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

APPEAL NO. 09F-07057

PETITIONER,

Vs.

AGENCY FOR HEALTH
CARE ADMINISTRATION
CIRCUIT: 09 Osceola
UNIT: AHCA

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing convened telephonically with the undersigned hearing officer on December 7, 2009, at 11:52 a.m. The petitioner's mother, , represented her. Lisa Sanchez, human services program specialist, Area 7 Medicaid, and Mary Cerasoli, program analyst, Agency for Health Care Administration (AHCA), represented the respondent.

The record was left open for additional evidence which has been entered as the Petitioner's Exhibit 1 and the Respondent's Exhibit 3.

ISSUE

At issue is the action taken by the agency to deny orthodontic services to the petitioner. The petitioner has the burden of proof in this matter.

FINDINGS OF FACT

1. The petitioner is a 12 year old child who receives Medicaid services. Her date of birth is A request for orthodontic services was submitted by a provider on the petitioner's behalf.

2. In consideration of the request for Medicaid reimbursement for orthodontic coverage, a prior authorization review of materials submitted by Dr. was completed by the agency's orthodontic evaluators. The Initial Assessment Form (AIF) submitted by the attending dentist is included in the Petitioner's Exhibit 1.

3. The Respondent's Exhibit 1 is the Agency's Statement of maters. It explains the requirements for consideration of orthodontic services to be paid by Medicaid. The agency explained that orthodontic services are limited to those children with the most severely handicapping malocclusions. Children with a handicapping malocclusion that creates a disability and impairment to their physical development are considered for orthodontic services. The conditions are: syndromes involving the head and maxillary or mandible jaws, such as a cleft lip or palate, cross-bite with the expectation of one posterior tooth that is causing no colossal interferences, head injury involving traumatic deviation, or orthognathic surgery.

3. The agency determined that medical necessity standards for Medicaid reimbursement coverage were not met due to the level of points assigned by the attending physician. Twenty points were assigned. The level of severity is determined by the scoring on the Medicaid Orthodontic Initial Assessment Form (IAF). To meet the medical necessity criteria, the score must be at least a 26 and certain other medical conditions must be met which creates a disability and impairment to the child's physical

development. The agency denied two requests for the same service using the same IAF. The IAF form in addition to x-rays and other medical information is used in the determination of medical necessity in conjunction with the rules governing orthodontic services in the Denial Services Coverage and Limitations Handbook.

4. The petitioner's mother believes the petitioner needs braces because her teeth are twisted. She took pictures and sent them to the agency. She asserts that the braces are not for cosmetic purposes, and she cannot afford to have her teeth fixed. She explained that her daughter was premature, anemic, and has growth problems.

CONCLUSIONS OF LAW

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 Fla. Stat. ch. 120.80.

Fla. Admin. Code 59G-1.010 *Definitions* states in part:

> (166) "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.

The defined medical necessity criteria cited above indicates that services must be at the level to "protect life, prevent significant illness or significant disability, or to alleviate severe pain."

Fla. Admin. Code 59G-4.060 addresses dental services with subsection (2) informing:

> (2) All dental services providers enrolled in the Medicaid program must be in compliance with the Florida Medicaid Dental Services Coverage and Limitations Handbook, January 2006, updated January 2007, 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. All handbooks are available from the Medicaid fiscal agent's Web Portal at http://mymedicaid-florida.com. Click on Public Information for Providers, then on Provider Support, and then on Provider Handbooks. Paper copies of the handbooks may be obtained by calling the Medicaid fiscal agent, Provider Contact Center at (800)289-7799 and selecting Option 7.
>
> (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), Initial Assessment Form...

The Florida Medicaid Dental Services Coverage and Limitations Handbook beginning on page 2-14 sets forth specific limitations to Medicaid compensable orthodontic services for recipients under age 21. It states that Prior authorization (PA) is required for all orthodontic services. The beginning statement of this limitation is as follows:

> Orthodontic services are limited to recipients under age 21 whose 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 Initial
> Assessment Form. A minimum score of 26 points should be required for full banding;
> • Syndromes involving the head and maxillary or mandible jaws such as cleft lip or cleft palate;
> • Cross-bite therapy, with the exception of one posterior tooth that is causing no occlusal interferences;
> • Head injury involving traumatic deviation; or
> • Orthognathic surgery, to include extractions, required or provided in conjunction with the application of braces...
>
> And on page 2-16:
>
> The Initial Assessment Form (IAF) is to be completed by the orthodontic provider at the initial evaluation of the recipient.
> The IAF is:
> • Designed for use as a guide by the provider in the office to determine whether a prior authorization (PA) request should be sent to the Medicaid orthodontic consultant;
> • A means by which the orthodontic provider may communicate to Medicaid's orthodontic consultant all the distinctive details pertaining to an individual case; and
> • To be sent to Medicaid's orthodontic consultant in borderline situations with diagnostic photographs and a prior authorization form (DPA 1041) to determine if the provider should proceed with a full diagnostic work-up.

The Findings of Fact do not show that the petitioner's orthodontic condition was severe enough to be at the level of a "severe handicapping malocclusion" based on the opinion of her treating dentist. He graded her orthodontic condition to be less than the 26 points needed to meet the described medical necessity criteria before payment could be approved by Medicaid. There is no evidence that she has a condition that meets the medical necessity criteria to be considered for Medicaid approved orthodontic services.

The standard required for Medicaid reimbursement was not demonstrated. Therefore, the denial was justified.

DECISION

The appeal is denied and the agency's action is upheld.

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 13th day of January, 2010,

in Tallahassee, Florida.

Margaret Poplin
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
850-488-1429

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