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

[redacted]

PETITIONER,

APPEAL NO. 15F-07361

vs.

AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 10 Polk
UNIT: AHCA

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice and agreement, Hearing Officer Patricia C. Antonucci convened hearing in the above-captioned matter on November 2, 2015 at approximately 2:00 p.m. All parties and witnesses appeared via teleconference.

APPEARANCES

For the Petitioner: [redacted] Petitioner's mother

For the Respondent: Stephanie Lang, Registered Nurse Specialist,
Agency for Health Care Administration

STATEMENT OF ISSUE

At issue is a decision by Respondent, the Agency for Health Care Administration (AHCA), through its contracted peer review organization, eQHealth Solutions, Inc., to terminate Petitioner's Prescribed Pediatric Extended Care (PPEC) services. Respondent bears the burden of proving, by a preponderance of the evidence, that said termination is proper.

PRELIMINARY STATEMENT

Prior to hearing on the merits, a preliminary hearing convened via teleconference at approximately 2:00 p.m. on October 7, 2015 to determine whether Petitioner's benefits would continue pending outcome of Petitioner's appeal. After it was established that the benefit would, indeed, continue, the parties agreed to proceed to final hearing on November 2, 2015.

At hearing on November 2, 2015, the minor Petitioner was not present, but was represented by her mother, [redacted] Respondent was represented by Stephanie Lang, RN, on behalf of AHCA. Respondent presented one additional witnesses: Rakesh Mittal, M.D., Physician Reviewer with eQHealth Solutions (eQHealth).

Respondent's Exhibits 1 through 6, inclusive, were admitted into evidence. Administrative Notice was taken of Fla. Stat. § 409.905, Fla. Admin. Code R. 59G-1.001, Fla. Admin. Code R. 59G-1.010, Fla. Admin. Code R. 59G-4.260, and pertinent pages of the September 2013 Florida Medicaid Prescribed Pediatric Extended Care Services Coverage and Limitations Handbook (PPEC Handbook).

FINDINGS OF FACT

1. The Petitioner is a 2-year old female, born August 28, 2013. She was born premature at 27-28 weeks gestation, and had a g-tube placed for feeding. The g-tube has since been removed, and Petitioner is on a regular diet. She is diagnosed with [redacted]

2. Petitioner is and has been eligible to receive Medicaid services at all times relevant to these proceedings.

3. On or about May 21, 2015, Petitioner's PPEC provider submitted a request on behalf of the Petitioner, to continue her previously authorized PPEC services (full day Monday through Friday, partial day some Saturdays) into her new certification period, spanning June 4, 2015 through November 30, 2015.

4. This prior service authorization request was submitted to AHCA's peer review organization (PRO), along with information and documentation required to make a determination of medical necessity. The PRO contracted by AHCA to review PPEC requests is eQHealth Solutions, Inc. (eQHealth).

5. On May 27, 2015, the PRO reviewed Petitioner's request for services and all supporting documentation. By letter dated May 28, 2015, the PRO notified Petitioner's provider of its decision to terminate PPEC, stating, in pertinent part:

> PR Principal Reason – Denial: Requested services are denied because the clinical information does not support the medical necessity.
>
> The patient is a 21 month old with a history of prematurity, asthma, and gastro esophageal reflux. The clinical information provided does not appear to supports [*sic*] skilled nursing interventions and does not meet the medical complexity requirement of PPEC services. The additional services are not approved: denied[.]

6. The May 28, 2015 denial letter sent to Petitioner did not include this explanation, noting only:

> The reason for the denial is that the services are not medically necessary as defined in 59G-1.010 (166), Florida Administrative Code (F.A.C.), specifically the services must be:
> Individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness under treatment, and not in excess of the patient's needs.

> 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.

7. On or about August 27, 2015, Petitioner requested a hearing to challenge this denial.

8. Per AHCA and eQHealth, Petitioner's services have continued pending the outcome of her appeal.

9. At hearing, Dr. Mittal testified based upon his review of Petitioner's request for services, in conjunction with her Plan of Care and some progress notes.

10. Petitioner's Plan of Care reflects that she is totally dependent on others for activities of daily living (ADL) care. While she requires precautions/monitoring, the only interventions indicated on the Plan are the administration of a nebulizer, as needed, and use of ambu-bag, in case of emergency. The "Current Medical Condition" portion of Petitioner's Plan states that she is monitored for respiration, reflux, and potential for aspiration due to [redacted] It also notes that she receives Speech Therapy (ST) while at PPEC and has recently been evaluated for Occupational Therapy (OT).

11. It is Dr. Mittal's opinion that at this time, Petitioner does not require skilled nursing interventions on a regular basis. Per Dr. Mittal, Petitioner's need for ADL care is consistent with her age, and ST and OT can be provided as distinct services, outside of the PPEC program.

12. Petitioner's mother confirmed that Petitioner's medications are provided on an as-needed basis, with the exception of her Pulmicort (twice per day), vitamins, and

Singulair. She is concerned because she has been unable to find a non-PPEC daycare that will administer medications to the Petitioner, or provide Albuterol, if needed.

13. The Agency noted that because Petitioner is enrolled with Children's Medical Services (CMS), she should have a CMS case manager who can assist Petitioner's mother in finding appropriate day care options.

CONCLUSIONS OF LAW

14. By agreement between AHCA and the Department of Children and Families, the Office of Appeal Hearings has jurisdiction to conduct this hearing, pursuant to Florida Statutes Chapter 120.

15. Respondent, the Agency for Health Care Administration, administers the Medicaid Program. Legal authority governing the Florida Medicaid Program is found in Fla. Stat., Chapter 409, and in Chapter 59G of the Florida Administrative Code.

16. The September 2013 Florida Medicaid Prescribed Pediatric Extended Care Services Coverage and Limitations Handbook (PPEC Handbook) has been promulgated into rule by Fla. Admin. Code R. 59G-4.260.

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, in accordance with Fla. Admin. Code R. 65-2.056.

19. The burden of proof in the instant case is assigned to Respondent, who seeks to terminate Petitioner's PPEC services. The standard of proof in an administrative hearing is preponderance of the evidence. (See Fla. Admin. Code R. 65-2.060(1).)

20. Fla. Stat. § 409.905 addresses mandatory Medicaid services under the State Medicaid Plan:

> Mandatory Medicaid services.--The agency may make payments for the following services, which are required of the state by Title XIX of the Social Security Act, furnished by Medicaid providers to recipients who are determined to be eligible on the dates on which the services were provided. Any service under this section shall be provided only when medically necessary and in accordance with state and federal law....
> (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 all services determined by the agency to be medically necessary for the treatment, correction, or amelioration of these problems and conditions, including personal care, private duty nursing, durable medical equipment, physical therapy, occupational therapy, speech therapy, respiratory therapy, and immunizations.

21. Page 1-1 of the PPEC Handbook notes that, "[t]he purpose of the Florida Medicaid Prescribed Pediatric Extended Care (PPEC) Services Program is to enable recipients under the age of 21 years with medically complex conditions to receive medical and therapeutic care at a non-residential pediatric center."

22. On page 2-1 – 2-2, the PPEC Handbook lists the requirements for PPEC services.

> To receive reimbursement for PPEC services, a recipient must meet all of the following criteria:
> - Be Medicaid eligible.
> - Diagnosed with a medically-complex or medically fragile condition as defined in Rule 59G-1.010, F.A.C.
> - Be under the age of 21 years.
> - Be medically stable and not present significant risk to other children or personnel at the center.
> - Require short, long-term, or intermittent continuous therapeutic interventions or skilled nursing care due to a medically-complex condition.

23. Fla. Admin. Code R. 59G-1.010 defines "medically complex" and "medically fragile" as follows:

> (164) "Medically complex" means that a person has chronic debilitating diseases or conditions of one or more physiological or organ systems that generally make the person dependent upon 24-hour-per-day medical, nursing, or health supervision or intervention.
> (165) "Medically fragile" means an individual who is medically complex and whose medical condition is of such a nature that he is technologically dependent, requiring medical apparatus or procedures to sustain life, e.g., requires total parenteral nutrition (TPN), is ventilator dependant, or is dependent on a heightened level of medical supervision to sustain life, and without such services is likely to expire without warning.
> (emphasis added)

24. Consistent with the law, AHCA's agent, eQHealth, performs service authorization reviews under the Prior Authorization Program for Medicaid recipients in the state of Florida. Once eQHealth receives a PPEC service request, its medical personnel conduct file reviews to determine the medical necessity of requested services, pursuant to the authorization requirements and limitations of the Florida Medicaid Program.

25. Fla. Admin. Code Rule 59G-1.010(166) defines medical necessity, as follows:

> "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.

26. As the petitioner is under the age of 21, a broader definition of medically necessary applies, to include the Early and Periodic Screening, Diagnosis, and Treatment Services (EPSDT) requirements. Both EPSDT and Medical Necessity requirements (both cited, above) have been considered in the development of this Order.

27. EPSDT augments the Medical Necessity definition contained in the Florida Administrative Code via the additional requirement that all services determined by the agency to be medically necessary for the *treatment, correction, or amelioration* of problems be addressed by the appropriate services.

28. United States Court of Appeals for the Eleventh Circuit clarified the states' obligation for the provision of EPSDT services to Medicaid-eligible children in Moore v. Reese, 637 F.3d 1220, 1255 (11th Cir. 2011). The Court provided the following guiding principles in its opinion, (which involved a dispute over private duty nursing):

> (1) [A state] is required to provide private duty nursing services to [a child Medicaid recipient] who meets the EPSDT eligibility requirements, when such services are medically necessary to correct or ameliorate [his or her] illness and condition.
> (2) A state Medicaid plan must include "reasonable standards ... for determining eligibility for and the extent of medical assistance" ... and such standards must be "consistent with the objectives of" the Medicaid Act, specifically its EPSDT program.
> (3) A state may adopt a definition of medical necessity that places limits on a physician's discretion. A state may also limit required Medicaid

> services based upon its judgment of degree of medical necessity so long as such limitations do not discriminate on the basis of the kind of medical condition. Furthermore, "a state may establish standards for individual physicians to use in determining what services are appropriate in a particular case" and a treating physician is "required to operate within such reasonable limitations as the state may impose."
> (4) The treating physician assumes "the primary responsibility of determining what treatment should be made available to his patients." Both the treating physician and the state have roles to play, however, and "[a] private physician's word on medical necessity is not dispositive."
> (5) A state may establish the amount, duration, and scope of private duty nursing services provided under the required EPSDT benefit. The state is not required to provide medically unnecessary, albeit desirable, EPSDT services. However, a state's provision of a required EPSDT benefit, such as private duty nursing services, "must be sufficient in amount, duration, and scope to reasonably achieve its purpose."
> (6) A state "may place appropriate limits on a service based on such criteria as medical necessity." In so doing, a state "can review the medical necessity of treatment prescribed by a doctor on a case-by-case basis" and my present its own evidence of medical necessity in disputes between the state and Medicaid patients (citations omitted).

29. In the instant case, PPEC is requested to treat and ameliorate the supervisory and monitoring needs which Petitioner's health conditions require. As such, in a general sense, PPEC is in keeping with Fla. Admin. Code R. 59G-1.010(166)(1). Because PPEC is a recognized Medicaid service, it is consistent with generally accepted medical standards, per Fla. Admin. Code R. 59G-1.010(166)(3).

30. More specifically, however, Fla. Admin. Code R. 59G-1.010(166) also requires that any authorized service not be in excess of a patient's needs, be furnished in a manner not intended for convenience, and be a service for which no equally effective and less-costly treatment is available. In order for PPEC to fulfill these criteria, the Petitioner must meet the requirements for PPEC, as provided in the PPEC Handbook.

31. There is little evidence to suggest that the Petitioner is dependent upon 24-hour per day medical or nursing care, or that she is dependent upon life-sustaining medical intervention or equipment, such that she would properly be deemed "Medically Complex" or "Medically Fragile." Her need for supervision, general monitoring, and precautions do not constitute a need for "intermittent continuous therapeutic interventions or skilled nursing care."

32. Tellingly, there is currently no skilled therapy or intervention provided to Petitioner at the PPEC site. While the PPEC program is "hosting" ST services, these services, as well as OT and any other needed therapy, can be authorized as distinct services, outside the PPEC environment. Petitioner is encouraged to pursue coordination of same.

34. When jointly considering the requirements of both ESPDT and Medical Necessity, along with a review of the totality of the evidence and legal authority, the undersigned concludes that Respondent has met its burden of proof to terminate PPEC.

36. Petitioner's mother is further encouraged to coordinate with AHCA and Petitioner's CMS case manager, to determine her options for day care, or any other service to meet Petitioner's needs. Should Petitioner request a service and receive a notice denying same, she will retain the right to appeal that/those, specific denial(s).

DECISION

Based upon the foregoing, 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 petitioner is responsible for any financial obligations incurred as the agency has no funds to assist in this review.

DONE and ORDERED this 28 day of December, 2015,

in Tallahassee, Florida.

Patricia C. Antonucci
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
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Copies Furnished To: [redacted] Petitioner
Don Fuller, Area 6, AHCA Field Office Manager

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

[redacted]

PETITIONER,

Vs.

AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 20 Lee
UNIT: AHCA

RESPONDENT.
_____/

APPEAL NO. 15F-07364

CASE NO.

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing in the above-referenced matter telephonically on October 22, 2015, at 3:20 p.m.

APPEARANCES

For the Petitioner: [redacted]
Petitioner's mother

For the Respondent: Patricia Brooks
Program Administrator
Agency for Health Care Administration

STATEMENT OF ISSUE

Did the petitioner prove by a preponderance of the evidence that the Agency for Health Care Administration incorrectly denied his request to remove his wisdom teeth?

PRELIMINARY STATEMENT

[redacted] the petitioner's mother, appeared on behalf of the petitioner, [redacted] ("petitioner"), who was not present. [redacted] appeared as a witness for the petitioner. [redacted] may sometimes hereinafter be referred to as the petitioner's "representative". [redacted] Interpreter [redacted] with Propio Language Services, provided Spanish-English translation for the hearing.

Patricia Brooks, Program Administrator with the Agency for Health Care Administration ("AHCA" or "Agency"), appeared on behalf of the Agency for Health Care Administration. The following individuals appeared as witnesses on behalf of the Agency: Alta Recio, Coordinator at Staywell; Alexandria Hicks, Senior Grievance Coordinator at Staywell; Stephanie Shupe, Senior Grievance Coordinator at Staywell; and John Singer, D.D.S., State of Florida Director for Liberty Dental Plan. Gregory Watson, a Hearing Officer with the Office of Appeal Hearings, was present solely for the purpose of observation.

The respondent introduced respondent's Exhibits "1" through "5", inclusive, at the hearing, all of which were accepted into evidence and marked accordingly. The hearing record in this matter was left open until the close of business on October 29, 2015 for the respondent to provide a copy of the prior authorization request from the petitioner's dentist. Once received, this information was accepted into evidence and marked as respondent's Exhibit "6". The hearing record was then closed.

At the respondent's request, the hearing officer took administrative notice of the Dental Services Coverage and Limitations Handbook.

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 is a minor male.

2. Petitioner was eligible to receive Medicaid services at all times relevant to this proceeding.

3. Petitioner is an enrolled member of Staywell. Staywell is a health maintenance organization ("HMO") contracted by the Agency for Health Care Administration to provide services to certain Medicaid eligible recipients in Florida.

4. Petitioner's effective date of enrollment with Staywell was June 1, 2014.

5. Staywell provides certain dental benefits to its members. With regard to its members under age 21, these benefits include the surgical extraction of wisdom teeth when such medical intervention is determined to be medically necessary.

6. Staywell has contracted Liberty Dental to be its dental vendor. Liberty Dental completes prior authorization reviews of requests for dental services submitted to it by Staywell members.

7. On or about June 30, 2015, the petitioner's dental provider submitted a prior authorization request to Liberty Dental for the following services:

1. Surgical removal of erupted tooth #17;
2. Removal of impacted tooth – partially bony #32;
3. Surgical removal of erupted tooth #1;
4. Surgical removal of erupted tooth #16;
5. Other drugs and/or medicaments, by report #Q3C;
6. Other drugs and/or medicaments, by report #Q4C;
7. Intravenous moderate (conscious) sedation/analgesia – first 30 minutes;
8. Inhalation of nitrous oxide/analgesia, anxiolysis.

8. In a Notice of Action dated July 2, 2015, Staywell informed the petitioner it was denying his request for the removal of his wisdom teeth. The Notice of Action provides the following explanation for the denial of each of the line items referenced in the preceding paragraph:

# 7	This service cannot be authorized because it is related to a denied procedure in the same treatment plan submitted by your dentist.
# 1, 2, 3, 4	Removal of asymptomatic (healthy) tooth/teeth is not a covered benefit.
# 8	This procedure is considered to be a part of an included in a more inclusive procedure. No additional payment or benefit is available.
# 5, 6	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.

9. Teeth # 1, 16, 17, and 32 are an individual's wisdom teeth. They are the last teeth on both the left and right sides of both the top and bottom jaw.

10. The petitioner's dentist included a panoramic x-ray of the petitioner's mouth along with the prior authorization request for the removal of the petitioner's wisdom teeth.

11. The documentation submitted by the petitioner's dentist does not indicate pathology or disease associated with any of the petitioner's wisdom teeth.

12. The documentation submitted by the petitioner's dentist does not indicate any of the petitioner's wisdom have cavities.

13. The petitioner's dentist did not include a narrative along with the prior authorization request explaining the necessity for the removal of the wisdom teeth.

CONCLUSIONS OF LAW

14. 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, Fla. Stat.

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

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

17. In the present case, the petitioner is requesting an additional service. Therefore, in accordance with Fla. Admin. Code R. 65-2.060(1), the burden of proof is assigned to the petitioner.

18. The standard of proof in an administrative hearing is a preponderance of the evidence. The preponderance of the evidence standard requires proof by "the greater weight of the evidence." (Black's Law Dictionary at 1201, 7th Ed.).

19. The Florida Medicaid program is authorized by Chapter 409, Fla. Stat. and Chapter 59G, Fla. Admin. Code. The Medicaid program is administered by respondent.

20. Section 409.905, Fla. Stat. addresses mandatory Medicaid services under the State Medicaid Plan:

> Mandatory Medicaid services.--The agency may make payments for the following services, which are required of the state by Title XIX of the Social Security Act, furnished by Medicaid providers to recipients who are determined to be eligible on the dates on which the services were provided. Any service under this section shall be provided only when medically necessary and in accordance with state and federal law…

21. The definition of medically necessary is found in the Fla. Admin Code. R. 59G-1.010, which states:

> (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.

22. 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. The Handbook states the following 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.

23. Page 1-28 of the Florida Medicaid Provider General Handbook provides a list of HMO covered services. Page 1-30 of the Handbook explains "Other services that plans may provide include dental services, transportation, nursing facility and home and community-based services."

24. 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."

25. The Dental Services Coverage and Limitations Handbook – November 2011 is incorporated by reference in the Medicaid Service Rules by Fla. Admin. Code Rule 59G-4.060.

26. The Dental Services Coverage and Limitations Handbook addresses Covered Child Services (Ages under 21) on Page 2-3 and states as follows:

> The Medicaid children's dental services program may provide reimbursement for diagnostic services, preventive treatment, restorative, endodontic, periodontal, surgical procedures and extractions, orthodontic treatment, and full and partial dentures (fixed and removable) for recipients under age 21.

The removal of wisdom teeth falls under the category of surgical procedures and extractions.

27. The Dental Services Coverage and Limitations Handbook describes Oral Surgery Services on Page 2-13. It explains as follows:

> Oral surgery services include extractions as well as surgical and adjunctive treatment of diseases, injuries, deformities, and defects of the oral and maxillofacial regions.

28. The Staywell Member Handbook explains that Staywell will approve oral surgery for children under age 21. Staywell dental policy is not more restrictive than that of the Agency for Health Care Administration.

29. The petitioner did not provide information documenting the need for the removal of any of his four wisdom teeth. The information submitted by the petitioner's dentist does not indicate any of the four wisdom teeth have pathology or cavities which

would necessitate their removal. The petitioner's dentist also did not include a narrative explaining the medical necessity for the removal of the wisdom teeth.

30. The petitioner has not shown by a preponderance of the evidence that the respondent incorrectly denied his request for the removal of his wisdom teeth.

DECISION

The 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 petitioner is responsible for any financial obligations incurred as the agency has no funds to assist in this review.

DONE and ORDERED this 24 day of November, 2015,

in Tallahassee, Florida.

Peter J. Tsamis

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