

Before the  
Administrative Hearing Commission  
State of Missouri

JAMES DYE, D.D.S., DENTAL OFFICE,	)	
and ALL ABOUT SMILES, L.L.C.,	)	
	)	
Petitioners,	)	
	)	
vs.	)	No. 14-0868 SP
	)	
DEPARTMENT OF SOCIAL SERVICES,	)	
MISSOURI MEDICAID AUDIT AND	)	
COMPLIANCE UNIT, and	)	
MOHEALTHNET DIVISION	)	
	)	
Respondents.	)	

**DECISION**

The Department of Social Services (“the Department”), denied reimbursement claims submitted by James Dye, D.D.S., and Dr. Brenda Hermann, D.D.S. (“the dentists”) through their billing agent, All About Smiles, L.L.C. (together, “Petitioners”). Petitioners appealed the denial of these claims. Hermann subsequently filed a motion to dismiss her claims, which we granted. We deny Dye’s claims for reimbursement for services provided by Dr. Hermann because she dismissed them and Dye has no standing to pursue them. We determine that Dye is entitled to reimbursement of \$713.25.

**Procedure**

On May 28, 2014, Petitioners filed a complaint appealing the decision by the Department’s Missouri Medicaid Audit and Compliance Unit (“MMAC”) to deny reimbursement of the claims for dental services. MMAC filed a motion to dismiss on July 3, 2014, and Petitioners filed a motion for leave to file an amended complaint on July 15, 2014. By order dated July 16, 2014, we granted the motion to file the amended complaint and denied the

motion to dismiss. MMAC filed an answer on July 24, 2014. On September 15, 2014, Petitioners filed a second amended complaint.

On October 17, 2014, MMAC and the Department's MO HealthNet Division ("MO HealthNet," together "Respondents") jointly filed an amended answer to the second amended complaint. On October 20, 2014, Respondents filed a motion to dismiss All About Smiles as a party, and on October 31, 2014, they filed a motion to dismiss certain claims as untimely. We denied both motions on November 5, 2014.

On October 30, 2014, Hermann filed a motion to dismiss her claims, which we granted. At the hearing, Respondents renewed their motion to dismiss certain claims and their motion to dismiss All About Smiles as a party. For the reasons discussed below, we now grant both motions. We change the caption of this case to reflect that MO HealthNet is now a party, and All About Smiles is not.

We held a hearing on this matter on November 12, 2014. James Arneson represented Petitioners. Assistant Attorney General Matthew J. Laudano represented Respondents. At the hearing, Petitioners dismissed certain claims and Respondents conceded others.

After the hearing, the parties submitted the depositions of Dye and MMAC Director Jessica Dresner. We admit them into evidence as Exhibits T and 6, respectively, and make them a part of the record in this case. On December 19, 2014, the parties filed a joint stipulation of the remaining claims at issue. We admit the joint stipulation with its Exhibit 1. The case became ready for our decision on February 9, 2015, the date the last written argument was filed.

### **Findings of Fact**

1. Dye is, and was at all relevant times, enrolled in the Missouri Medicaid dental services program. All About Smiles supplies clerical staff for him and acts as his billing agent.

Hermann, who was also enrolled in the Medicaid program, was employed by Dye to perform dental services to clients.

2. As Medicaid dental service providers, the dentists entered into Title XIX provider agreements with the Department prior to the relevant time periods in this case. Each dentist was assigned a provider number.

3. All About Smiles has a National Provider Identifier (“NPI”),<sup>1</sup> but it does not hold, nor has it ever held, a Title XIX participation agreement with the Department, and it has never been a Missouri Medicaid provider.

4. The dentists provided dental services, including dentures, to Medicaid participants. All About Smiles submitted claims for reimbursement of those services to the Department. The dentists’ services were billed under their respective provider numbers.

5. The Department reimburses claims for dental services provided to adult Medicaid participants if they are pregnant, blind, or residents of Medicaid vendor nursing facilities. All other adults are “adults with limited benefits.” The Department reimburses claims for dental services for adults with limited benefits only if they are referred by a physician and the services are required as a result of physical trauma, or in order to not adversely affect a pre-existing medical condition.

6. MMAC audited All About Smiles and the dentists in March 2013. On July 2, 2013, MMAC gave notice to the dentists that it would sanction them by requiring them to submit their dental claims to pre-payment review. Petitioners filed an action in the Cole County Circuit Court challenging that sanction.

7. On December 10, 2013, Petitioners filed a complaint with this Commission challenging MMAC’s denial of reimbursement for denture claims. We opened *James Dye*,

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<sup>1</sup> A numbering system issued by the Centers for Medicaid and Medicare.

*D.D.S., Brenda Hermann, D.D.S., and All About Smiles, L.L.C.*, No. 13-2108 SP. We held a hearing in that case on April 15, 2014, and issued a decision on July 18, 2014. We decided Petitioners were entitled to partial reimbursement of those claims.

8. Claims subject to pre-payment review must be submitted in paper form with supporting documentation. A provider review analyst reviews the claims and supporting documents to determine whether the claims should be paid or denied. The analyst then sends MMAC’s determination to the administrators of the MO HealthNet electronic claims system for further processing.

9. Most of the claims at issue in this case were submitted to MMAC under the above process. Some claims may have been submitted electronically to the fiscal agent for MO HealthNet.

10. Claims for 23 patients are at issue in this case.<sup>2</sup> The Department has no record of having received or denied several of them. It denied the others for failure to include a physician’s statement that the absence of dentures would adversely affect the patient’s pre-existing medical condition or failure to properly identify the Departmental Client Number (“DCN”) and/or Patient ID.<sup>3</sup>

11. One claim in this case, for upper and lower dentures for participant Di.M., was denied in Case No. 13-2108 SP.

12. The following claims for seven participants lacked a physician referral:

<u>DOS</u>	<u>Participant</u>	<u>Physician Referral?</u>
13/19/14	M.A.	No – FNP-C <sup>4</sup>
2/18/14	S.A.	No – PA
3/5/14	T.B.	No – NP

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<sup>2</sup> Although more claims were originally at issue, the number has been reduced. See Joint Stipulation and Exhibit 1 thereto.

<sup>3</sup> The Department coded the various reasons for denial by letter. The two most important reasons for denial, set forth in this finding of fact, were coded as type A and type B denials, respectively.

<sup>4</sup> FNP is a family nurse practitioner, FP is a nurse practitioner, and PA is a physician’s assistant.

12/23/13	A.K.	No – FNP
11/22/13	M.S.	No – FNP
10/28/13	N.V.	No – (illegible, but not the doctor’s name listed as printed on form)
11/20/13	J.P.	No – FNP-C

13. The claims set forth below for three participants contain a physician referral, but they do not identify any pre-existing medical conditions.

<u>DOS</u>	<u>Participant</u>	<u>Physician Referral</u>
12/17/13	A.F.	“current condition of mouth” (G-14)
3/4/14	D.W.	“at risk for bacterial systemic infection” (4-6)
12/18/13	N.T.	“open gaps where the teeth once were” (4-20)

14. The following claims for dentures for 11 participants contain a referral from a physician who identified a pre-existing condition, but the physician did not specifically request dentures or state how the absence of dentures or the ability to chew would adversely affect the identified pre-existing condition.

<u>DOS</u>	<u>Participant</u>	<u>Physician Referral -- Purpose</u>
01/14/14	T.M.	“adversely affect her health” (4-21)
11/13/13	R.L.	“adversely affected” (4-15)
11/21/13	E.C.	“adversely affect her health” (G-7)
11/20/13	K.J.	“adversely affect her health” (G-22)
11/11/13	L.J.	“adverse health problems” (G-30)
11/18/13	R.M.	“health risk to him, albeit not of high emergent risk” (G-41)
3/25/13	M.D.	did not request dentures (4-25)
12/4/13	M.B.	“dental caries are very significant” (G-2)
10/29/13	V.H.	“ extensive dental caries” (G-18)

11/7/13	Da.M.	“very bad dentition, with most teeth being carious, and many severely eroded;” “has had several severe abscesses;” I have recommended he have a full-mouth extraction[.]” (G-37)
2/20/14	R.B.	did not request dentures.

15. A claim for a limited oral evaluation and dentures for J.E. included a physician referral that identified a pre-existing condition (gastric bypass surgery) and stated that soft sources of protein were inadequate after her surgery.

16. The following claims are for participants whose physician referrals do not state a need for dentures, but they do state the need for dental care or evaluation and link that need to a pre-existing condition.

<u>DOS</u>	<u>Participant</u>	<u>Service</u>	<u>Amount</u>
12/4/13	M.B.	Limited oral evaluation	\$23.25 (G-1)
11/21/13	E.C.	Limited oral evaluation	\$23.25 (G-5)
10/29/13	V.H.	Limited oral evaluation	\$23.25 (G-17)
11/12/13	K.J.	Limited oral re-evaluation	\$24.00 (G-21)
11/11/13	L.J.	Limited oral re-evaluation	\$24.00 (G-29)
11/13/13	R.L.	Limited oral evaluation	\$23.25 (G-33)
11/7/13	Da.M.	Limited oral evaluation	\$24.00 (G-36)

17. Dye also submitted claims for S.A. and T.J. Notice that S.A.’s claim was denied was posted on February 24, 2014. Notice that one of T.J.’s claims was denied was posted on January 13, 2014. Notice that another of T.J.’s claims was denied was posted on May 26, 2014 (Memorial Day).<sup>5</sup> Dye filed an appeal of these denials in his second amended complaint, which he filed on September 15, 2014.

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<sup>5</sup> Because there is no sequential page numbering, we have rearranged the pages so that this information is found on the first three pages of Exhibit BB.

18. There is no evidence that the Department denied the claims that may have been submitted for participants M.A., T.M., T.B., M.D, or R.B.

19. Under the MO HealthNet Dental Manual, November 1, 2011 (“the Manual”), dentures and related services are reimbursed at the following maximum rates:

Complete upper	\$503.75
Complete lower	\$503.75
Upper partial, resin base	\$377.81
Lower partial, resin base	\$379.75
Upper partial, metal framework	\$542.50
Lower partial, metal framework	\$542.50
Denture Adjustment (upper or lower)	\$28.68
Limited Oral Evaluation	\$23.50
Limited Oral Re-Evaluation	\$24.00

20. None of the Medicaid participants at issue were blind, pregnant, children, or residents of Medicaid nursing facilities. None were referred for dentures because of trauma to the mouth, teeth, or jaw.

21. Teeth are necessary to eat certain foods, but not others.

### **Conclusions of Law**

We have jurisdiction under §§ 208.156.2<sup>6</sup> and 621.055, both of which provide that any person authorized under section 208.153 to provide services for which benefit payments are authorized under section 208.152 may seek review with this Commission of certain actions of the Department in regard to payments. Section 208.156.2 specifically provides the right of review to a

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<sup>6</sup>Statutory references are to RSMo 2000 unless otherwise noted.

person authorized to provide services “whose claim for reimbursement for ... services is denied[.]”  
Petitioners bear the burden of proof. Section 621.055.1.

### I. Petitioners’ Constitutional Claims

In their complaint, Petitioners allege they were denied due process of law. In their reply brief, they state that they are not pursuing that claim, but ask us to consider that MMAC audited them in March 2013, yet never prepared an audit report. It is unclear how this would violate their due process rights. Regardless of whether Petitioners intended to state a constitutional claim, this Commission does not have authority to decide constitutional issues. *Sprint Communications Co., L.P. v. Director of Revenue*, 64 S.W.3d 832, 834 (Mo. banc 2002); *Cocktail Fortune, Inc. v. Supervisor of Liquor Control*, 994 S.W.2d 955, 957 (Mo. banc 1999).

### II. All About Smiles

Respondents argue that All About Smiles is not a proper party in this case. For a party to have standing to appeal the denial of claims, it must be a “person authorized under section 208.153 to provide services for which benefit payments are authorized under section 208.152 whose claim for reimbursement for services is denied[.]” Section 208.156.2. Sections 208.156.6 and .7 refer to such person as a “provider of service.” The definition of “provider” under 13 CSR 70-3.020 is:

(1)(I) Provider—Any person having an effective, valid, and current written provider enrollment application and application for provider direct deposit with the MO HealthNet agency for the purpose of providing services to eligible participants and obtaining reimbursement excluding, for the purposes of this rule only, all persons receiving reimbursement in their capacity as owners or operators of a licensed nursing home[.]

13 CSR 70-3.020 also states:

(9)The provider is responsible for all services provided and all claims filed using her/his MO HealthNet provider identifier regardless to whom the reimbursement is paid and regardless of whom in her/his employ or services produced or submitted the MO

HealthNet claim, or both. The provider is responsible for submitting proper diagnosis codes, procedure codes, and billing codes. When the length of time actually spent providing a service (begin and end time) is required to be documented, the provider is responsible for documenting such length of time by documenting the starting clock time and the end clock time . . . regardless to whom the reimbursement is paid and regardless of whom in the provider's employ or services produced or submitted the MO HealthNet claim.

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(11) MO HealthNet reimbursement shall not be made for any services performed by an individual not enrolled as a MO HealthNet provider, except for those services performed by the employee of the enrolled provider who is acting within their scope of practice and under the direct supervision of the enrolled provider. . . .

All About Smiles has an NPI, but not all NPI number holders are providers. All About Smiles does not hold, nor has it ever held, a Title XIX participation agreement, and has never been a Missouri Medicaid provider. Additionally, All About Smiles is not an employee who performed covered services under the direct supervision of Dye or Hermann, the providers who submitted the claims. All About Smiles is a billing agent. It is not authorized under § 208.153 to provide services for which benefit payments are authorized under § 208.152. We agree that All About Smiles has no standing in the complaint before us, and we dismiss it as a party. For the remainder of this decision, we will reference Dye as the only Petitioner in this case.

### III. Brenda Hermann's Claims – Exhibit 5

Respondents argue that the claims identified in Exhibit 5 (Exhibit 2 of the Joint Stipulation of Remaining Claims) should not be considered because Hermann, who submitted the claims, dismissed them on October 30, 2014. Respondents objected to Exhibit 5, and we took the objection with the case. We sustain the objection.

This complaint was filed to appeal the denial of claims for services performed by Dye and Hermann. Hermann was a provider who also billed services through All About Smiles, and she

was Dye's employee. On October 20, 2014, Hermann filed a motion to dismiss her claims without prejudice. By order dated November 5, 2014, we granted the motion and deemed the claims dismissed as of October 30, 2014. Respondents argue that the claims associated with Hermann are no longer at issue in this case because they were dismissed. Dye argues that Hermann's claims should be considered his claims because Hermann was his employee and all of the patients she treated were his patients.

We agree that under 13 CSR 70-3.020(11), Dye could have billed Medicaid under his provider number for "services performed by the employee of the enrolled provider who is acting within their scope of practice and under the direct supervision of the enrolled provider." This makes sense in the context of a dentist billing for the work of his employees, such as dental assistants, who are providing covered services to his patients. All covered services for a dental office could be billed under one provider number if the conditions imposed by 13 CSR 70-3.020(11) were met. But that is not what occurred in this case. Dye billed for services to certain patients under his provider number, and Hermann billed for her services to patients under her provider number. 13 CSR 70-3.020(9) makes it clear that the *provider* is responsible for all claims billed under his or her provider number. In this case Hermann was the provider for the patients she treated, and she was the one with the right to appeal – and dismiss – those claims. Dye has no standing to pursue those claims on her behalf.

#### IV. Dye's Claims Submitted to the Department

Respondents' Exhibit G contains claims that were submitted to MMAC by Dye and denied. Dye's Exhibit 4 contains these claims and six others that Dye asserts were submitted to MMAC. MMAC argues that some of these claims were not submitted. Cindy Lenger, the MMAC provider review analyst who reviewed Dye's claims, testified that the only claims she received and reviewed were those in Exhibit G. Pamela VanDrie, the General Manager of All

About Smiles, testified that she submitted all of the paperwork in Exhibit 4 for Dye's claims. Because the evidence in this case indicates that some claims may have been submitted electronically to MO HealthNet rather than on paper to MMAC, we review the documentation in Exhibit 4. We discuss below whether the claims of the following participants whose records were in Exhibit 4 and whose names were included in the joint stipulation of the remaining claims at issue – A.K., M.A., T.B., .M., M.D., and R.B., -- are properly before us.

#### V. Motion to Dismiss

On October 31, 2014, Respondents filed a motion to dismiss certain claims, asserting that they were untimely filed. By order dated November 5, 2014, we denied the motion because it was filed too close to the hearing. We stated that Respondents could renew their motion at the hearing. Respondents did so, and we took the motion with the case. The parties dismissed many of the claims that were the subject of the motion, but three claims remain for two patients: Patient S.A. (#4914049074843) and Patient T.J. (#4914010046010 and #4914133042833).

MMAC argues the claims should be dismissed because § 208.156.8 gives the provider “thirty days from the date of mailing or delivery of a decision of the department of social services” to file an appeal. MMAC attached an affidavit and electronic Missouri Medicaid Information System (“eMMIS”) records to its motion, which were admitted into evidence at the hearing as Exhibit BB. The affidavit of Agnes Boehm provides information about how notice of denial was given to providers:

Each remittance advice shows the date on which it was created. That date is found at the top of the document, where the document states “Remittance Advice as of [DATE].” Each remittance advice was available electronically on the Monday that follows the date referenced above for the provider under whose provider number the claim was submitted. This electronic document gave the provider notice of the Medicaid agency’s decisions with respect to the claims identified in these remittance advices. Each claim has its own Individual Claim Number (“ICN”). For each ICN that has a code “4,” the Medicaid agency denied the provider’s claim.

Patient S.A.'s claim #4914049074843 has a Remittance Advice date of February 21, 2014. The Monday following that date was February 24, 2014. Patient T.J.'s claim #4914010046010 has a Remittance Advice date of January 10, 2014. The Monday following that date was January 13, 2014. Patient T.J.'s claim #4914133042833 has a Remittance Advice date of May 23, 2014. The Monday following that date was May 26, 2014 (Memorial Day). All three claims had a code 4, so they were denied. Thus, the relevant dates are February 24, 2014, January 13, 2014, and May 26, 2014 (or May 27, 2014, if Memorial Day is exempted).

Respondents point out that these claims were not appealed until September 15, 2014, the date Dye filed his second amended complaint. They argue that the date does not relate back to the original complaint filing date of May 28, 2014, because the claims do not arise "out of the conduct, transaction, or occurrence set forth or attempted to be set forth in the original pleading" in this case. *TGB, Inc., v. City of St. Louis Bd. of Building Appeals*, 154 S.W.3d 353, 356 n.1 (Mo. App., E.D. 2004).

We agree with Respondents. Dye's appeal of the denial of these claims was untimely. We dismiss these claims.

#### VI. Medicaid Coverage for Dentures/Dental Care

Dye provides dental services, including dentures, to Medicaid participants. The threshold issue in this case is the extent to which dentures are a covered service under Missouri's Medicaid program. We considered this issue Case No. 13-2108. In that case, as in this one, Dye argues that federal Medicaid law mandates that the State of Missouri cover extensive dental services for Medicaid patients. Dye repeats many of the same arguments that we rejected in the previous case. We reject them again here, for the same reasons. Because this is a separate decision, however, we repeat that analysis here.

Under federal law, dental services are an optional service that a state may choose to provide. 42 U.S.C. § 1396d(a)(10). But once the state makes that choice, Dye contends, it must provide coverage sufficient to reasonably achieve its purpose and that dental services “shall at a minimum include relief of pain and infection, restoration of teeth and maintenance of dental health.” Pet Brief at 4. In other words, he claims that once a state has decided to provide any dental services under its Medicaid program, it must provide all dental services that fit into the above description, including dentures, to all Medicaid participants.

Dye cites 42 CFR § 440.230(b), which states: “Each service must be sufficient in amount, duration, and scope to reasonably achieve its purpose.” He argues, therefore, that once a state elects to provide any dental services, it must provide “sufficient” dental services, which include dentures. Dye overlooks the last part of the regulation, however, which provides that “The agency may place appropriate limits on a service based on such criteria as medical necessity or on utilization control procedures.” 42 CFR § 440.230(d). In fact, that is what the Missouri legislature has done in § 208.152.1(21), RSMo. Supp. 2013, which provides that “[p]rescribed medically necessary dental services” are covered under the state’s Medicaid program (emphasis added).

Dye cites 42 U.S.C. § 1396d(r)(3)(B) to argue that dental services must “at a minimum include relief of pain and infection, restoration of teeth and maintenance of dental health.” But that regulation does not purport to prescribe the scope of dental services that must be covered by a state for all Medicaid participants. Rather, the description of dental services contained therein is part of a larger paragraph within the regulation defining “early and periodic screening, diagnostic, and treatment services” for children. In short, it is completely inapposite.

Nor do the cases Dye cites support his position. He cites *Jensen v. Mo. Dep’t of Health & Senior Services*, 186 S.W.3d 857 (Mo. App. W.D. 2006), for the propositions that once a state

elects to participate in a federal program, it must comply with all statutory and regulatory requirements imposed by law, *id.* at 860, and that if a state elects to provide an optional Medicaid program, it must provide coverage sufficient to achieve its purpose, *id.* at 861. While these statements are true, they do not help Dye here because he has inaccurately characterized the underlying requirements of the Medicaid statutes and regulations.

Likewise, *McNeil-Terry v. Roling*, 142 S.W.3d 828 (Mo. App. E.D. 2004), does not help Dye. In that case, the court of appeals held that the Division of Medical Services (MO HealthNet's predecessor) could not suspend or terminate dental benefits for Medicaid participants. In response to reduced appropriations, the Division in 2002 promulgated an emergency rule that drastically curtailed covered dental services for adults. But § 208.152.1(7), RSMo 2000, provided that benefit payments for adult dental services "shall be made on behalf of those eligible needy persons who are unable to provide for [them] in whole or in part." As the court phrased the issue, "the Division's actions in suspending or terminating the State of Missouri's Medicaid adult dental services program, by emergency rule or other non-statutory means, violated [section 208.152.1(7).]" 142 S.W.3d at 836. Since then, however, the statutory law has changed. The general assembly amended § 208.152.1 in 2005 and 2007 so that Missouri's Medicaid program now covers only "medically necessary" dental benefits for most adult Medicaid participants.

Dye also argues that the Department relied on an unpromulgated rule when it rejected these claims. He contends that Lenger, the MMAC analyst, relied on the guidelines contained in the Dental Manual dated July 26, 2012, which explicitly exclude dentures from coverage for adults with limited benefits. Rather, Dye argues, the governing Dental Manual is the version dated November 1, 2011, because that was the version incorporated by reference into 13 CSR 70-35.010. He argues that dentures are not clearly excluded from coverage under the November 1, 2011 version of the Manual.

Section 19.1.G of the 2011 Manual contains the procedure codes related to denture services. Under each code related to dentures, the following language appears:

\*Coverable for children under 21 or for persons under a category of assistance for pregnant women, the blind or vendor nursing facility residents.

Pet. Ex. 3 at 244-47. We agree with Dye that this language does not definitively limit denture coverage to Medicaid participants who fall into the categories set forth above. It states that dentures are coverable for those participants, but it does not state they are not coverable for other participants. We also agree that the Department may define the requirements for Medicaid reimbursement only by published rule. *NME Hospitals v. Department of Social Services*, 850 S.W.2d 71, 74 (Mo. banc 1993). As in the previous case, we find the best guidance for determining whether Medicaid claims should be reimbursed is contained in the Department's regulation itself. The Department was required to promulgate that regulation under § 208.153.1, RSMo. Supp. 2013, in order to "define the reasonable costs, manner, extent, quantity, quality, charges and fees of MO HealthNet benefits" authorized under § 208.152. Regulation 13 CSR 70-35.010 now provides in pertinent part:

(3)(A) MO HealthNet reimbursement of dental services shall be limited to MO HealthNet eligible children or persons receiving MO HealthNet under a category of assistance for pregnant women or the blind.

(B) MO HealthNet participants living in a nursing facility will not experience dental service reductions. . . .

(C) For all other eligibility categories of MO HealthNet assistance dental services will only be reimbursed if the dental care is related to trauma of the mouth, jaw, teeth, or other contiguous sites as a result of injury or is related to a medical condition when a written referral from the participant's physician states the absence of dental treatment would adversely affect the stated pre-existing medical condition.

Dye attached excerpts from a deposition of Cindy Lenger, the Medicaid analyst that reviewed Dye's claims, to his trial brief, and he criticizes her knowledge and her actions. He argues that this Commission has the authority to review the actions of MMAC and Lenger, that Lenger acted outside the scope of her authority, and that MMAC does not have the authority to determine what benefits are available to participants. Respondents protest that Lenger's deposition from Case No. 13-2108 was not admitted into the record in this case and that Dye should not cite or rely on it.

Our task in this case is not to review the actions of MMAC, MO HealthNet, or Department personnel. Rather, we find facts and make an independent decision by applying existing law to facts. *Department of Soc. Services v. Peace of Mind Adult Day Care Ctr.*, 377 S.W.3d 631, 639 (Mo. App., W.D. 2012). Thus, the actions of the Department and its employees are therefore irrelevant to our determination of the ultimate issues in this case, which is whether the claims at issue are properly reimbursable under the law.

#### VII. The Claims at Issue

None of the claims at issue involved trauma of the mouth, jaw, teeth, or other contiguous sites as a result of injury to the patient. We analyze them, therefore, to determine whether they meet the elements of the second prong of 13 CSR 70-35.010(3)(C). We break down the regulation's requirements further into five subparts:

- 1) There must be a written referral
- 2) from a physician
- 3) that requests dental care
- 4) that states a pre-existing medical condition
- 5) that states the absence of dental care would adversely affect the pre-existing condition.

We have reviewed all of the claims and made our determinations as set forth in our Findings of Fact.

A. Claims Denied by MO HealthNet for  
Failure to Properly Identify the DCN

MMAC argues that certain claims coded Error Type B were properly denied because the claims failed to properly identify the DCN and/or Patient ID. Lenger testified that there was no DCN number in field 23 on the claim form where it requests “Patient ID/Account # (Assigned by Dentist.” She testified that she did not deny claims for this reason, but when she sent them to MO HealthNet for processing, that agency denied them for failure to provide the DCN.

All of the claims denied for this reason were submitted on forms with a number under field 15, “Subscriber Identifier (SSN or ID#),” and an attachment on all but two of the forms lists that number as the DCN. The claim forms for A.F. and R.L. do not have an attachment verifying the number, but both are similar numbers with the same number of characters as the verified numbers. Therefore we find that the DCN is on the claim forms – and on the attachments – even if it was provided in the wrong field.

We do not deny these claims solely because of the lack of the DCN. As noted below, even if the referral does not support reimbursement for dentures, it may support reimbursement for the evaluation.

B. The Claims in Exhibit 4, but not in Exhibit G

VanDrie testified that all the claims in Petitioners’ Exhibit 4 were submitted, but for several of the patients – M.A., T.M., T.B., M.D., and R.B. – there is no evidence that the claims were denied. Under § 208.156.2, we consider only claims that were denied or not acted upon with reasonable promptness.

Respondents allege that we should not consider A.K.’s claim for the same reason, but the documentation accompanying her claim includes a page showing a submitted charge and an

amount paid. Thus, we can make the determination that the claim was submitted for \$542.50 (maxil partial), \$542.50 (mand partial), and \$30.00 (eval). Of this, \$22.25 was paid. A.K.'s claim for the partial dentures is properly before us, although, as we discuss later, the claim documentation did not identify any pre-existing condition.

Patient M.A.'s claim form shows that a claim was submitted for \$542.50 (maxillary denture) and \$542.50 (mandibular denture). But the page showing the submitted charge and amount paid shows only that \$23.25 was submitted and \$22.25 was paid. There is no evidence M.A.'s claim for dentures was denied. Even if we assume M.A.'s claim is properly before us, we note that his claim lacks a physician referral. There is no documentation to show that the claims for services to T.M., T.B., M.D., and R.B. were denied. Even if we considered these claims, we note the following deficiencies:

- T.M. – Physician did not specifically state how the absence of dental care would adversely affect the pre-existing condition (“adversely affect her health”).
- T.B. – Lacks a physician referral.
- M.D. – The physician did not request dentures.
- R.B. – The physician did not request dentures.

Finally, the parties make the same arguments with respect to Di.M.'s claim, but that claim was denied in Case No. 13-2108. It is barred by *res judicata*.

### C. The Remaining Claims

Of the remaining claims, four – for A.K., M.S., N.V., and J.P. – had no physician referral and are ineligible for reimbursement.

Three claims – for A.F., D.W., and N.T. – had a referral from a physician, but the referral did not identify a pre-existing medical condition, so these are also ineligible.

The claim for J.E. included a physician referral that identified a pre-existing condition and linked the need to be able to chew solid food to that pre-existing condition. We conclude that claim for dentures and a limited oral evaluation is eligible for reimbursement.

Eight claims – for R.L., E.C., K.J., L.J., R.M., M.B., V.H., and Da.M. – included a physician referral that identifies a pre-existing condition and a need for dental care – such as extraction of teeth or filling of cavities -- that is connected to the pre-existing condition. We do not imply that such services would not have been reimbursable under the law. But Dye did not submit claims for such services; he submitted claims for dentures. The referrals for these participants do not clearly request or indicate a need for dentures. Therefore, we deny those claims for dentures. But seven of these claims, for M.B., E.C., V.H., K.J., L.J., R.L, and Da.M., include a separate charge for a limited oral examination. Having found that some type of dental care for these participants would have been reimbursable under the law, we believe the charges for limited oral examinations should be reimbursed.

#### VIII. Reimbursement

To determine the proper reimbursement due, we list the claims for services we have found were covered under 13 CSR 70-35.010(3)(C), and the amount allowed for the service by the Manual.

<u>DOS</u>	<u>Participant</u>	<u>Service</u>	<u>Amount</u>
12/4/13	M.B.	Limited oral evaluation	\$23.25 (G-1)
11/21/13	E.C.	Limited oral evaluation	\$23.25 (G-5)
11/8/13	J.E.	Limited oral evaluation Complete Denture-Maxillary	\$23.25 (G-9) \$525.00
10/29/13	V.H.	Limited oral evaluation	\$23.25 (G-17)

11/12/13	K.J.	Limited oral re-evaluation	\$24.00 (G-21) <sup>7</sup>
11/11/13	L.J.	Limited oral re-evaluation	\$24.00 (G-29)
11/13/13	R.L.	Limited oral evaluation	\$23.25 (G-33)
11/7/13	Da.M.	Limited oral re-evaluation	\$24.00 (G-36)
	<u>TOTAL</u>		<u>\$713.25</u>

We determine that Dye is eligible for reimbursement of \$713.25 for dentures and dental evaluations he provided to adult Medicaid participants with limited benefits.

### **Summary**

Dye is entitled to partial reimbursement in the amount of \$713.25 for denied claims for dental care and dentures provided to Medicaid participants.

SO ORDERED on March 19, 2015.

*\s\ Karen A. Winn*

KAREN A. WINN

Commissioner

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<sup>7</sup> A \$542.50 charge was listed as a Type B error, but we assume it was a Type A error since the claim was denied because it did not adequately identify the pre-existing medical condition.