



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

**FILED**

Jan 25, 2024, 3:55 pm

OFFICE OF FAIR HEARINGS

[REDACTED],

PETITIONER,

AHCA Case No.: 23-FH2737

Plan ID No.: [REDACTED]

vs.

DENTAQUEST OF FLORIDA, INC.,

RESPONDENT.

\_\_\_\_\_ /

**FINAL ORDER**

Pursuant to notice, the undersigned Hearing Officer convened a telephonic Fair Hearing in the instant case on December 7, 2023, at 1:00 p.m. Eastern Standard Time (“EST”).

**APPEARANCES**

For the Petitioner:

[REDACTED]

Petitioner’s Authorized Representative

For the Respondent:

Mayckol Chamorra  
Grievances and Appeals Specialist  
DentaQuest 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 (preventative services) was incorrect.

**PRELIMINARY STATEMENT**

All parties and witnesses appeared for the scheduled Fair Hearing telephonically.

[REDACTED] (“[REDACTED]”), appeared on behalf of Petitioner.

Mayckol Chamorra, Complaints and Grievances Specialist for DentaQuest of Florida, Inc. (“DentaQuest”) appeared on behalf of the Respondent.

Chrissie Simmons, Program Operations Administrator for the Agency for Health Care Administration (“Agency” or “AHCA”), appeared as an observer.

Petitioner did not introduce any exhibits at the Fair Hearing.

Prior to the Fair Hearing, Respondent filed with the Office of Fair Hearings and Petitioner a thirty-four (34)-page evidence packet. The evidence packet appears in the Office of Fair Hearings’ case management system as “23-FH2737 Evidence Packet.pdf.” Without objection, the evidence packet was admitted into evidence as Respondent’s Composite Exhibit 1.

#### **FINDINGS OF FACT**

1. Petitioner is an enrolled member of DentaQuest, a managed care organization contracted by the Agency to provide services to eligible Medicaid recipients in Florida. See page 10 of Respondent’s Composite Exhibit 1.
2. Petitioner is [REDACTED]. *Id.*
3. Petitioner’s provider, [REDACTED], DDS, submitted a treatment authorization request for preventative services for Petitioner, namely for codes D0120, D1120, D1208, and D1330, which services were performed on July 31, 2023. *Id.*
4. On or about July 31, 2023, DentaQuest reviewed Petitioner’s pre-treatment authorization request for preventative services. *Id.* at 12. On or about August 4, 2023, in a Notice, the requested preventative services (D0120, D1120, D1208, and D1330) were all denied for the reason that “[t]his service is allowed one time every 6 months. Our records show that you received this service less than 6 months ago. Therefore, this service is denied.” *Id.*

5. On or about August 21, 2023, Petitioner requested an appeal of the denial. *Id.* at 26. On August 28, 2023, Respondent issued a Notice of Plan Appeal Resolution (“NPAR”) upholding the denial of the plan appeal, in pertinent part, as follows:

We made this decision based on all the information we got during the appeal process. This is a summary of our investigation and our decision about your appeal:

We received your request for claim [REDACTED] for services D0120 exam; D1120; cleaning; D1208 fluoride; D1330 toothbrushing instructions. Our records show that you received this service on [REDACTED]. Your benefit plan covers this service once every six months. The denial is upheld.

*Id.* at 29 - 30.

6. Petitioner timely requested a Fair Hearing on October 24, 2023. The Office of Fair Hearings issued an Order Scheduling Fair Hearing by Telephone and Prehearing Instructions on November 17, 2023. The order set this matter for hearing on December 7, 2023. *Id.* at 2 – 6.

7. [REDACTED] argued that the preventative services are necessary because Petitioner needed [REDACTED] six (6) month check-up and cleaning. [REDACTED] testified that they always follow the rules, going to the dentist every six (6) months, but their regular dentist was closed and kept cancelling [REDACTED] [REDACTED] appointment, cancelling three (3) times. [REDACTED] explained that [REDACTED] then found another dentist who was able to see [REDACTED] in [REDACTED]. They scheduled the second next appointment for [REDACTED], because that would have kept [REDACTED] on schedule of twice a year, counting from when [REDACTED] should have been seen by the other dentist in [REDACTED], notwithstanding the cancelled appointments.

8. Mr. Chamorra testified that all the submitted documentation was taken into consideration in this case, and that the denial of preventative services was based on Florida Medicaid and DentaQuest Policy guidelines. Mr. Chamorra testified that a review of Petitioner’s

records reflect that [REDACTED] has already received the requested preventative services in [REDACTED], which is only five (5) months before [REDACTED] dental services were provided in [REDACTED]. Mr. Chamorra referred to a claim invoice from dental provider Salvatore M. Colombo, for preventative dental services for Petitioner rendered on [REDACTED]. *Id.* at 34.

### **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 (2019). 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 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 Dental Services Coverage Policy (August 2018) ("Dental Coverage Policy"), which is incorporated by reference in Fla. Admin. Code R. 59G-4.060. The Dental Coverage Policy provides the following:

#### **1.0 Introduction**

Florida Medical Dental services provide for the study, screening, assessment, diagnosis, prevention, and treatment of diseases, disorders, and conditions of the oral cavity.

...

#### **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 reimburses for the following services in accordance with the American Dental Association 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:

...

#### **4.2.6 Preventive Services**

Florida Medicaid covers preventive services for recipients under the age of 21 years to promote oral health and function by preventing or reducing the onset and development of oral diseases or deformities as follows:

##### **4.2.6.1 Oral Prophylaxis**

One oral prophylaxis within a 181 day period, per recipient

##### **4.2.6.2 Sealants**

Once per tooth (permanent molar), every three years, per recipient

##### **4.2.6.3 Topical Fluoride Application**

- Varnish
  - Once every 90 days, per recipient under the age of six years
  - Once every 181 days, per recipient age six years and older
- Non-varnish fluoride applications
  - Once every 181 days, per recipient
- Silver diamine fluoride
  - Once every 181 days, per tooth

...

#### **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 1396(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.

Dental Coverage Policy at pages 1-4.

14. The Dental Coverage Policy also establishes dental services specifically not covered under

Florida Medicaid:

#### **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 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 Specific 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 screening
- Individual periapical radiograph(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

Dental Coverage Policy at page 5.

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. Petitioner is under age 21, 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). Section 409.905(2), Florida Statutes, 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.

17. Section 2.83 of the Florida Medicaid Definitions Policy (August 2017)(“Definitions Policy”), which is incorporated by reference in Fla. Admin. Code R. 59G-1.010, defines “medically necessary” or “medical necessity” as follows:

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 severe 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.

Definitions Policy at page 7.

18. The Dental Policy requirements necessitate review of Respondent’s denial of Petitioner’s request for preventative services according to “other authority.” Respondent, through the issuance of the NPAR, determined that the preventative services are not available to Petitioner

because their “records show that you received this service on [REDACTED]. Your benefit plan covers this service once every six months.” See supra ¶ 5.

19. As established on the record, Respondent denied Petitioner’s request for preventative services because the services were already provided five (5) months from the last time the same services were provided. See supra ¶ 5.

20. The Dental Coverage Policy, in section 4.2.7, states that Florida Medicaid covers preventive services for recipients under the age of 21 years to promote oral health and function by preventing or reducing the onset and development of oral diseases or deformities as follows:

Oral Prophylaxis, one oral prophylaxis within a 181 day period, per recipient;  
Sealants, once per tooth (permanent molar), every three years, per recipient;  
Topical Fluoride Application: Varnish, once every 90 days, per recipient under the age of six years and once every 181 days, per recipient age six years and older;  
Non-varnish fluoride applications, once every 181 days, per recipient; Silver diamine fluoride, Once every 181 days, per tooth.

See supra ¶ 12.

21. In this case, Petitioner’s previous provider provided the requested preventative services to Petitioner on July 31, 2023. See supra ¶ 3. As Mr. Chamorra testified, the documentation does not support a finding that Petitioner is eligible to receive preventative services before the six (6) month interval requirement, under the Dental Coverage Policy. See supra ¶ 4, 5, 8.

22. As the Petitioner bears the burden of proof, [REDACTED] must show by a preponderance of the evidence that Respondent’s decision was incorrect. As established on the record, Petitioner did not meet the criteria for preventative services less than six (6) months after a previous preventative service was rendered, based on the Dental Coverage Policy, as well as the provider claim for services already submitted. As such, the greater weight of evidence shows that the requested services have already been provided to Petitioner. Therefore, Petitioner did not

demonstrate that [REDACTED] is eligible for the requested preventative services. Furthermore, based on Petitioner's age, [REDACTED], both the Dental Policy and the EPSDT requirements necessitate review of Respondent's denial of Petitioner's request for dental services according to "medical necessity." Section 409.905(2), Florida Statutes, limits EPSDT services with a medically necessity standard. See supra ¶ 12, 15, 16. While [REDACTED] testified that Petitioner needs the regular six (6) month check-up and cleaning, see supra ¶ 7, there was no medical evidence presented that Petitioner's teeth required or qualified for those procedures before a six (6) month interval had expired.

23. Looking at all the evidence relevant to the particular needs of Petitioner, Petitioner has not shown that the services at issue are necessary to correct or ameliorate a defect or a physical and mental illness or condition, or are otherwise medically necessary to receive before the six (6) month interval had expired. Accordingly, based on both parties' testimony, Respondent's Composite Exhibit 1, and the Dental Coverage Policy, Petitioner did not prove by a preponderance of the evidence that Respondent's denial of preventative services for Petitioner, for codes D0120, D1120, D1208, and D1330, was incorrect.

### **DECISION**

The Respondent's denial of preventative services for Petitioner, for codes D0120, D1120, D1208, and D1330 is **AFFIRMED**. The Petitioner's appeal based on Respondent's denial is hereby **DENIED**.

**DONE and ORDERED** this 25th day of January, 2024, in Tallahassee, Leon County, Florida.



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**DEBBIE K. WINICKI, 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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