



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

FILED

Aug 13, 2024, 4:24 pm

OFFICE OF FAIR HEARINGS

[REDACTED]

PETITIONER,

AHCA Case No.: 24-FH1083

Plan ID No.: [REDACTED]

vs.

LIBERTY DENTAL PLAN OF FLORIDA, INC.,

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic Fair Hearing in the instant case on May 21, 2024, at 1:00 p.m. Eastern Standard Time ("EST").

APPEARANCES

For the Petitioner:

[REDACTED]

Petitioner's Authorized Representative

For the Respondent:

Monica Aguillar
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, specifically insertion and adjustment of orthodontic braces, was incorrect.

PRELIMINARY STATEMENT

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

Shonda Rushing, Complaints and Grievances Specialist for Liberty Dental Plan of Florida, Inc. (“Liberty”) appeared on behalf of the Respondent. Tamara Tibby, DDS, (“Dr. Tibby”) Dental Consultant for Liberty, attended as a witness for Respondent.

Lee Ann Williams, Medical Health Care Program Analyst and Fair Hearing Liaison for the Agency for Health Care Administration (“Agency” or “AHCA”) appeared as an observer.

Prior to the Fair Hearing, Petitioner sent to the Office of Fair Hearings a thirteen (13)-page evidence packet. The evidence packet appears in the Office of Fair Hearings’ case management system as the file title “24-FH1083 Petitioner Evidence.pdf”. Without objection the evidence packet was admitted into evidence as Petitioner’s Composite Exhibit 1 (“PCE1”)

Prior to the Fair Hearing, Respondent sent to the Office of Fair Hearings and Petitioner a sixty-one (61)-page evidence packet. The evidence packet appears in the Office of Fair Hearings’ case management system as file title “[PETITIONER] SFH 24-FH1083 Evidence Packet_5.5.2024.pdf.” Without objection, the evidence packet was admitted into evidence as Respondent’s Composite Exhibit 1 (“RCE 1”).

FINDINGS OF FACT

1. Petitioner is an enrolled member of Liberty, which is a managed care organization contracted by the Agency to provide services to eligible Medicaid recipients in Florida. See page 2 at RCE 1.

2. Petitioner is [REDACTED]. *Id.* at 5. On or around February 13, 2024, Petitioner’s Provider, [REDACTED] requested an authorization for insertion and adjustment of orthodontic braces *Id.* at 7.

3. Petitioner’s Provider also submitted a Florida Medicaid Orthodontic Initial Assessment Handicapping Labio-Lingual Deviations (“HLD”) Index Score Sheet dated February 14, 2024. *Id.* at

17. The provider selected:

[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]

No HLD scores or other comments were provided. *Id.*

4. Petitioner’s Provider submitted color photographs of Petitioner’s face and mouth and dental x-rays. *Id.* at 8.

5. Respondent denied the Petitioner’s request for Orthodontic services in a Notice of Adverse Benefit Determination (“NABD”) dated February 14, 2024. *Id.* at 19-20. The NABD gave the following reasons for the denial:

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 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 facts that we used to make our decision are:

1, 2 MMFLOrtho.1MMFLOrtho.1 Our dentist looked at your records to see if you have problems with your top and bottom teeth when you chew, bite, talk or breathe. We also looked to see if you might have those problems later. Based on your records you do not have these issues. Since your records show that you do not have those problems our dentist looked at your records to see if there was a medical need that would allow you to have braces. There is no medical need based on the records that your dentist sent in. Braces are only covered for members under 21 years of age with a handicapping malocclusion per AHCA Dental Services Policy 4.2.4 Orthodontic Services.

Id. at 19-20.

6. On March 27, 2024, Respondent issued a Notice of Plan Appeal Resolution (“NPAR”) upholding the denial of Comprehensive Orthodontic Treatment, based on medical necessity. *Id.* at 29-30. The NPAR included the rationale for the denial, as follows:

On March 12, 2024, we received your timely plan appeal request regarding LIBERTY Dental Plan’s (LIBERTY’s) Notice of Adverse Benefit Determination dated February 14, 2024, NABD Number [REDACTED], denying the braces (orthodontic treatment).

On March 27, 2024, after consideration of the information you provided in support of your plan appeal, LIBERTY hereby denies the request for braces.

On March 27, 2024, LIBERTY’s Staff Orthodontist, Dr. Yen Phi Le, a dentist who specializes in braces and did not take part in the first decision, reviewed your plan appeal and dental records.

The Agency for Health Care Administration’s (AHCA’s) Florida Medicaid Dental Services Coverage Policy says: “Florida Medicaid covers braces for persons under the age of 21 years with “handicapping malocclusion.” AHCA defines “handicapping malocclusion” as: “A condition that results in a disability or impairment of the person’s physical development”.

Both of LIBERTY’s Staff Dentists, who specialize in braces, reviewed the dental records, and decided that [PETITIONER], does not have “handicapping malocclusion” as defined above. Therefore, the requested braces are not

medically necessary to treat a condition that is causing a disability or impairment of physical development.

LIBERTY's Staff Dentists also used the Handicapping Labio-Lingual Deviation (HLD) Index form, which the treating dentist was required to score and submit in support the need for braces. The HLD score was re-calculated by LIBERTY's Staff Dentists. The HLD score did not support that [PETITIONER] has any other conditions that when combined would meet the benefits of "handicapping malocclusion" under the Florida Medicaid Program.

Medicaid Dental Plans, like LIBERTY, must cover "other necessary health care, diagnostic services, treatment, and other services to correct or ameliorate defects and physical or mental conditions discovered by the screening services, whether or not the services are Medicaid benefits." This is called Early and Periodic Screen, Diagnosis and Treatment (EPSDT).

In this case, LIBERTY did not receive any documentation from the treating dentist stating that [PETITIONER] requires medically necessary treatment beyond that needed to treat "handicapping malocclusion". LIBERTY's NABD denial, and this plan appeal denial, were not based on EPSDT.

Please note that just because your dentist recommended braces for [PETITIONER] does not mean that the braces are medically necessary or a covered benefit.

Id. at 29-30.

7. Petitioner timely requested a Fair Hearing on April 4, 2024. The Office of Fair Hearings issued an Order Scheduling Fair Hearing by Telephone and Prehearing Instructions on April 22, 2024. The order set this matter for hearing on May 21, 2024, at 1:00 p.m. EST.

8. [REDACTED], Petitioner's Authorized Representative and [REDACTED] testified as follows:

- a. Petitioner was receiving treatment in [REDACTED] and was approved for braces in [REDACTED]. [REDACTED] has requested the same orthodontic treatment as Petitioner was receiving in [REDACTED].

9. Dr. Tibby testified as follows:

- a. The Florida Medicaid Rules do not support authorization of the services requested.

- b. There is no handicapping malocclusion to support the approval of the requested services.
- c. On the HLD form, no auto qualifier is checked, and the score [REDACTED]. In order to qualify, the score must be 26. *Id.* at 17.

CONCLUSIONS OF LAW

10. 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).

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

12. 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.)

13. Petitioner’s request for dental services is governed by the Florida Medicaid 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.

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 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:

...

4.2.4 Orthodontic Services

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

- Up to 25 units within a 36 month period, including the removal of the appliances and retainers at the end of treatment

- Once 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 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. Based on Petitioner’s age, both the Dental Policy and the EPSDT requirements necessitate review of Respondent’s denial of Petitioner’s request for orthodontic services according to “medical necessity.” Respondent, through the issuance of the NPAR, determined that

orthodontic services are not “medically necessary” for Petitioner. 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. In the instant case, Petitioner’s Provider sent a preauthorization requesting dental services, specifically insertion and adjustment of orthodontic braces. See ¶ 2. In an NABD dated February 14, 2024, 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 ¶ 5, 6, 17.

19. 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 ¶ 13, 14.

20. Section 2.2 of the Dental Policy reflects that “Florida Medicaid recipients requiring medically necessary dental services” may receive services. See ¶ 14. 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 ¶ 17. Accordingly, all five (5) of the conditions must be met in order for Liberty to approve the requested dental services.

21. Petitioner is under age 21, and therefore eligible for EPSDT services. See ¶ 2, 15 and 16. 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 ¶ 15 and 16. 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 ¶ 15 and 16.

22. Florida Medicaid covers orthodontic services for recipients under the age of 21 years with *handicapping malocclusions*.... See ¶ 14 (emphasis added). The HLD Index Score Sheet is used to determine whether a handicapping malocclusion exists. See ¶ 3. In order to demonstrate a handicapping malocclusion, the patient must have an automatically qualifying condition or a total HLD score over 26. See ¶ 3.

23. Here, Liberty reviewed the records from Petitioner’s Provider. Dr. Tibby provided credible and persuasive testimony that, based on the documentation, photos and x-rays, Petitioner’s

overbite is not severe enough to be considered a handicapping malocclusion. See ¶ 9. Petitioner did not demonstrate a qualifying HLD score of 26 or greater. See ¶ 3.

24. 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 a handicapping malocclusion.

25. 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 ¶ 17. Given the facts of this case, 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 ¶ 17.

26. [REDACTED] believes that Petitioner needs braces because they were authorized in [REDACTED] and recommended by Petitioner's current provider, [REDACTED]. See ¶ 8. The record also reflects that Petitioner's provider submitted a claim form on behalf of Petitioner requesting preauthorization of dental services. See ¶ 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 ¶ 17.

27. In light of the testimony and evidence presented, and the applicable laws and policies, the undersigned 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 insertion and adjustment of orthodontic braces was incorrect

DECISION

The Respondent's denial of insertion and adjustment of orthodontic braces is **AFFIRMED**.

The Petitioner's appeal based on Respondent's denial is hereby **DENIED**.

DONE and ORDERED this 13th day of August 2024, in Tallahassee, Leon County, Florida.



Lynne Ringers
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LYNNE RINGERS, 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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