3. The petitioner is enrolled in Staywell. Staywell is a health maintenance organization ("HMO") which is contracted by the Agency for Health Care Administration, the respondent, to provide services to certain Medicaid eligible persons in the State of Florida.

4. The petitioner was enrolled in Staywell effective June 1, 2014.

5. Humana has contracted with Liberty Dental Plan to review prior authorization requests for dental services.

6. The petitioner had an appointment to get his teeth cleaned at the [redacted] sometime in February 2015. At the time of his appointment, students/staff at the Clinic noticed an infection surrounding one of his wisdom teeth.

7. The petitioner subsequently saw a dentist at [redacted] due to tooth pain.

8. On or about July 23, 2015, the petitioner's dental provider submitted a request for the following services:

- Molar endodontic therapy (exclude final restoration) #31
- Gingival irrigation – per quadrant #31

Molar endodontic therapy is the medical term for a root canal.

9. In a Notice of Action dated July 28, 2015, Staywell informed the petitioner that his request was denied. The Notice of Action explains, in part:

> # 1 DG-2 Denied – This procedure appears to have a poor prognosis. Alternative treatment choices may be available.
> # 2 DG-5 Denied – This procedure is not listed as covered by the plan. Please refer to the Evidence of Coverage (EOC) booklet or Schedule of Benefits for details or you may call us for additional information.

10. On August 17, 2015, Liberty Dental completed an administrative review of the petitioner's request and all available documentation. Based on that review, Liberty Dental determined that the denial of the pre-treatment authorization was denied for the incorrect reason. Upon further review after the denial, Liberty Dental determined that a root canal is not a covered benefit according to the petitioner's Schedule of Benefits.

11. The dentist testifying for the respondent stated that tooth # 31 is a poor candidate for a root canal because the infection has encircled the entire tooth. He also testified that a root canal is not a covered benefit under the petitioner's dental plan.

12. The dentist testifying for the respondent testified that extracting tooth #31 is a better alternative for the petitioner and that extraction of the tooth will alleviate the petitioner's pain.

13. The Dental Fee Schedule is a complete list of the dental procedures for which benefits are payable under the petitioner's Plan. The Dental Fee Schedule states non-listed procedures are not covered.

14. The procedure code for a root canal is D3330.

15. Procedure code D3330 does not appear on the Dental Fee Schedule. A root canal is not a covered benefit under the petitioner's dental plan.

CONCLUSIONS OF LAW

16. 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.

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

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

19. The petitioner in the instant matter is requesting a new service. Therefore, in accordance with Fla. Admin. Code R. 65-2.060 (1), the burden of proof is assigned to the petitioner.

20. The standard of proof in an administrative hearing is by a preponderance of the evidence. (See Fla. Admin. Code R. 65-2.060(1)). The preponderance of the evidence standard requires proof by "the greater weight of the evidence," (Black's Law Dictionary at 1201, 7th Ed.).

21. The Florida Medicaid program is authorized by Fla. Stat. ch. 409 and Fla. Admin. Code R. 59G. The Medicaid program is administered by the respondent.

22. Fla. Admin. Code R. 59G-1.010(166) explains that medical or allied care, goods, or services furnished or ordered must meet the definition of medically necessary or medical necessity, and defines medical necessity as:

> (a) "Medical necessary" or "medical necessity" means that medical or allied care, goods or services furnished or ordered must 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 patent's needs;
> 3. Be consistent with generally accepted professional medical standards as defined by the Medicaid program and not be experimental or investigational;
> 4. Be reflective of the level of service that can safely be furnished, 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.

23. The Florida Medicaid Provider General Handbook – July 2012 is incorporated by reference in the Medicaid Services Rules found in Fla. Admin. Code Chapter 59G-4. In accordance with the above Statute, the Handbook states 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.

24. Pages 1-28 and 1-29 of the Florida Medicaid Provider General Handbook provide a list of HMO covered services.

25. Page 1-30 of the Florida Medicaid Provider General Handbook, Optional Services, explains: "Other services that plans may provide include dental services, transportation, nursing facility and home and community-based services. Plans may also provide services under their contracts that Medicaid does not cover, such as over-the-counter drugs."

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

27. The Dental Services Coverage and Limitations Handbook – November 2011 is incorporated by reference into the Medicaid Service Rules by Rule 59G-4.060, Florida Administrative Code.

28. The Dental Services Coverage and Limitations Handbook addresses Covered Adult Services (Ages 21 and Over) on Page 2-8. It explains:

> The adult dental program provides for the reimbursement of full and removable partial dentures. Extractions and other surgical procedures essential to the preparation of the mouth for dentures are reimbursable if the patient is to receive dentures. Procedures relating to dentures such as repairs, relines and adjustments are reimbursable.
>
> Medicaid will reimburse for medically-necessary emergency dental procedures to alleviate pain and or infection for eligible adult Medicaid recipients 21 years of age or older. Emergency dental care shall be limited to emergency problem-focused evaluations, necessary radiographs to make a diagnosis, extraction, and incision and drainage of abscess.

29. The Agency for Health Care Administration does not cover endodontic services for individuals 21 years of age and older.

30. The respondent's witness testified that endodontic services are not a covered benefit under the petitioner's health plan. The procedure code for a root canal is absent from the Staywell Dental Fee Schedule which sets forth a comprehensive list of the dental procedures for which benefits are payable under the petitioner's plan.

31. In the present case, a root canal is not a covered benefit under the petitioner's plan. Furthermore, the dentist who appeared at the hearing testified that a root canal is not the best alternative for petitioner because the infection has encircled

the entire tooth. The dentist also explained the petitioner's pain will stop when he has the tooth extracted.

32. The dentist appearing for the respondent stipulated to the approval of tooth # 31 for the petitioner.

33. Pursuant to the above, the petitioner has not met his burden of proof to demonstrate the respondent improperly denied his request for a root canal.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of 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 November, 2015, in Tallahassee, Florida.

Peter Tsamis

Peter J. Tsamis
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Copies Furnished To: [redacted] Petitioner
Dietra Cole, Area 8, AHCA Field Office Manager