth has to hot and cold foods. She asserted her daughter needs this procedure and will work with the dentist to provide the information requested by DentaQuest.

6. It was noted that the dental fee schedule issued in January 2015 does not require a prior authorization for procedure D8660. However, DentaQuest understands it has the right to require prior authorization per its contract.

7. The agency representative understood that a managed care plan could not have more restrictive services than Medicaid fee for service. The agency representative stated she would seek clarification from the contract manager. DentaQuest also referenced page155 of its members explanation of benefits form, which outlines the requirements for procedure code D8660. The record was held open to November 2, 2015 to allow time for the agency representative to provide a copy of DentaQuest's page 155 as well as a clarification from the contract manager of the prior authorization requirements for procedure code D8660 with attention to any appropriate EPSDT requirements.

8. Respondent Exhibit 5 provides general billing information for Orthodontics and states in relevant part:

> 1.) A Pre-orthodontic visit (code D8660) which includes diagnostic casts, photographs, radiographs (panoramic and cephalometric), an IAF form, a ADA claim form, and a narrative including the diagnosis and treatment plan. These services are not reimbursed separately.
>
> 2.) Comprehensive orthodontic treatment which is the coordinated diagnosis and treatment leading to the improvement of a patient's craniofacial dysfunction or dentofacial deformity including anatomical and functional relationships. Comprehensive orthodontic treatment utilizes fixed orthodontic appliances through procedure codes D8070, D8080 or D8090 in conjunction with the appropriate state of dentition development.

CONCLUSIONS OF LAW

9. By agreement between the Agency for Health Care Administration and the Department of Children and Families, the Agency for Health Care Administration has conveyed jurisdiction to the Office of Appeal Hearings to conduct this hearing pursuant to Chapter 120.80 Florida Statutes.

10. The hearing was held as a de novo proceeding pursuant to Fla. Admin. Code R.65-2.056.

11. Florida Statutes 409.971 – 409.973 establishes the requirement for Medicaid recipients to be enrolled in the statewide managed medical assistance program and the minimum benefits the managed care plans shall cover. Dental services are one of the mandatory services that must be provided.

12. § 409.912, Fla. Stat. also provides that the Agency may mandate prior authorization for Medicaid services.

13. Fla. Admin. Code R. 59G-1.010 defines "prior authorization" as:

> (226) "Prior authorization" means the approval by the Medicaid office for a Medicaid provider, or by a prepaid health plan for its affiliated providers, to deliver Medicaid covered medical or allied care, goods, or services in advance of the delivery of the care, goods, or services.

14. Fla. Admin. Code R. 59G-1.010 (166) also provides…

> "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.

> (b) "Medically necessary" or "medical necessity" for inpatient hospital services requires that those services furnished in a hospital on an inpatient basis could not, consistent with the provisions of appropriate medical care, be effectively furnished more economically on an outpatient basis or in an inpatient facility of a different type.
>
> (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 Florida Medicaid Coverage and Limitations Handbooks are incorporated by reference in the Medicaid Services Rules in Chapter 59G-4, 59G-8, and 59G-13, Florida Administrative Code. The Florida Medicaid Provider General Handbook, promulgated July 2012, states on page 1-30 in regard to HMO limitations: "An HMO's services cannot be more restrictive than those provided under Medicaid fee-for-service." On the same page, it also explains exemptions from HMO authorizations:

> All services **may** be prior authorized by the HMO plan except for the following [emphasis added]:
> □ 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.

16. The Florida Medicaid Provider General Handbook, promulgated July 2012, page 1-42 is also applicable because the Petitioner is under 21 years of age. It states:

> Florida Medicaid provides all medically necessary services to eligible children under 21 years of age, to correct or ameliorate a defect, a condition, or a physical or mental illness, even if the services are not

> covered for adults. Included are diagnostic services, treatment, equipment, supplies, and other measures described in Section 1905(a) of the Social Security Act, codified at 42 USC 1396d(a).
> Prior authorization is required in order to receive reimbursement for special services that meet one or more of the following conditions:
>
> □ The service is not listed in the service-specific Medicaid Coverage and Limitations Handbook as a covered service;
> □ The service is not included in the applicable fee schedule;
> □ The service is described in the service-specific handbook as an □ "excluded service";
> □ The amount, frequency, or duration of the service exceeds the limitations specified in the service-specific handbook or the fee schedule.
>
> Providers seeking prior authorization for special services should first refer to the service-specific handbook for a description of the prior-authorization process. For example, if the provider is seeking additional units of occupational therapy which exceed the service limits, the provider should refer to the Medicaid Therapy Services Coverage and Limitations Handbook for instructions on prior authorization.
> If the service is not listed in the service-specific handbook, or if there are not any instructions for requesting additional services, the provider can submit a request for prior authorization to their local Medicaid area office. An optional form for requesting prior authorization for special services is available online at ahca.myflorida.com/CHCUP.

17. The general Dental Fee Schedule published by the Agency for Health Care Administration with an effective date of January 1, 2015 indicates no prior authorization is required for procedure D8660.

18. The Florida Medicaid Dental Services Coverage and Limitations Handbook-November 2011 (Handbook), incorporated by reference into Chapter 59G-4, Fla. Admin. Code, sets standards for dental services and states on page 1-1:

> The purpose of the dental program is to provide dental care to recipients under the age of 21 years, emergency dental services to recipients age 21 and older, and denture and denture-related services and oral and maxillofacial surgery services to all Medicaid-eligible recipients.

19. Because the Petitioner is under 21, the federal regulations regarding Early and Periodic Screening, Diagnosis, and Treatment, also called Child Health Check-Up by Florida Medicaid, apply. This is a comprehensive, preventive child-health screening to identify and correct medical conditions before the conditions become serious or disabling. Fla. Stat. 409.905 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, including personal care, private duty nursing, durable medical equipment, physical therapy, occupational therapy, speech therapy, respiratory therapy, and immunizations.

20. The Florida Medicaid Child Health Check-Up handbook has been promulgated by reference in the Florida Administrative Code at 59G-4.080 (2). Section 2-3 of the Child Health Check-Up manual states under the paragraph titled "Diagnosis, Treatment, Referral, and Follow-Up", that...

> Once the child has had a Child Health Check-Up, **any further diagnoses and treatments, referrals and follow-up are provided through the applicable Medicaid program, such as physician services** [emphasis added].

21. Based on the above citations, medical necessity needs to be established prior to a service being provided. Page 1-30 of the general handbook indicates the HMO may require prior authorizations except in limited exceptions as listed on the page. (See paragraph 14 above.) DentaQuest testified that it requires prior authorization for this procedure. The HMO asserts Petitioner failed to provide a plan of treatment and an

Initial Assessment Form (IAF) which are necessary for it to determine medical necessity.

22. The Agency for Health Care Administration has contracted with managed care plans, such as Humana, to provide comprehensive medical care and authorizes them to establish procedures to determine medical necessity.

23. While the Petitioner's mother testified that her daughter is in pain and needs the service, Respondent has provided proof that the provider has failed to provide the necessary information for them to determine medical necessity. The Petitioner's mother is encouraged to work with her provider, Humana, and AHCA in order to ensure the proper documentation is submitted for dental procedure code D8660.

DECISION

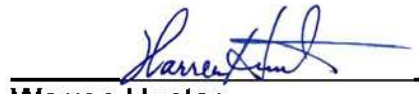
Based on the evidence presented at the final hearing and on the entire record of this proceeding, the Agency for Health Care Administration acted correctly when it denied procedure code D8660, pre-orthodontic treatment examination to monitor growth and development (braces). Therefore, Petitioner's appeal is hereby 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 agency has no funds to assist in this review, and any financial obligations incurred will be the Petitioner's responsibility.

DONE and ORDERED this 22 day of December, 2015,

in Tallahassee, Florida.



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