

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



FILED

Feb 02, 2024, 1:25 pm
OFFICE OF FAIR HEARINGS

[REDACTED]

PETITIONER,

AHCA Case No.: 23-FH2784

Plan ID No.: [REDACTED]

vs.

DENTAQUEST OF FLORIDA, INC.,

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned Hearing Officer convened a telephonic Medicaid Fair Hearing on the above-styled case on January 23, 2024, at 9:00 a.m., Eastern Standard Time ("EST").

APPEARANCES

For the Petitioner:

[REDACTED]

Petitioner's Authorized Representative

For the Respondent:

Mayckol Chamorro
Complaints and Grievance 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 (dental code D8080 for braces; dental code D8670 for monthly visits and dental code D8220 for non-removable appliance) was incorrect.

PRELIMINARY STATEMENT

All parties appeared telephonically. [REDACTED] (“[REDACTED]”), Petitioner’s Authorized Representative and [REDACTED], appeared on behalf of Petitioner at the Fair Hearing.

Mayckol Chamorro, Complaints and Grievance Specialist for DentaQuest of Florida, Inc. (“DentaQuest”), appeared as a representative for Respondent. Dr. Frank Manteiga (“Dr. Manteiga”), Senior Dental Consultant for DentaQuest, appeared as a witness for Respondent.

Stephanie Lang, 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 hearing.

Prior to the hearing, Respondent sent to the Office of Fair Hearings and Petitioner a forty-three (43)-page evidence packet. The evidence packet appears in the Office of Fair Hearings’ case management system as “23-FH2784 Evidence Packet.pdf.” Absent an objection from Petitioner, the undersigned admitted Respondent’s evidence packet into evidence as Respondent’s Composite Exhibit 1.

FINDINGS OF FACT

1. Petitioner is an enrolled member of DentaQuest’s Florida Statewide Medicaid Dental Health Program. See Respondent’s Composite Exhibit 1 on page 19. DentaQuest is a Managed Care Organization contracted by AHCA to provide services to eligible Medicaid recipients in Florida.

2. Petitioner is [REDACTED]. Petitioner’s dental services provider (“Provider”) submitted an ADA Dental Claim Form on behalf of Petitioner requesting preauthorization of dental services. *Id.* at 10. Petitioner’s Provider requested the following dental services: D8080 – Comprehensive orthodontic treatment of the adolescent dentition (braces upper and lower

arch), D8220 - fixed appliance therapy and D8670 – Periodic orthodontic treatment visit. *Id.* at 10, 19-20.

3. DentaQuest included in the evidence packet, a sample of the DentaQuest Orthodontic Criteria Index Form. *Id.* at 38-39. Dr. Manteiga testified that if any of the criteria listed are checked “yes”, that is an automatic qualifier of the request. Petitioner’s Provider did not complete and submit the DentaQuest Orthodontic Criteria Index Form.

4. Petitioner’s Provider submitted dental x-rays, 3D Model Images, and color photographs of Petitioner’s face and mouth. *Id.* at 21-24.

5. On October 9, 2023, DentaQuest issued a Notice of Adverse Benefit Determination (“NABD”) denying Petitioner’s request for dental services. *Id.* at 12 – 16. DentaQuest stated that Petitioner’s requested dental services were denied because they were not medically necessary.

Id. The NABD stated as follows:

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*)

- 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:

Our dentist looked at the information sent by your dentist. You did not meet the criteria needed to approve braces. The information sent shows a lack of medical

necessity or a handicapping malocclusion. The criteria measure how your teeth are different from normal alignment. It also measures how your teeth are different from normal contact between the teeth when you chew or bite down. The criteria reviewed includes: a deep impinging overbite (this is when your upper teeth come too far down over your lower teeth and the lower teeth cause gum damage to the roof of your mouth); open-bite with your front teeth (this is when there is a space between the biting surface of the front teeth when the back teeth bite together); cross-bite with your front teeth (this is when the front teeth don't line up with the bottom teeth); impacted front teeth (this is when your teeth will not grow in to your mouth without help); over-jet bigger than 9mm or negative over-jet bigger than 3.5mm (this is when your top teeth or bottom teeth are too far forward and do not line up correctly); cleft lip; cleft palate (this is an opening in the roof of your mouth); or issues with your teeth that would need braces and surgery in order to fix them. We have also told your dentist. Please talk to your dentist about your treatment choices.

This denial applies to this service(s):

- D8080 braces

We based this decision on:

DentaQuest Clinical Criteria for Comprehensive Orthodontics

- D8670 monthly visit

We based this decision on:

DentaQuest Clinical Criteria for Other Orthodontic Service

...

- D8220 non-removable appliance

We based this decision on:

DentaQuest Clinical Criteria for Harmful Habits *Id.*

6. Petitioner appealed the denial of the requested dental services. *Id.* at 26. On

November 7, 2023, DentaQuest issued a Notice of Plan Appeal Resolution (“NPAR”)

upholding the denial of the dental services. *Id.* at 31-32. The NPAR explained as follows:

On 10/23/2023 we received your timely plan appeal request regarding DentaQuest’s Notice of Adverse Benefit Determination dated 10/09/2023, NABD Number ACME-16-000156, for authorization number [REDACTED] DENYING the SERVICE provided to [Petitioner].

On 11/07/2023 after consideration of the information you provided to DentaQuest in support of your plan appeal, DentaQuest hereby DENIES your plan appeal.

Id. at 31.

7. DentaQuest relied upon their internal Clinical Criteria for Orthodontics in their decision to deny dental services. The Clinical Criteria for Orthodontics states as follows:

18.11 Clinical Criteria for Orthodontics

Florida Medicaid requires that for any orthodontic case to be determined as medically necessary the case must demonstrate a “handicapping malocclusion”. The state defines “handicapping malocclusion” as “a condition that results in a disability or impairment to the recipient’s physical development.” DentaQuest has set the criteria in the Orthodontic Criteria Index Form included below. **Please note, that if a provider does not check any criteria, DentaQuest will deny the case.** The Pre-orthodontic visit (code D8660) is only covered on denied prior authorization requests for comprehensive orthodontic care. The pre-orthodontic visit includes diagnostic casts, photographs, radiographs (panoramic and cephalometric), a [sic] Orthodontic form, a ADA claim form, and a narrative including the diagnosis and treatment plan These services are not reimbursed separately.

Orthodontic services will not be covered for the following conditions:

- Treatment primarily for cosmetic purposes; or
- Split phase treatment, with exception of cleft palate cases
- Cases that do not meet one of the auto qualifiers in the orthodontic form.

Documentation

Orthodontic treatment requires the following documentation to show medical necessity:

- Prior Authorization by DentaQuest
- Orthodontic Form
- Examination and records that show a narrative or rationale including diagnosis/prognosis/treatment plan
- (On a case by case basis).
- Appropriate radiographs and facial photographs - Lateral cephalometric radiograph, study models or
- OrthoCad equivalent.
- The participant must have good oral hygiene and have all dental work up to date. Both should be noted in narrative.

Appropriate photographic requirements include:

- Facial photographs (right and left profiles in addition to a straight-on facial view)
- Frontal view, in occlusion, straight-on view
- Frontal view, in occlusion, from a low angle
- Right buccal view, in occlusion
- Left buccal view, in occlusion
- Maxillary Occlusal view
- Mandibular Occlusal view

...

Id. at 36

8. On November 1, 2023, [REDACTED] requested a Medicaid Fair Hearing on behalf of Petitioner, based on DentaQuest's denial of Petitioner's request for dental services. The undersigned scheduled the Fair Hearing for January 23, 2024, at 9:00 a.m. EST, and all parties were duly notified.

9. [REDACTED] is Petitioner's parent. [REDACTED] believes that Petitioner needs braces based on the Provider's recommendation. Petitioner has sought and obtained additional opinions that [REDACTED] needs braces. Also, [REDACTED] stated that [REDACTED] would, in the future, need surgery on [REDACTED] jaw but that the braces needed to be completed before the surgery. [REDACTED] also said that [REDACTED] own medical issues may preclude [REDACTED] from advocating for [REDACTED]'s needs in the future.

10. Dr. Manteiga is a licensed Florida dentist and a Senior Dental Consultant with DentaQuest. Referring to section 18.11 of DentaQuest's Clinical Criteria for Orthodontics, Dr. Manteiga noted that if a provider checked any criteria on DentaQuest's Orthodontic Criteria Index Form, that would constitute an auto qualifier for the orthodontic request. Dr. Manteiga testified that the Provider in this case did not submit the DentaQuest Clinical Criteria Index Form. Additionally, Dr. Manteiga explained that based upon [REDACTED] review of the documentation and photos submitted by Petitioner's Provider, there are no auto qualifiers that would be checked off. Dr. Manteiga

personally reviewed all documentation submitted to Respondent for this case, including all documents admitted in evidence, and he agreed with Respondent's denial in this case as the Petitioner did not qualify for Orthodontic services, at this time. Dr. Manteiga did state that the Petitioner could re-apply for services if there were changes in [REDACTED] dental circumstances.

CONCLUSIONS OF LAW

11. 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. This order is the final administrative decision of AHCA under section 409.285(2)(a).

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

13. The burden of proof in this proceeding is governed by Fla. Admin. Code R. 59G-1.100(17)(g), which provides as follows:

The burden of proof is on the party asserting the affirmative of an issue, except as otherwise required by statute. The burden of proof is on the Agency or plan, whichever is applicable, when the issue presented is the suspension, reduction, or termination of a previously authorized service. The burden of proof is on the recipient or enrollee, when the issue presented is the denial or a limited authorization of a service. The party with the burden of proof shall establish its position to the satisfaction of the Hearing Officer by a preponderance of the evidence.

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

15. Petitioner's request for dental services is governed by the Florida Medicaid Dental Services Coverage Policy (August 2018) ("Dental Policy"), which is incorporated by reference in Fla. Admin. Code R. 59G- 4.060. The Dental Policy provides as follows:

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.

...

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.

...

2.2 Who Can Receive

Florida Medicaid recipients requiring medically necessary dental services. Some services may be subject to additional coverage criteria as specified in section 4.0.

If a service is limited to recipients under the age of 21 years, it is specified in section 4.0. Otherwise, the service is covered for recipients of all ages.

...

4.1 General Criteria

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

- Are determined 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:

...

4.2.4 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.

...

5.1 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

16. 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)(3) and (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.

...

(5) 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.

17. Petitioner is under age 21, and therefore eligible for EPSDT services. However, a state may place appropriate limits on a service based on such criteria as medical necessity. *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.

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

19. In the instant case, Petitioner requested dental services (orthodontic braces). *See supra* ¶ 2 - 4. The evidence admitted and testimony presented in this case establish that Respondent denied Petitioner's request for dental services, because the requested services were not medically necessary according to section 2.83 of the Definitions Policy. *See supra* ¶ 5 and 6.

20. Florida Medicaid reimburses for services that meet all of the following: are determined medically necessary; do not duplicate another service; and meet the criteria as specified in this policy. *See supra* ¶ 15.

21. Section 2.2 of the Dental Policy reflects that "Florida Medicaid recipients requiring medically necessary dental services" may receive services. *See supra* ¶ 15. Pursuant to section 2.83 of the Definitions Policy, the five (5) conditions of medical necessity must be met in order for "medical or allied care, goods, or services furnished or ordered" to be determined medically

necessary. *See supra* ¶ 18. Accordingly, all five (5) of the conditions must be met in order for DentaQuest to approve the requested dental services.

22. Petitioner is under age 21, and therefore eligible for EPSDT services. *See supra* ¶ 2 and 17. Fla. Stat. § 409.905(2) limits EPSDT services with a medical necessity standard, and requires that the Agency “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” *See supra* ¶ 17. Pursuant to 42 U.S.C. § 1396d(r)(3), EPSDT services includes medically necessary dental services and “at a minimum include relief of pain and infections, restoration of teeth, and maintenance of dental health.” *See supra* ¶ 16.

23. The testimony and evidence presented in this case reflects that Respondent’s denial of dental services was warranted under the circumstances of this case, as Petitioner failed to demonstrate the medical necessity of the requested services. [REDACTED] believes that Petitioner needs braces to prevent dental issues and to prepare [REDACTED] for jaw surgery in the future. *See supra* ¶ 9. However, Petitioner’s Provider did not submit the DentaQuest Orthodontic Criteria Index Form which includes a list of dental conditions that auto qualify the Petitioner for Orthodontic services. Dr. Manteiga, a licensed dentist and Senior Dental Consultant for DentaQuest, explained that based upon [REDACTED] review of the documentation, and photos submitted by Petitioner’s provider, there are no auto qualifiers that would be checked off, at this time. *See supra* ¶ 10.

24. Section 2.83 of the Definitions Policy sets forth the definition of medical necessity, which mandates that “[t]he medical or allied care, goods, or services furnished or ordered must . . . [b]e

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." See supra ¶ 18. Regarding the DentaQuest Orthodontic Criteria Index Form, DentaQuest's Clinical Criteria for Orthodontics states, "if a provider does not check any criteria, DentaQuest will deny the case." See supra ¶ 7. In this case, the Provider failed to submit the Orthodontic Criteria Index Form. Petitioner's Provider failed to satisfy the requirements of Respondent's internal criteria for approval of braces. Based upon Dr. Manteiga' review of the documentation submitted by Petitioner's Provider, Petitioner did not meet any of the criteria set forth on the DentaQuest Orthodontic Criteria Index Form, as he noted that there are no auto qualifiers that would be check off. See supra ¶ 10. Given these facts, Petitioner has not demonstrated that the requested dental services are "individualized, specific, consistent with symptoms or diagnosis of illness or injury" and not "in excess of the patient's needs." See supra ¶ 18.

25. The record also reflects that Petitioner's Provider submitted an ADA Dental Claim form on behalf of Petitioner requesting preauthorization of dental services. See supra ¶ 2. However, section 2.83 of the Definitions Policy mandates that "[t]he 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 ¶ 18. Therefore, the ADA Dental Claim form does not make the requested dental service a covered service.

26. In light of the testimony and evidence presented, and the applicable laws and policies, the undersigned Hearing Officer finds that Petitioner failed to establish that the requested dental services are medically necessary. Looking at all the evidence relevant to the particular needs of


Petitioner, Petitioner did not demonstrate that the requested services are necessary to correct or ameliorate a defect or a physical and mental illness or condition. Accordingly, Petitioner did not prove by a preponderance of the evidence that Respondent's denial of Petitioner's request for dental services was incorrect.

DECISION

Respondent's denial of Petitioner's request for dental services (dental code D8080 for braces and dental code D8670 for monthly visits) is **AFFIRMED**. Petitioner's request for relief is **DENIED**.

DONE and ORDERED this 2nd day of February 2024, in Tallahassee, Leon County, Florida.

George L. Winslow, Jr.

 23-FH2784
2024.02.02 07:18:44
-05'00'

GEORGE WINSLOW, 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:



DentaQuest of Florida, Inc.
CGATeam3@dentaquest.com

AHCA Medicaid Hearing Unit
MedicaidHearingUnit@ahca.myflorida.com