



STATE OF FLORIDA
AGENCY FOR HEALTH CARE ADMINISTRATION
OFFICE OF FAIR HEARINGS

FILED

Mar 06, 2023, 9:58 am
OFFICE OF FAIR HEARINGS

[REDACTED]

PETITIONER,

AHCA Case No.: 22-FH2274

Plan ID No.: [REDACTED]

vs.

LIBERTY DENTAL PLAN OF FLORIDA, INC.,

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, a Hearing Officer with the Office of Fair hearings convened a telephonic Fair Hearing on the instant case on February 7, 2023, at 8:32 a.m. Eastern Standard Time ("EST").

APPEARANCES

For the Petitioner:

[REDACTED]
Authorized Representative

For the Respondent:

Kerriann Piccione
State Fair Hearing Analyst
Liberty Dental Plan of Florida, Inc.

STATEMENT OF ISSUE

The issue is whether Petitioner proved by a preponderance of the evidence that Respondent's denial of Dental services [REDACTED]
[REDACTED] was incorrect.

PRELIMINARY STATEMENT

All parties appeared for the Fair Hearing telephonically. [REDACTED]

[REDACTED] Petitioner's Authorized Representative, appeared for the Fair Hearing to provide testimony and did not call any witnesses.

Kerriann Piccione, a State Fair Hearing Analyst for Liberty Dental Plan of Florida, Inc. ("LIBERTY") appeared for the Fair Hearing as a representative for Respondent. Dr. Tamara-Kay Tibby ("Dr. Tibby"), a Clinical Specialist for LIBERTY, appeared for the Fair Hearing as a witness for Respondent.

Marielisa Amador, a Medical Health Care Program Analyst for the Agency for Health Care Administration ("Agency" or "AHCA"), appeared for the Fair Hearing as an observer.

Petitioner did not introduce any exhibits at the Fair Hearing. Prior to the Fair Hearing, Respondent sent to the Office of Fair Hearings and Petitioner a 32-page evidence packet, which was admitted into evidence a Respondent's Composite Exhibit 1. Respondent's Composite Exhibit 1 includes the following documents: an email; a Table of Contents; a cover letter; Member Profile Status; Pre-Authorization Screen Image; a Dental consultation; Dental records; a Dental invoice; a Dental radiograph; a Notice of Adverse Benefit Determination ("NABD") (dated November 16, 2022); Conduent Standard Embedded Dashboard; a Notice of Plan Appeal Resolution ("NPAR") (dated December 9, 2022); and Clinical Dentistry Guidelines.

FINDINGS OF FACT

1. Petitioner is an enrolled member of [REDACTED]. See Respondent's Composite Exhibit 1, pages 3, 6, 21. [REDACTED] is a managed care organization contracted by the Agency to provide services to eligible Medicaid recipients in the state of Florida.

2. As of the date of the Fair Hearing, Petitioner is [REDACTED]. *Id.* at 10. Petitioner's Dental provider is [REDACTED] DMD PA. *Id.* at 3. Petitioner experiences [REDACTED]. *Id.* at 10. Petitioner's dental provider recommended the [REDACTED]. *Id.* at 10-11. Petitioner submitted a dental radiograph. *Id.* at 14. Petitioner's provider submitted a request for requesting the following dental services: [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED] x3." *Id.* at 3,
6. [REDACTED]
[REDACTED]

3. On November 16, 2022, [REDACTED] issued an NABD denying Petitioner's request for Dental services, *supra* ¶ 2, based on medical necessity. *Id.* at 15-18. The NABD explained the basis of the denial as follows, in pertinent part:

[REDACTED] Dental Plan of Florida [REDACTED] has reviewed your request for:

[REDACTED]

[REDACTED] After our review, this service has been **denied** as of 11/16/2022.

We made our decision because:
We determined that your requested services are **not medically necessary** because the services do not meet the reason(s) checked below: (See Rule 59G-1.010) # 1

- **Must be needed to protect life, prevent significant illness or disability, or alleviate severe pain.**
- **Must be individualized, specific, consistent with symptoms or diagnosis of illness or injury and not be in excess of the patient's needs.**
- Must meet accepted medical standards and not be experimental or investigational.

- **Must be able to be 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.**
- **Must be furnished in a manner not primarily intended for convenience of the recipient, caretaker, or provider.**

(The convenience factor is not applied to the determination of the medically necessary level of private duty nursing (PDN) for children under the age of 21.)

The facts that we used to make our decision are:

1, 2 MMM721MM721: The service is denied. **For this service to be approved you must have signs of pain or infection in the tooth. Based on your x-rays/notes you do not have any signs of pain or infection. Please check with your dentist for other options. This decision was based on LIBERTY Dental Plan Clinical Criteria.**

...

Sincerely,

Dr. John Soumi - Licensed Dentist

LIBERTY Dental Plan

Respondent's Composite Exhibit 1, pages 15-18. (Emphasis added).

4. On December 8, 2022, Petitioner requested a plan appeal. *Id.* at 21-22. On December 9, 2022, [REDACTED] issued an NPAR upholding the denial of Petitioner's request for Dental services.

Id. The NPAR states the following, in pertinent part:

On December 8, 2022, we received your timely plan appeal request regarding [REDACTED] Dental Plan's [REDACTED] Notice of Adverse Benefit Determination dated November 16, 2022, NABD Number 40786064, denying the tooth removal partially covered (D7230) teeth #s 1 and 16.

On December 9, 2022, after consideration of the information you provided to LIBERTY in support of your plan appeal [REDACTED] **hereby denies your plan appeal because teeth #s 1 and 16 have a clear path come through, there is no x-ray to show infection, pain or blocking another tooth from coming out.** Therefore, they do not meet the standard needed to be covered.

...

Sincerely,

Dr. Rosa Roldan, Dental Director

Respondent's Composite Exhibit 1, pages 23-24. (Emphasis added).

5. [REDACTED] Clinical Dentistry Guidelines for Dentures state the following:

ORAL SURGERY

Each dental extraction should be based on a clearly recorded diagnosis for which extraction is the treatment of choice of the dentist and the patient.

- A. General dentists are expected to provide routine oral surgery, including:
 - 1. uncomplicated extractions and emergency palliative care
 - 2. routine surgical extractions
 - 3. incision and drainage of intra-oral abscesses
 - 4. minor surgical procedures and postoperative services
- B. Extractions may be indicated in the presence of non-restorable caries, untreatable periodontal disease, pulpal and periapical disease not amendable to endodontic therapy, to facilitate surgical removal of a cyst or neoplasm, or when overriding medical conditions exist, providing compelling justification to eliminate existing or potential sources of oral infection.
 - 1. When teeth are extracted, all portions of the teeth should be removed. If any portion of a tooth (or teeth) is not removed, patient notification must be documented.
 - 2. Post extraction socket irrigation, regardless of the type of material used, is inclusive with the extraction. Medicaid enrollees cannot be charged for oral surgery irrigation materials.
 - 3. Local anesthesia is preferred in the absence of specific indications for the use of general anesthesia.
 - 4. Minor contouring of bone and soft tissues during a surgical extraction are considered a part of and included in a surgical extraction, D7210.
 - 5. Documentation of a surgical procedure should include the tooth number, tissue removed, a description of the surgical method used, a record of unanticipated complications such as failure to remove planned tissue/root tips, displacement of tissue to abnormal sites, unusual blood loss, presence of lacerations and other surgical or non-surgical defects.
 - 6. All extractions must be coded in accordance with the current CDT manual in addition to guidelines developed by the ADA:
- C. Each dental extraction should be based on a clearly recorded diagnosis for which extraction is the treatment of choice of the dentist and the patient. **A surgical extraction includes local anesthesia, suturing if needed, and postoperative care following extraction (e.g., dry socket, infection, bleeding, re-suturing).**
 - 1. For extraction of a deciduous tooth (Codes D7111 and D7140) there must be evidence of medical necessity showing that the tooth has pathology and will not exfoliate soon (within the next six months) or a patient complaint of acute pain.
 - 2. During our clinical review of requests for extraction of impacted and/or erupted teeth, LIBERTY may determine that treatment better fits the

description of a different, more appropriate procedure code. In that situation, LIBERTY may approve the extraction under a different code.

...

THIRD MOLAR EXTRACTIONS AND BENEFIT DETERMINATION

- A. LIBERTY licensed clinical reviewers adjudicate benefits on a case-by-case basis.
- B. Third molar extractions are only covered when listed as a Plan Benefit and there is active pathology present.
- C. Definition of Active Pathology: Pain, swelling, bleeding, or infection. Each tooth must qualify individually.
- D. Definition of Impacted Tooth: An unerupted or partially erupted tooth that is positioned against another tooth, bone, or soft tissue so that complete eruption is unlikely.

The ADA's position is that when coding for removal of impacted teeth the selection of either D7230 or D7240 is dependent on the definition of an "anatomical crown". The full entries for these codes, as published in the CDT Manual, are:

D7230 removal of impacted tooth – partially bony

Part of crown covered by bone; requires mucoperiosteal flap elevation and bone removal.

D7240 removal of impacted tooth – completely bony

Most or all of crown covered by bone; requires mucoperiosteal flap elevation and bone removal. An "anatomical crown" as defined by the ADA's Glossary of Dental Clinical and Administrative Terms is as follows: anatomical crown: That portion of tooth normally covered by, and including, enamel.

Given this definition, the "crown" referenced in these codes' descriptors are the portion of the tooth above the cemento-enamel junction. It follows that "part of the crown" should be interpreted as "less than 50% of the entire crown" and "most or all of the crown" should be interpreted as "at least or more than 50% of the entire crown."

- E. **The prophylactic removal of a tooth or teeth that appear to exhibit an unimpeded path of eruption and/or exhibit no active pathology is not covered.**
- F. The removal of asymptomatic, unerupted, third molars in the absence of active pathology is not covered.
- G. By definition, completely covered and unerupted third molars cannot exhibit pericoronitis.
 - a. Narratives describing the presence of pericoronitis on a fully erupted tooth are ambiguous. In such cases, the radiographic or

photographic presentation will be the determining factor in the determination of coverage.

- H. Coronectomy (Code D7251) is an intentional partial removal of an impacted tooth when a neurovascular complication is likely if the entire impacted tooth is removed.
- I. All suspicious lesions should be biopsied and examined microscopically.

Deep sedation/general anesthesia – Pre-authorization is required, however if treatment is approved separate from deep sedation/general anesthesia payment is subject to documentation review prior to payment. Refer Section 7 above for process to obtain a medically necessary review for an acute care hospital, sedation or surgery center service, by LIBERTY.

Respondent’s Composite Exhibit 1, pages 28-32. (Emphasis added).

6. On December 9, 2022, [REDACTED] requested a Fair Hearing on behalf of Petitioner regarding the denial of dental services. On January 19, 2023, the Office of Fair Hearings issued a notice to all parties of record scheduling the Fair Hearing to be conducted by telephone on February 7, 2023, at 8:30 a.m. EST.

7. According to [REDACTED]’ testimony presented at the Fair Hearing, Petitioner is requesting the extraction of [REDACTED]

8. According to Ms. Piccione’s testimony and Dr. Tibby’s testimony presented at the Fair Hearing, LIBERTY denied Petitioner’s request because there was no evidence that [REDACTED]

[REDACTED] Dr. Soumi and Dr. Roldan reviewed Petitioner’s case, reached the same conclusion, and issued the NABD and NPAR. See supra ¶ 3-4. LIBERTY’s Staff Dentist Dr. Puja Patel (Dr. Patel) also reviewed the request for Dental services and determined that, “teeth #’s 1 and 16 appear to be impacted with no signs of apical pathosis or caries. There appears to be a straight path of eruption for each

tooth and neither tooth appears to be impeding the eruption of any other.” *Id.* at 3. Dr. Tibby also reviewed the case and opined that Petitioner’s pain will be alleviated with the approved

[REDACTED]

CONCLUSIONS OF LAW

9. The Agency’s Office of Fair Hearings has jurisdiction over the subject matter of this proceeding and the parties pursuant to section 409.285(2), Florida Statutes (2022). This order is the final administrative decision of AHCA under Fla. Stat. § 409.285(2)(a).

10. This hearing was held as a *de novo* proceeding pursuant to Florida Administrative Code Rule (“Fla. Admin. Code R.”) 59G-1.100(17)(b).

11. Because Petitioner is requesting a new service, Fla. Admin. Code R. 59G-1.100(17)(g) assigns the burden of proof to Petitioner. 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.).

12. Petitioner’s request for Dental services is governed by the Florida Medicaid Dental Coverage Policy (August 2018) (“Dental Policy”), which is incorporated by reference in Fla. Admin.

Code R. 59G-4.060. The Dental Policy provides the following:

1.0 INTRODUCTION

Florida Medicaid provides dental services for the study, screening, assessment, diagnosis, prevention, and treatment of diseases, disorders, and conditions of the oral cavity.

1.1 Florida Medicaid Policies

This policy is intended for use by providers that render dental services to eligible Florida Medicaid recipients. It must be used in conjunction with Florida Medicaid’s general policies (as defined in section 1.3) and any applicable service-specific and claim reimbursement policies with which providers must comply.

Note: All Florida Medicaid policies are promulgated in Rule Division 59G, Florida Administrative Code (F.A.C.). Coverage policies are available on the Agency for Health Care Administration's (AHCA) Web site at <http://ahca.myflorida.com/Medicaid/review/index.shtml>.

1.2 Statewide Medicaid Managed Care Plans

Florida Medicaid managed care plans must comply with the service coverage requirements outlined in this policy, unless otherwise specified in the AHCA contract with the Florida Medicaid managed care plan. The provision of services to recipients enrolled in a Florida Medicaid managed care plan must not be subject to more stringent service coverage limits than specified in Florida Medicaid policies. 1.4 Definitions

1.4 Definitions

The following definitions are applicable to this policy. For additional definitions that are applicable to all sections of Rule Division 59G, F.A.C., please refer to the Florida Medicaid Definitions Policy.

1.4.6 Medically Necessary/Medical Necessity

As defined in Rule 59G-1.010, F.A.C.

1.4.7 Provider

The term used to describe any entity, facility, person, or group enrolled with AHCA to furnish services under the Florida Medicaid program in accordance with the provider agreement.

1.4.8 Recipient

For the purpose of this coverage policy, the term used to describe an individual enrolled in Florida Medicaid (including managed care plan enrollees).

...

4.0 COVERAGE INFORMATION

4.1 General Criteria

Florida Medicaid reimburses for services that meet all of the following:

- Are determined to be medically necessary
- Do not duplicate another service
- Meet the criteria as specified in this policy

4.2 Specific Criteria

Florida Medicaid covers dental services in accordance with the American Dental Association's Current Dental Terminology Manual, the American Academy of Pediatrics' Periodicity Schedule, and the applicable Florida Medicaid fee schedule(s), or as specified in this policy:

4.2.9 Surgical Procedures and Extractions

Florida Medicaid covers surgical procedures and extraction services for recipients under the age of 21 years.

Florida Medicaid covers emergency dental services for recipients age 21 years and older to alleviate pain, infection, or both, and procedures essential to prepare the mouth for dentures.

4.3 Early and Periodic Screening, Diagnosis, and Treatment

As required by federal law, Florida Medicaid provides services to eligible recipients under the age of 21 years, if such services are medically necessary to correct or ameliorate a defect, a condition, or a physical or mental illness. Included are diagnostic services, treatment, equipment, supplies, and other measures described in section 1905(a) of the SSA, codified in Title 42 of the United States Code 1396d(a). As such, services for recipients under the age of 21 years exceeding the coverage described within this policy or the associated fee schedule may be approved, if medically necessary. For more information, please refer to Florida Medicaid's Authorization Requirements Policy.

...

5.0 EXCLUSION

5.1 General Non-Covered Criteria

Services related to this policy are not covered when any of the following apply:

- The service does not meet the medical necessity criteria listed in section 1.0
- The recipient does not meet the eligibility requirements listed in section 2.0
- The service unnecessarily duplicates another provider's service

5.2 Specified Non-Covered Criteria

Florida Medicaid does not cover the following as part of this service benefit:

- Anesthesia for restorative services, when billed separately
- Dental screening and assessment performed by an RDH on the same date of service as an evaluation performed by a dentist
- Fixed partial dentures for recipients 21 years and older
- Full mouth scaling performed on the same date of service as root planning or periodontal scaling
- Individual periapical radiographs(s) on the same date of service when the reimbursement amount exceeds that of a complete series
- Intraoral-completes series and a panoramic film on the same date of service

13. States must provide Early and Periodic Screening, Diagnostic, and Treatment ("EPSDT") services to Medicaid-eligible children under age 21 when requested under the Medicaid state

plan. See 42 U.S.C. § 1396a(a)(43); 42 U.S.C. § 1396d(a)(4). According to 42 U.S.C. § 1396d(r)(5),

EPSDT services mean, in relevant part, the following items and services:

Such other necessary health care, diagnostic services, treatment, and other measures described in subsection (a) of this section to correct or ameliorate defects and physical and mental illness and conditions discovered by the screen services, whether or not such services are covered under the state plan.

14. Petitioner is under the age of 21 years, and therefore EPSDT applies to [redacted] request for services. However, a state may place medical necessity limitations on EPSDT services. See 42 C.F.R. §§ 440.230(a), (b), (d). Fla. Stat. § 409.905(2) limits EPSDT services with a medical necessity standard:

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.

15. The Florida Medicaid Definitions Policy (August 2017) (“Definitions Policy”), incorporated by reference in Fla. Admin. Code R. 59G-1.010, provides definitions of commonly used terms that are applicable to all sections of Rule Division 59G, Florida Administrative Code (F.A.C.), unless specifically stated otherwise in a service-specific coverage policy or rule. The Definitions Policy defines “Medically Necessary” or “Medical Necessity” as follows:

2.83 Medically Necessary or Medical Necessity

The medical or allied care, goods, or services furnished or ordered must meet the following conditions:

- Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate pain
- **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**

- Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational
- 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
- Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient’s caretaker, or the provider

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.

(Emphasis added).

19. Petitioner requested the extraction of their four (4) [REDACTED]. [REDACTED]. See supra ¶ 2. Respondent approved the extraction [REDACTED] as well [REDACTED] after determining that the Dental services were medically necessary. See supra ¶ 2. In NABD, Petitioner’s request was denied based on the submitted documentation and Respondent’s internal criteria. See supra ¶ 3. Respondent explained that Petitioner’s request was not medically necessary, as Petitioner’s request was not “needed to protect life, prevent significant illness or disability, or alleviate severe pain” nor was it “individualized, specific, consistent with symptoms or diagnosis of illness or injury” and was “in excess of the patient’s needs.” *Id.* Respondent determined that the criteria for [REDACTED]. [REDACTED]. [REDACTED]” See supra ¶ 3-4. Based on the assessment of Dr. Patel, Dr. Soumi, and Dr. Roldan, Petitioner’s Dental provider did not show Petitioner’s [REDACTED]. [REDACTED]

20. As Petitioner bears the burden of proof, Petitioner must show by a preponderance of the evidence that Respondent's decision was incorrect. Here, Petitioner did not establish that the extractions of Petitioner's [REDACTED] were not "in excess of the patient's needs." As shown by the record, there is no sign of infection or pathology, *supra* ¶ 8, that warrant extractions of these teeth. See *supra* ¶ 3-4, 8. Moreover, Petitioner's [REDACTED] at issue are [REDACTED]. See *supra* ¶ 8. The dental pain that Petitioner is experiencing would be alleviated after [REDACTED]. See *supra* ¶ 8. Petitioner and [REDACTED] relied upon the recommendation of the dental provider. See *supra* ¶ 7. The Hearing Officer considered the dental provider's recommendation. However, the fact that a provider has recommended services does not, in itself, make such services medically necessary. See *supra* ¶ 18. Here, the Hearing Officer found Dr. Tibby's testimony, *supra* ¶ 8, regarding Petitioner's dental condition and dental needs to be credible and reliable. The greater weight of evidence, the assessment of Respondent's four (4) dental consultants (Dr. Soumi, Dr. Roldan, Dr. Patel, and Dr. Tibby), reflects that Petitioner's teeth do not need to be removed.

21. Dr. Tibby's credible testimony at the Fair Hearing established that she is qualified in making medical necessity determinations regarding the extractions of [REDACTED]. See *supra* ¶ 8. Dr. Tibby's professional assessment is that the Petitioner's [REDACTED] [REDACTED] do not present an infection or pathology. See *supra* ¶ 8. The records indicates that Petitioner experiences some level of pain, *supra* ¶ 2, but as of right now, there is no evidence Petitioner is experiencing more than normal eruption pain or that the pain would not be alleviated by extracting the teeth already approved (teeth #17, #32). As such,

Petitioner did not show that [REDACTED] request was “individualized, specific, [and] consistent with the symptoms or diagnosis of illness or injury” and not “in excess of the patient’s needs.” Further, regarding Petitioner’s request for sedation, Petitioner did not provide any testimony or evidence on the record as to why this service would be medically necessary once the underlying services are denied. As such, Petitioner did not demonstrate that the requested dental services were medically necessary.

22. Upon consideration of the testimony provided at the Fair Hearing, the documentary evidence submitted, and the applicable policies, the undersigned Hearing Officer concludes that Petitioner did not prove by a preponderance of the evidence that the requested Dental services are medically necessary. Looking at all the evidence relevant to the particular needs of Petitioner, Petitioner has not shown that the requested services are necessary to provide “relief of pain and infections, restoration of teeth, and maintenance of dental health” or to correct or ameliorate a defect or a physical and mental illness or condition. Accordingly, the undersigned Hearing Officer finds that Petitioner *has not* proved by a preponderance of the evidence that Respondent’s denial of Dental services was incorrect.


IT IS THEREFORE ORDERED AND ADJUDGED:

Respondent’s denial of Dental services (the Dental Extractions of two [REDACTED]
[REDACTED] is hereby **AFFIRMED**. Petitioner’s appeal based on Respondent’s denial is hereby **DENIED**.

DONE and ORDERED this 6th day of March 2023, in Tallahassee, Leon County, Florida.

Laura Gallagher

22-FH2274

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LAURA GALLAGHER, Hearing Officer
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NOTICE OF A RIGHT TO JUDICIAL REVIEW

A PARTY WHO IS ADVERSELY AFFECTED BY THIS FINAL ORDER IS ENTITLED TO JUDICIAL REVIEW, WHICH SHALL BE INSTITUTED BY FILING THE ORIGINAL NOTICE OF APPEAL WITH THE AGENCY CLERK OF AHCA, AND A COPY, ALONG WITH THE FILING FEE PRESCRIBED BY LAW, WITH THE DISTRICT COURT OF APPEAL IN THE APPELLATE DISTRICT WHERE THE AGENCY MAINTAINS ITS HEADQUARTERS OR WHERE A PARTY RESIDES. REVIEW PROCEEDINGS SHALL BE CONDUCTED IN ACCORDANCE WITH THE FLORIDA APPELLATE RULES. THE NOTICE OF APPEAL MUST BE FILED WITHIN 30 DAYS OF THE RENDITION OF THE ORDER TO BE REVIEWED.

Copies Furnished To:



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AHCA Medicaid Hearing Unit
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