

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



FILED

May 23, 2023, 11:46 am

OFFICE OF FAIR HEARINGS

[REDACTED]
PETITIONER,

AHCA Case No.: 23-FH0085

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 March 20, 2023, at 12:02 p.m. Eastern Standard Time ("EST").

APPEARANCES

For the Petitioner:

[REDACTED]
Petitioner's Authorized Representative

For the Respondent:

Megan Peake
Manager of Grievance and Appeals
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 (Orthodontic Braces) was incorrect.

PRELIMINARY STATEMENT

All parties appeared for the Fair Hearing telephonically. [REDACTED] (“[REDACTED]”), Petitioner’s Authorized Representative and [REDACTED] appeared for the Fair Hearing to provide testimony and did not call any witnesses.

Megan Peake, the Manager of Grievances and Appeals 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.

The following persons appeared for the Fair Hearing as an observer: Sandra Durden, Medical Health Care Program Analyst for the Agency for Health Care Administration (“Agency” or “AHCA”); Angela Aguilar, State Fair Hearing Analyst for LIBERTY; Dr. Kelly Clair, Dental Quality Specialist for LIBERTY; Sharon Calvin, a State Fair Hearing Analyst for LIBERTY.

Petitioner did not introduce any exhibits at the Fair Hearing. Prior to the Fair Hearing, Respondent sent to the Office of Fair Hearings (“Office”) and Petitioner an eighty-four (84)-page evidence packet, which was admitted into evidence a Respondent’s Composite Exhibit 1. Respondent’s Composite Exhibit 1 includes the following documents: a Table of Contents; a cover letter; Member Profile Status; a Dental Claim Form; [REDACTED] email; a Notice of Adverse Benefit Determination (“NABD”) (dated November 30, 2022); Conduent Standard Embedded Dashboard; a Notice of Plan Appeal Resolution (“NPAR”) (dated December 19, 2022); the Florida Medicaid Definitions Policy (August 2017); the Florida Medicaid Dental Services Coverage Policy (August 2018); and LIBERTY’s Florida Medicaid Dental Program Member Handbook (Effective date: October 1, 2021).

FINDINGS OF FACT

1. Petitioner is an enrolled member of LIBERTY. See Respondent's Composite Exhibit 1, pages 1-2, 12. LIBERTY 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] old. *Id.* at 4. Petitioner's dental provider is Dr. Marina Amelinckx-Stasi ("Dr. Amelinckx-Stasi") of [REDACTED]. *Id.* at 5, 15. Petitioner submitted a claim for comprehensive orthodontic treatment (code D8080) ("Orthodontic Braces"). *Id.* at 5. Petitioner received the requested Orthodontic Braces on [REDACTED], and submitted a bill for [REDACTED] to LIBERTY for reimbursement. *Id.* at 7-8.

3. On June 21, 2022, LIBERTY issued an NABD denying Petitioner's request. *Id.* at 7-9. The NABD explained the basis of the denial as follows, in pertinent part:

This is to let you know you had medical claim(s) that was (were) not paid. This letter doesn't mean you must pay the covered services. **This is not a bill.**

What is a Notice of Adverse Benefit Determination (NABD)?

A Notice of Adverse Benefit Determination (NABD) lets you know that a claim a provider submitted for services you got is not being paid.

What do the terms on the NABD mean?

Date of Service-the date you visited your provider 09/19/2022

Service(s) Provided-the type of service(s) you got from the provider

Submitted Charges-the amount that was billed by the provider for each service

Denial Reason-the reason LIBERTY Dental is not paying the provider for the service

Do you owe the provider any money?

No. You don't owe the provider any money. There are some exceptions. For instance, if you requested a non-covered service and agreed in advance to pay the provider. For any exceptions, the provider must clearly tell you before you get the service that you will have to pay for it.

...

Denial reason

1 Payment for this service is denied because this plan does not cover services from a provider who is not in network. This provider was not contracted on the date of service. Please refer to the Member Handbook or Evidence of Coverage (EOC) booklet. For additional information, you may contact us at LIBERTYDentalPlan.com or call us at 888-703-6999.

Respondent's Composite Exhibit 1, pages 7-9.

4. On December 7, 2022, Petitioner requested a plan appeal. *Id.* at 12. On December 19, 2022, LIBERTY issued an NPAR upholding the denial. *Id.* at 17-19. The NPAR states the following, in pertinent part:

On December 19, 2022, after consideration of the information you provided to LIBERTY in support of your plan appeal, LIBERTY hereby denies your plan appeal.

This is because on December 19, 2022, LIBERTY completed an administrative review of the denial and determined that the dentist you saw on [REDACTED] is out of network with your Florida Medicaid Child Plan. LIBERTY's records support that Dr. Marina Amelinckx at Marina Amelinckx, D.D.S. is out of network with your plan. To utilize your dental benefits, you must visit a contracted and in network dental office.

You don't owe the provider any money. There are some exceptions. For instance, if you requested a non-covered service and agreed in advance to pay the provider. For any exceptions, the provider must clearly tell you before you get the service that you will have to pay for it. Should you need assistance in locating in-network providers in her area and determining your dental benefits, please contact LIBERTY's Member Services Department at (888) 703-6999, Monday through Friday 8:00 a.m. to 5:00 p.m.

Please note that Page 13 of the Florida Medicaid Member Handbook says: *"For the most part, you must use dentists and other dental providers that are in our provider network. Our provider network is the group of dentists and other dental providers that we work with. You can choose from any provider in our provider network. This is called your freedom of choice. If you use a dental provider that is not in our network, you may have to pay for that appointment or service."*

Respondent's Composite Exhibit 1, pages 17-19. (Emphasis added).

5. LIBERTY's Member Handbook states the following, in pertinent part:

Providers in Our Plan

For the most part, you must use dentists and other dental providers that are in our **provider network**. Our provider network is the group of dentists and other dental providers that we work with. You can choose from any provider in our provider network. This is called your freedom of choice. If you use a dental provider that is not in our network, you may have to pay for that appointment or service. You will find a list of providers that are in our network in our provider directory. If you do not have a provider directory, call 1-833-276-0850 or TTY 1-877-855-8039 to get a copy or visit our website at www.libertydentalplan.com/FLMedicaid.

Providers Not in Our Plan

There are times when you can get services from providers who are not in our plan when the services are reviewed and approved by LIBERTY. If you need a service and we cannot find a provider in our plan for these services, we will help you find another provider that is not in our plan. Remember to check with us first before you use a provider that is not in our provider network. If you have questions, call Member Services.

Respondent's Composite Exhibit 1, page 55.

6. On January 17, 2023, [REDACTED] requested a Fair Hearing on behalf of Petitioner. On February 9, 2023, the undersigned issued a notice to all parties of record scheduling the Fair Hearing to be conducted by telephone on March 20, 2023, at 12:00 p.m. EST.

7. At the Fair Hearing, [REDACTED] testified that [REDACTED] mistakenly believed that Petitioner received preauthorization for Orthodontic Braces. [REDACTED] took Petitioner to several in-network dental providers before deciding on an out-of-network dental provider to perform the orthodontic services at issue. [REDACTED] testified that [REDACTED] signed an installment agreement with the out-of-network dental provider to pay for the orthodontic services that Petitioner received. [REDACTED] would like to be reimbursed for the out-of-network dental services.

8. Ms. Peake testified that LIBERTY approved an orthodontic consultation to determine if Orthodontic Braces are needed. Ms. Peake asserted that LIBERTY did not approve the Petitioner to actually receive Orthodontic Braces and monthly visits, which is what Petitioner is seeking

reimbursement for. Ms. Peake testified that Petitioner's request for Orthodontic Braces was denied because the provider is out-of-network. Ms. Peake testified that orthodontic services require pre-authorization and no authorization or approval was given for Orthodontic Braces.

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 section 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. Fla. Admin. Code R. 59G1.100(3)(g) states that the Agency has jurisdiction and must provide a fair hearing for "[a] recipient who makes a hearing request regarding a denial or reduction to a medically necessary Florida Medicaid service and seeks corrective action." A Hearing Officer may prescribe corrective action retroactively to the date the incorrect action was taken. Fla. Admin. Code R. 59G-1.100(18)(f).

13. Florida Medicaid Provider General Handbook, at page 1-4, states:

Payments for Services

Direct Payments to Providers

Medicaid provides an eligible recipient with access to Medicaid services by direct payment to the Medicaid provider upon submission of a payable claim to the Medicaid fiscal agent. Payments for Medicaid services must be made by direct payment to the provider, except in the following circumstances:

- Payment may be made in accordance with a reassignment from the provider to a government agency or reassignment by court order.
- Payment may be made in the name of the provider to the provider's Medicaid-enrolled billing agent's address.

14. 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. See Respondent's Composite Exhibit 1, pages 35-42. The Florida Medicaid Dental Policy provides the following, in pertinent part:

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

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.

1.4.4 Handicapping Malocclusion

A condition that results in a disability or impairment to the recipient's physical development.

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).

...

3.0 Eligible Provider

3.1 General Criteria

Providers must meet the qualifications specified in this policy in order to be reimbursed for Florida Medicaid dental services.

3.2 Who Can Provide

Services must be rendered by one of the following:

- Practitioners licensed in accordance with Chapter 466, F.S. and working within the scope of their practice
- County health departments administered by the Florida Department of Health in accordance with Chapter 154, F.S.
- Federally qualified health centers approved by the Public Health Service
- Dental interns and dental graduates permitted or temporarily certified to practice in accordance with section 466.025, F.S.

Registered dental hygienists (RDH) working within the scope of their practice may provide services to recipients in health access settings in accordance with Chapter 466, F.S.

...

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:

4.2.4 Orthodontic Services

Florida Medicaid covers orthodontic services for recipients under the age of 21 years with handicapping malocclusions as follows:

- Up to 24 units within a 36 month period, including the removal of the appliances and retainers at the end of treatment
- One replacement retainer(s) per arch, per lifetime

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

Respondent's Composite Exhibit 1, pages 35-42.

15. Because Petitioner is under the age of 21 years, the requirements of Early and Periodic Screening, Diagnostic, and Treatment (“EPSDT”) apply. According to 42 U.S.C. § 1396d(r)(5), EPSDT services mean, in relevant part, the following items and services:

(3) Dental Services

(A) which are provided –

(i) at intervals which meet reasonable standards of dental practice, as determined by the State after consultation with recognized dental organizations involved in child health care, and

(ii) at such other intervals, indicated as medically necessary, to determine the existence of a suspected illness or condition; and

(B) which shall at a minimum include relief of pain and infections, restoration of teeth, and maintenance of dental health.

Further, according to 42 U.S.C. § 1396d(r)(5), EPSDT include, 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.

16. The Florida Medicaid Definitions Policy (August 2017) (“Definitions Policy”), incorporated by reference in Fla. Admin. Code R. 59G-1.010, 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.

Respondent's Composite Exhibit 1, page 23-34. (Emphasis added).

17. In the instant case, Petitioner requested reimbursement for orthodontic services rendered on [REDACTED]. See supra ¶ 3. Petitioner's request for reimbursement was denied because the charges related to services provided by an out of network provider without prior authorization. See supra ¶ 4.

18. As provided in Rule 59G1.100(3)(g), F.A.C., a hearing officer may prescribe corrective action "regarding a denial or reduction to a medically necessary Florida Medicaid service." See supra ¶ 15. A Hearing Officer may prescribe corrective action retroactively to the date the incorrect action was taken. See supra ¶ 12-13.

19. Section 4.1 of the Dental Policy provides that Florida Medicaid reimburses for services that: (a) are determined medically necessary pursuant to the Dental Policy; (b) do not duplicate another service; and (c) meet the criteria as specified in the Dental Policy. See supra ¶ 14. The Definitions Policy requires that a request for dental services meet all five conditions of medical necessity. See supra ¶ 16. As stated in the Dental Policy, Florida Medicaid reimburses according to the applicable Florida Medicaid fee schedule(s). See supra ¶ 14. Payments are made directly to the Medicaid provider upon submission of a payable claim to the Medicaid fiscal agent. See supra ¶ 13.

20. The records reflects that the denial was warranted in this case. As the NPAR and Ms. Peake's testimony show, LIBERTY did not pre-authorize the Petitioner to receive Orthodontic

Braces and monthly visits. *See supra* ¶ 4, 8. Accordingly, Respondent never determined that Orthodontic Braces are medically necessary for Petitioner. *See supra* ¶ 7-8. Further, [REDACTED] testified that [REDACTED] made the decision to take Petitioner to an out-of-network provider and entered into a financial agreement for the Orthodontic Braces at issue. *See supra* ¶ 7. Therefore, [REDACTED] [REDACTED] seeks reimbursement for the services of an out-of-network provider. In this case, there was no evidence (e.g., testimony, dental narrative, ADA dental claim form, or dental radiographs) presented to show that Orthodontic Braces and monthly visits are medically necessary. 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. *See supra* ¶ 16.

21. The Florida Medicaid program only covers medically necessary services rendered by an eligible provider. *See supra* ¶ 13. Petitioner did not establish that the Orthodontic Braces are pre-authorized and medically necessary. Nor did Petitioner establish that the orthodontist is in network. Accordingly, Petitioner has not met his burden of demonstrating that the Orthodontic Braces rendered on [REDACTED], are medically necessary or a covered benefit.

22. Based on the testimony, Respondent's Composite Exhibit 1, and the applicable laws and policies, the undersigned concludes that Respondent correctly denied Petitioner's request for Orthodontic Braces and correctly denied Petitioner's request for reimbursement in the amount of \$5,495.00.

IT IS THEREFORE ORDERED AND ADJUDGED:

Respondent's denial of dental services (Orthodontic Braces and monthly visits) is hereby **AFFIRMED**. Petitioner's appeal based on Respondent's denial is hereby **DENIED**.

Petitioner's request for Correction Action is hereby **DENIED**.

DONE and ORDERED this 23rd day of May, 2023, in Tallahassee, Leon County, Florida.

Laura Gallagher

23-FH0085



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LAURA GALLAGHER, Hearing Officer
Agency for Health Care Administration
Office of Fair Hearings
2727 Mahan Drive, Mail Stop # 11
Tallahassee, FL 32308-5407

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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