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

[redacted]

APPEAL NO. 15F-07557

PETITIONER,

Vs.

CASE NO.

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

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on September 30, 2015, at approximately 11:06 a.m.

APPEARANCES

For Petitioner: [redacted] Petitioner

For Respondent: Stephanie Lang, RN Specialist
Agency for Healthcare Administration

STATEMENT OF ISSUE

Whether the Agency was correct in denying Petitioner's request for teeth extractions. Petitioner held the burden of proof by a preponderance of the evidence.

PRELIMINARY STATEMENT

Appearing as witnesses for Respondent were India Smith (Grievance and Appeals Coordinator) and Donna Laber, R.N. (Manager of Grievance and Appeals) with

Sunshine Health Plan, and Dr. Kimberly Anderson (Dental Consultant) with Dental Health and Wellness. Tiffany Smith (Grievance and Appeals Coordinator) with Sunshine Health Plan, Karen Greyhack (Appeal Specialist) and Elias Vega (Appeals Specialist) both with Dental Health and Wellness, observed the hearing.

Respondent admitted five exhibits into evidence, which were marked and entered as Respondent's Exhibits 1 through 5. Petitioner submitted no documentary evidence. Administrative notice was taken of Florida Statutes Sections 409.910, 409.962 through 409.965, and 409.973. Administrative notice was also taken of Florida Administrative Code Rules 59G-1.001, 1.010, and 4.060.

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 over 21 years of age who receives services through Sunshine Health Plan. She saw an oral surgeon in March who pulled some of her teeth in the hospital due to infection. She has a blood clot issue which her dentist could not handle in his office during a surgery, so surgical procedures need to be done in a hospital. The surgeon advised her to return if she had future need of him. She is back in the hospital with another infection.

2. Petitioner's primary dentist suggested the remaining teeth be pulled because of her degenerative bone disease, with the ultimate goal to be dentures. Petitioner returned to the oral surgeon she saw in March. He submitted a request for prior authorization for the extractions, bone adjustment to Sunshine Health. Dental

authorization requests are reviewed by Sunshine's Dental vendor, Dental Health and Wellness. Sunshine received Petitioner's authorization request on August 18, 2015.

3. Sunshine denied the request by notice dated September 14, 2015. The notice stated the service was denied because the provider is out of network.

4. Petitioner was able to see the oral surgeon in March because at the time, Sunshine was transitioning to using Dental Health and Wellness. Providers had a "grace period" to accept Sunshine patients and receive payment for services through Sunshine. However, the providers could not be paid by Sunshine if they did not become credentialed (in network) by a set date. In this case, the oral surgeon did not agree to become an in-network provider with Sunshine, and was considered out of network as of April 1, 2015.

5. Sunshine's case manager has been working with Petitioner to refer her to an in network surgeon. Petitioner has not yet found a surgeon willing to perform the surgery in a hospital. The authorization request from Petitioner's oral surgeon included "hospital call" but included no other indication that this would be done in a hospital or why it was necessary to be done there. Petitioner's testimony is the only evidence that the surgery needs to be done in the hospital.

6. Sunshine agreed that the services as requested could be approved but only if Petitioner uses an in network provider. Petitioner can work with her primary dentist to find an in network provider that will meet her needs.

7. Once Petitioner finds an in network surgeon, that surgeon can evaluate her and submit a prior authorization request for the services he/she feels are appropriate for Petitioner's care. However, as far as the request to do the surgery in a hospital,

Sunshine cautioned that all requests must be medically necessary and accompanied by any information showing that.

CONCLUSIONS OF LAW

8. 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.

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

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

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.

12. The Florida Medicaid Provider General Handbook (Provider Handbook) – July 2012 is incorporated by reference in Florida Administrative Code Rule 59G-5.020(1). Regarding providers, the Provider Handbook states on page 1-2:

> Only health care providers that meet the conditions of participation and eligibility requirements and are enrolled in Medicaid may provide and be reimbursed for rendering Medicaid-covered services.

13. The Provider Handbook also discusses freedom to choose a Medicaid provider, stating on page 1-3:

> Per Title 42 of the Federal Code of Regulations Part 431.51, recipients may obtain services from any qualified Medicaid provider that undertakes to provide the services to them.

The exceptions to a recipient's freedom of choice of providers are as follows:

- The allowable restrictions that are specified in section 1915(a) of the Social Security Act.
- If the recipient is enrolled in a Medicaid managed care program. An exception is freedom of choice of providers for family planning services, which may not be restricted. Managed care plans are responsible for paying for family planning for their members regardless of whether the family planning provider is a plan subcontractor.

14. These authorities explain that a Medicaid recipient (even through a managed care plan) must see a participating Medicaid provider in order for Medicaid to cover the service. If a recipient obtains services from a non-Medicaid provider, the recipient may be responsible for payment for the services. Page 1-7 of the Provider General Handbook explains when a Medicaid recipient may have to pay a provider for care.

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

16. Regardless of Petitioner's medical need for the service, the authorities are clear that Medicaid will only reimburse providers who accept and bill Medicaid for services. Sunshine is not required to pay for services provided by a surgeon that is not in its network because the surgeon does not accept Sunshine/Medicaid.

17. Sunshine has shown that there are sufficient oral surgeons in its network in Petitioner's area that she could receive services from. Petitioner would need to show by a preponderance of the evidence that none of those surgeons would be appropriate to treat her. She did not provide any evidence that the available surgeons were unwilling or unable to treat her. Her testimony that she has made phone calls and was told no (because they won't operate in the hospital) is not sufficient to overcome Sunshine's

evidence that the surgeons are available. Whether or not the surgery needs to take place in a hospital is up to the treating surgeon to determine.

18. After careful review of the relevant authorities, the testimony and the evidence in this matter, the hearing officer concludes that Petitioner's request for services by an out of network provider was properly denied. Petitioner may resubmit her request for services through an in network provider, and will have appeal rights if denied.

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 01 day of December, 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