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

FILED
FEB 23 2015
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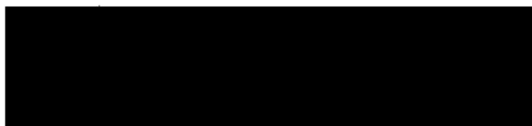
DEPT OF CHILDREN & FAMILIES



APPEAL NO. 14F-10905

PETITIONER,

Vs.

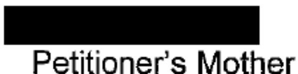
AGENCY FOR HEALTH
CARE ADMINISTRATION
CIRCUIT: 15 Palm Beach
UNIT: AHCA

RESPONDENT.
_______________________________/

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on January 27, 2015 at 8:36 a.m.

APPEARANCES

For the Petitioner: 
Petitioner's Mother

For the Respondent: Carol King, Registered Nurse Specialist
Agency for Health Care Administration (AHCA)

ISSUE

At issue is whether petitioner's request for reimbursement of $150.00 for dental procedures D9630 and D9911 was improperly denied.

PRELIMINARY STATEMENT

The petitioner was present and represented by his mother. Petitioner's exhibit "1" was entered into evidence.

Ms. King appeared as both a representative and witness for the respondent. Present from Molina Healthcare of Florida (Molina) was Alice Quiros, ABP of Government Contracts. Present from DentaQuest were Dr. Frank Mantega, Dental Director and Bibi Delacruz, Complaint and Grievance Specialist. Respondent's exhibit "1" was entered into evidence.

Hearing Officer's exhibit "1" was also entered into evidence.

Administrative notice was taken of Florida Statutes § 409.965; § 409.971; § 409.972; § 409.973; Fla. Admin. Code Rules 59G- 1.010; 59G-4.060; 59G-4.002; the Dental Services Coverage and Limitations Handbook; and the Dental General Fee Schedule (January 1, 2014).

The record was held open through February 3, 2015 for respondent to provide case notes associated with a phone conversation with petitioner's mother and further claim information for the procedures at issue. Information was timely received and entered as respondent's exhibit "2".

The record was also left open through February 10, 2015 for petitioner to submit a written response to respondent's post hearing submission. A timely response was not received.

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. Petitioner's date of birth is [redacted]

2. At all times relevant to this proceeding, petitioner was eligible to receive Medicaid services. Additionally, there has been no erroneous denial of Medicaid eligibility coupled with a successful appeal or agency determination in the petitioner's favor.

3. In 2014, petitioner transitioned to the Statewide Medicaid Managed Care Program. Molina is the managed care entity which provides his Medicaid services. Petitioner became a Molina plan member on August 1, 2014.

4. DentaQuest is Molina's dental vendor. Dental services requested by a Molina enrollee are sent to DentaQuest for review.

5. Neither procedure D9630 or D9911 are dental procedures covered by the Medicaid State Plan for an adult beneficiary.

6. Molina's Dental Plan cannot be more restrictive than the Medicaid State Plan. Molina can, however, provide expanded services not covered by Medicaid.

7. Procedures D9630 and D9911 are not expanded services provided by Molina for an adult member.

8. On August 13, 2014 the petitioner had two fillings and a cleaning completed by Group Dental of the Palm Beaches. The services were authorized by DentaQuest. A request for the following procedures, however, was not approved:

- Procedure D9630: Antimicrobial Irrigation $50.00
- Procedure D9911: Application of Desensitizing $100.00

9. A Primary Treatment Plan was signed. The plan shows the amount of insurance coverage as $0 and a patient cost of $150.00.

10. Petitioner paid the provider $150.00 for the two procedures not approved by DentaQuest.

11. On September 19, 2014 Molina received a grievance regarding non-coverage of the two procedures and a request for reimbursement.

12. On October 14, 2014 Molina issues a response to the grievance. The notice stated, in part:

> We have forwarded your complaint to DentaQuest of Florida, and they have concluded the following. The office of Group Dental of the Palm Beaches is indicating that the charges applied on dates of service were for procedures code D9630 (drugs/medication) at a $50 cost and two applications of D9911 (desensitizing) at a $50/each cost. The office indicates that they informed you that both services were not covered by your dental insurance plan and you agreed to cover the expenses anyway.
>
> Attached, please find the "financial Responsibility Form" you assigned assuming the responsibility for the charges applied for services not covered by your dental insurance. For this reason, your request for the reimbursement of $150 by the office of Group Dental of the Palm Beaches was not processed at this time.

13. In response to the above notice, on December 3, 2014 the Office of Appeal Hearings timely received petitioner's request for a Fair Hearing.

14. Petitioner asserts an attempt was made to opt out of the denied procedures. The treating dentist stated, however, it was not possible to proceed with the approved treatments without also providing procedures D9630 and D9911. Petitioner was told to not provide them in conjunction with the fillings and cleaning would constitute mal-practice.

15. Petitioner also asserts the procedures were actually medication and should be covered by Molina.

16. Petitioner's mother made several phone calls to Molina about reimbursement. She was told to send an explanation and receipts.

17. Respondent states the petitioner was misinformed by the treating dentist. The treatments could be performed without the denied procedures. DentaQuest plans to follow up with the dental provider regarding the information given to the petitioner.

CONCLUSIONS OF LAW

18. By agreement between the Agency for Health Care Administration 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.

19. This is a final order pursuant to § 120.569 and § 120.57, Fla. Stat.

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

21. The burden of proof is assigned to the petitioner. The standard of proof in an administrative hearing is by a preponderance of the evidence. (See Fla. Admin. Code R. 65-2060(1).) The preponderance of the evidence standard requires proof by "the greater weight of the evidence," (Black's Law Dictionary at 1201, 7th Ed.).

22. Federal Medicaid Regulations found at 42 C.F.R. § 447.25 "Direct payments to certain beneficiaries for physicians' or dentists' services" states in part:

> (a) Basis and purpose. This section implements section 1905(a) of the Act by prescribing requirements applicable to States making direct payments to certain beneficiaries for physicians' or dentists' services.
> (b) State plan requirements. Except for groups specified in paragraph (c) of this section, a State may make direct payments to beneficiaries for physicians' or dentists' services. If it does so, the State plan must—
> (1) Provide for direct payments; and
> (2) Specify the conditions under which payments are made.

23. Fla. Admin Code R 59G-5110, "Claim Payments" provides information regard the conditions under which direct payments can be made:

> (1)(a) The agency provides eligible individuals with access to Medicaid services and goods by direct payment to the Medicaid provider upon submission of a payable claim to the fiscal agent contractor. Except as provided for by law or federal regulation, payments for services rendered or goods supplied shall be made by direct payment to the provider except that payments may be made in the name of the provider to the provider's billing agent if designated in writing by the provider. **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** [Emphasis Added]. 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.

24. The above authority states direct payments are made to a Medicaid provider upon submission of a payable claim. Additionally, direct payment can be made to a Medicaid recipient who paid for medically necessary and covered services during the period of an erroneous denial of Medicaid eligibility coupled with a successful appeal or agency determination in the recipients favor.

25. The Findings of Fact establish the petitioner did not experience an erroneous denial of Medicaid eligibility which contributed to the denial of the dental procedures at issue. As such, the above authority does not allow for reimbursement.

26. It is also noted that the Findings of Fact establish neither D9630 nor D9911 are covered services under the Medicaid State Plan or an expanded dental service provided

by Molina. Additionally, the denied codes are for a dental procedure versus a prescription issued by a physician to be filled by a pharmacist.

27. The petitioner has not demonstrated, by the greater weight of the evidence, that respondent's action in this matter was improper.

DECISION

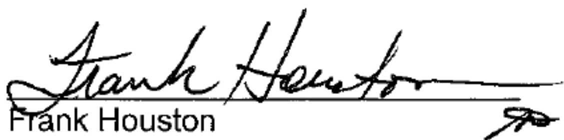
Based upon the foregoing Findings of Fact and Conclusions of Law, the petitioner's appeal is denied.

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 23rd day of February, 2015,

in Tallahassee, Florida.



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Tallahassee, FL 32399-0700
Office: 850-488-1429
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Copies Furnished To: [redacted] Petitioner
Carol King, Field Office 9 Medicaid