Office of Hearings and Appeals
3601 C Street, Suite 1322
P. O. Box 240249
Anchorage, AK 99524-0249
Phone: (907) 334-2239
Fax: (907) 334-2285

STATE OF ALASKA
DEPARTMENT OF HEALTH AND SOCIAL SERVICES
OFFICE OF HEARINGS AND APPEALS

In the Matter of:	)	
	)	
[redacted],	)	OHA Case No. 09-FH-2055
	)	
Claimant.	)	DHCS Case No. [redacted]
	)	

FAIR HEARING DECISION

STATEMENT OF THE CASE

[redacted] (Claimant) applied to receive upper and lower dentures under the Medicaid Dental Services Program (undisputed hearing testimony). The Claimant received preauthorization for the upper denture on May 4, 2009 and subsequently received retroactive authorization for the lower denture on September 2, 2009 (Ex. G-1; undisputed hearing testimony). However, for reasons discussed in more detail in the Findings of Fact below, the Division of Health Care Services (DHCS or Division) did not ultimately pay for all of the Medicaid dental benefits which had previously been authorized (Ex. G-1; undisputed hearing testimony).

No formal denial letter was issued to the Claimant by the Division. However, it was not disputed that DHCS did not ultimately pay out all of the dental benefits which had been authorized. Accordingly, even though no formal denial letter was issued by DHCS, the Division's Hearing Representative stipulated that there had been a *de facto* [1] or actual denial of dental benefits to the Claimant (undisputed hearing testimony).

The Claimant requested a fair hearing on August 3, 2009 (Ex. C-1). The Claimant's hearing began on October 13, 2009 before Hearing Officer Patricia Huna. [2] The Claimant participated by phone, represented himself, and testified on his own behalf. [redacted], Medical Assistance Administrator III for DHCS, attended the hearing in person, represented DHCS, and testified on its behalf. [redacted] of DHCS was also present in person and testified on behalf of DHCS.

---

[1] "De facto" is defined as "in fact, in deed, actually" (*Black's Law Dictionary* at 375 (West Publishing, Fifth Edition, 1979); and "in reality or fact; actually" (*Webster's II New Riverside University Dictionary*, Houghton Mifflin Co. 1984).

[2] Following completion of the hearing, this case was reassigned to Hearing Officer Jay Durych. He reviewed the entire case file, and listened to the digital recordings of both hearings, prior to issuing this decision.

The hearing of October 13, 2009 was hampered due to the fact that, as of that date, the parties had not yet received an up-to-date billing statement from the Claimant's dentist. Accordingly, after receiving testimony, the hearing was continued to November 18, 2009 in the hope that the dentist's billing statement would be received by that date. [3]

At the hearing of November 18, 2009 the same persons were present (and were acting in the same capacities) as at the prior hearing. The parties' testimony and exhibits were received into evidence. At the end of the hearing the record was closed, except that the Claimant was given until December 9, 2009 to file any response to DHCS' exhibits H and I, which the Claimant did not have the opportunity to review previously. No response from the Claimant was received.

This Office has jurisdiction to resolve this dispute pursuant to 7 AAC 49.010.

ISSUES

The Claimant's assertions at hearing were as follows:

1. He should have received a complete upper (maxillary) denture, paid for by Medicaid from fiscal year 2009 benefits, and a partial lower (mandibular) denture, paid for by Medicaid from fiscal year 2010 benefits. [4]

2. He paid $1,000.00 of his own money for his dentures, and this money should be refunded to him because Medicaid should have paid for the dentures in the first place.

The Division's assertions at hearing were as follows:

1. This case involves a notice of denial of a claim, not a notice of denial of prior authorization for services. The Division only sends out written denial notices with regard to denials of prior authorization.

---

[3] At the October 13, 2009 hearing much of the argument and testimony was based on what *might* happen (i.e. would the dentist re-bill for the upper denture; would the dentist bill for the lower denture, etc.). The dentist's billing statement was in fact received prior to the second (November 18, 2009) hearing. This statement confirmed various facts which had previously been mere conjecture. Accordingly, some of the testimony given at the first hearing became obsolete (was rendered incorrect or irrelevant) upon receipt of the Claimant's dentist's final bill. This obsolete or superseded testimony was disregarded during the preparation of this decision based on lack of relevance and is therefore not referenced in these Findings of Fact or in the Analysis.

[4] State fiscal year 2009 ended on June 30, 2009 and State fiscal year 2010 started on July 1, 2009. A fiscal year (FY) is the particular 12 month accounting period used by an organization. See David L. Scott, Wall Street Words*: An A to Z Guide to Investment Terms for Today's Investor* (Houghton Mifflin Company 2003). Many organizations end their accounting year on a date other than December 31. Accordingly, the fiscal year often differs from the calendar year. *Id* If a fiscal year covers more than one calendar year, it is designated by the calendar year in which it ends. See Farlex Financial Dictionary, accessed at http://financial-dictionary.thefree dictionary. Com / fiscal+year on January 15, 2009. The State of Alaska's fiscal year starts on July 1 and ends on June 30. See official website of the State of Alaska Department of Commerce, located at http://www.commerce.state.ak.us/dca/LOGON /finmgt/finmgt-budget.htm (date accessed January 15, 2010). Thus, Alaska's fiscal year 2009 ended on June 30, 2009 and its fiscal year 2010 began on July 1, 2009.

2. The Claimant requested his hearing *before* his dentist returned to Medicaid the money it paid for the upper denture. Accordingly, as of the date of the Claimant's hearing request, no benefits had been denied and therefore no notice of denial was issued by DHCS. However, under the circumstances, DHCS agreed that there had been a *de facto* denial of benefits to the Claimant (see footnote 1, above).

3. Medicaid paid for the Claimant's upper denture. The $1,000.00 paid directly by the Claimant went toward the Claimant's lower denture.

4. Had one set of dentures been provided during the 2009 fiscal year (i.e. on or before June 30, 2009), and the other set of dentures been provided during the 2010 fiscal year (i.e. on or after July 1, 2009), then Medicaid could have provided two (2) years' worth of dental benefits on behalf of the Claimant. However, the Claimant received *both* sets of dentures after June 30, 2009 and in the same (2010) fiscal year. Accordingly, Medicaid can only pay one year's worth of dental benefits (a maximum of $1,150.00).

Based on the parties' contentions, the issues are:

1. Has DHCS paid all of the Medicaid dental benefits that it should have paid on behalf of the Claimant for fiscal years 2009 and 2010?

2. Is the Claimant himself entitled to direct reimbursement *from DHCS* due to the fact that the Claimant paid his dentist $1,000.00 of his own money?

FINDINGS OF FACT

The following facts were established by a preponderance of the evidence:

1. The Claimant was Medicaid-eligible at all times relevant to this case (undisputed fact).

2. The Claimant had Alaska Medicaid program dental benefits available for his use for fiscal years 2009 and 2010 (i.e. he had not previously used-up his benefits) (undisputed fact).

3. The Claimant was entitled to use his Medicaid dental benefits for fiscal years 2009 and 2010 to obtain dentures because he had not obtained dentures using Medicaid benefits at any time during the previous 5 years (undisputed fact).

4. During the spring of 2009 the Claimant wished to obtain a set of dentures consisting of a full upper (maxillary) denture and a partial lower (mandibular) denture (Claimant testimony). It was his understanding that one denture could be approved by Medicaid before the end of one benefit year, and that the other denture could be approved at the beginning of the next benefit year. *Id.* It was also his understanding that Medicaid would cover all but $15.00 of the cost. *Id.*

5. $1,150.00 is the Medicaid "payment cap" for dentures for any one year (█████ testimony). Medicaid's fiscal year begins on July 1 of a calendar year and ends on June 30 of the next calendar year. *Id.*

6. Medicaid pays a maximum of $1,085.00 for upper dentures ([redacted] testimony). Medicaid pays a maximum of $910.00 for lower dentures. *Id.*

7. On March 26, 2009 the Claimant's dentist requested prior authorization from Medicaid for a "comprehensive oral evaluation" (code D0150) (Ex. G-1). This procedure was performed on May 4, 2009 (Ex. I-2).

8. On May 4, 2009 the Claimant's dentist requested prior authorization for additional procedures D0230 (basically an x-ray) and D5110 (a complete upper (maxillary) denture) (Ex. G-1). Medicaid granted prior authorization for all procedures requested on that same date (May 4, 2009) (Ex. G-1). This pre-authorization was, however, only good through the end of the 2009 fiscal year on June 30, 2009 ([redacted] testimony). The Claimant's dentist performed procedures D0230 and D0150 later that day (May 4, 2009) (Ex. G-1).

9. On May 12, 2009 the Claimant's dentist began the prep work for the D5110 (complete upper (maxillary) denture) and the D5214 (partial lower (mandibular) denture) (Ex. G-1; Ex. I-2).[5]

10. On May 14, 2009 the Claimant's dentist billed Medicaid $1,800.00 for the D5110 (complete upper (maxillary) denture) (Ex. G-1; [redacted] testimony).

11. On May 15, 2009 Medicaid paid the Claimant's dentist $1,070.00 for the D5110 (Ex. G-1). The last $15.00 of the $1,085.00 Medicaid rate for an upper denture was withheld by Medicaid due to an issue with the dentist's billing ([redacted] testimony). The Claimant's dentist applied this payment on account on May 26, 2009 (Ex. I-2).

12. In a letter to the Division's contractor (First Health Services Corporation) dated July 14, 2009, the Claimant's dentist wrote (Ex. E-1):

> We are requesting that the expiration for the prior authorization [which expired June 30, 2009] be extended until July 14, 2009 due to the fact that we were not able to seat the denture until today . . . . We started this process in early May [but] . . . the patient requested that we change the shade [and] the lab did not have teeth in stock in the requested shade so we did not receive the dentures in time to seat them before June 30.
>
> * * * * * * * * * * * *
>
> Due to the above circumstances we are requesting that Medicaid pay for the dentures on the new benefit period . . . or extend the expiration date of the above-referenced prior authorization.

13. On July 21, 2009 the D5110 (upper denture) and the partial lower denture (D5214) were "seated" (i.e. work on them was completed) (Ex. G-1) and the dentist delivered them to the Claimant

[5] For the sake of brevity the complete upper (maxillary) denture will subsequently be referred to as the "upper" or D5110, and the partial lower (mandibular) denture will subsequently be referred to as the "lower" or D5214.

(Ex. I-2). The Claimant thus took possession of both the upper and lower dentures [6] within the current (2010) fiscal year (undisputed hearing testimony).

14. As of July 21, 2009 the Claimant's dentist's account history showed a zero balance owing for the D5110 (complete upper/maxillary denture) (Ex. I-2). This was due to the fact that Medicaid had paid the Claimant's dentist $1,070.00 for the D5110 on May 15, 2009 (Ex. G-1), which payment had been applied to the Claimant's account on May 26, 2009 (Ex. I-2). However, the dentist later returned this payment to Medicaid in August 2009 (Exs. G-1, I-2; see Paragraph 17, below).

15. On July 21, 2009 the Claimant paid his dentist $1,000.00 (Ex. I-2). This payment was applied by the Claimant's dentist *after* the Claimant's account showed a zero balance for the D5110 (complete upper/maxillary denture) (Ex. I-2). Because the dentist's own records show that the D5110 was paid in full prior to receipt of the Claimant's payment, the Claimant's payment of July 21, 2009 was applied (and could *only* have been applied) toward the partial lower (mandibular) denture (D5214), *not* toward the complete upper/maxillary denture (D5110).

16. On August 3, 2009 the Claimant requested a hearing with regard to his Medicaid dental benefits (Ex. C-1).

17. On either August 18, 2009 (Ex. G-1) or August 25, 2009 (Ex. I-2) the Claimant's dentist voided his May 14, 2009 payment claim ($1,070.00) for the D5110 (upper denture), and returned the money to Medicaid, because the procedure had incorrectly been billed on the "prep" date rather on the later "seat" (completion) date (Ex. G-1) and was therefore not in compliance with Medicaid billing requirements (testimony).

18. On September 2, 2009 Medicaid issued a new, retroactive payment authorization for the upper denture (D5110), and an initial retroactive payment authorization for the lower partial denture (D5214) (Ex. G-1). The record does not reflect, however, the date(s) to which these payment authorizations were made retroactive (Ex. G-1).

19. On either September 4, 2009 (Ex. G-1) or September 22, 2009 (Ex. I-2) the Claimant's dentist re-billed Medicaid for the D5110 (complete upper (maxillary) denture) (Ex. G-1). However, this billing was denied by Medicaid on September 15, 2009 because the dentist's billing referenced the wrong (May 12, 2009) seat date (Ex. G-1; Ex. I-2).

20. On either October 12, 2009 (Ex. I-2) or October 15, 2009 (Ex. G-1) the Claimant's dentist billed Medicaid for the lower denture (D5214) (Ex. G-1). On either October 20, 2009 (Ex. G-1) or October 27, 2009 (Ex. I-2) Medicaid paid the Claimant's dentist $910.00 for the lower denture (D5214) (Ex. G-1).

21. It was not the Claimant's fault that both sets of dentures were received and billed during the same fiscal year (2010) ( ); there were some problems with the dentist's billings. *Id.*

[6] Although the record is not clear whether Medicaid issued prior authorization for the lower denture prior to this date, it is clear that a retroactive authorization was issued for the lower denture on September 2, 2009 (Ex. G-1).

PRINCIPLES OF LAW

I. Burden of Proof and Standard of Proof.

The party seeking a change in the status quo or existing state of affairs normally has the burden of proof. [7] This case involves the denial [8] of an initial application or claim for Medicaid benefits by the Division. Accordingly, the Claimant has the burden of proof here because he is attempting to change the existing status quo by obtaining Medicaid benefits.

A party in an administrative proceeding can assume that preponderance of the evidence is the standard of proof unless otherwise stated. [9] The Medicaid regulations applicable to this case do not specify any particular standard of proof. Therefore, the "preponderance of the evidence" standard is the standard of proof applicable to this case. This standard is met when the evidence, taken as a whole, shows that the fact sought to be proved is more probable than not or more likely than not. [10]

II. The Medicaid Program – In General.

Medicaid is an entitlement program created by the federal government. See DPA website at http://health.hss.state.ak.us/dpa/programs/medicaid/ (date accessed July 31, 2009). It is the primary public program for financing basic health and long-term care services for low-income Alaskans. *Id.* The Medicaid program is administered in Alaska by the Division of Health Care Services (DHCS). *Id.*

7 AAC 43.025 provides in relevant part as follows:

> (a) The division will be responsible for payment for service rendered to a recipient only when *the patient was eligible for Medicaid coverage* and when *the service was properly authorized by the division* if it was a service which requires prior authorization.
>
> * * * * * * * * * * * *
>
> (f) Instructions governing the provision of service to Medicaid recipients, including the methods for receiving prior authorization by the Division, are contained in the *Division's provider manuals*. [Emphasis added].

---

7 *State of Alaska Alcoholic Beverage Control Board v. Decker*, 700 P.2d 483, 485 (Alaska 1985).

8 As noted in the Statement of the Case, above, DHCS did not actually issue any notice denying the Claimant's dental benefits. However, the DHCS representative agreed that the Claimant was effectively denied benefits under the circumstances of this case, and that there was a *de facto* denial of benefits (see definition of *de facto* in footnote 1, above).

It should also be noted that, pursuant to 42 CFR 431.241(a), Medicaid hearings must cover not only state agency *action,* but also any *failure to act* on the part of the agency. Accordingly, the fact that there was no formal denial of services in this case does not divest this Office of jurisdiction

9 *Amerada Hess Pipeline Corp. v. Alaska Public Utilities Commission*, 711 P.2d 1170, 1179 n.14 (Alaska 1986).

10 *Black's Law Dictionary* 1064 (West Publishing, Fifth Edition, 1979); see also *Robinson v. Municipality of Anchorage*, 69 P.3d 489 (Alaska 2003).

Pursuant to 7 AAC 43.1990 (62), "prior authorization" is defined as "approval by the department of a certain type and number of units of Medicaid-covered services before those services are provided."

III. Medicaid Adult Dental Services.

On March 29, 2007, Alaska's adult Medicaid program began covering $1,150 worth of preventive dental care each year for Alaskans age 21 and older who receive Medicaid services. See State of Alaska Division of Health Care Services' web site at http://www.hss. state.ak.us/dhcs/ medicaid_medicare/dental_medicaid/default.htm (date accessed January 5, 2010). The State regulations regarding adult Medicaid dental services are located at 7 AAC 43.600 - 7 AAC 43.625.

Alaska Statute (AS) Section 47.07.067 provides in relevant part that the "maximum amount of benefits for preventative and restorative adult dental services [is] $1,150 for each eligible recipient in a fiscal year."

7 AAC 43.625 provides in relevant part as follows:

* * * * * * * * * * * *

> (b) The department will pay for dental claims under this section that are applied toward a recipient's annual limit *for service dates* from July 1 to June 30 of that year. *On July 1 of each year, a recipient's annual limit returns to the maximum limit permitted under this section.* Beginning April 1, 2007, the department will pay, up to an annual limit of $1,150 per recipient 21 years of age or older, for the following dental services . . . . *(6) prosthodontics, including complete or partial dentures and denture repair or reline*; the department will pay for replacement of complete or partial dentures only once per five calendar years; [Emphasis added].

* * * * * * * * * * * *

> (g) *A dental service provided when a recipient's annual limit has been reached is considered a non-Medicaid service.* The recipient is responsible for the full amount due for the service. The department will not provide reimbursement if the recipient's annual limit has been reached. [Emphasis added].
>
> (h) For a recipient 21 years of age or older, dental services must have prior authorization from the department. The department will assist a provider and recipient to the extent possible in monitoring the recipient's annual limit. However, the department will not assume financial responsibility for services provided that exceed the recipient's annual limit . . . .

7 AAC 43.615, titled "billings to patients," provides as follows: [11]

> Payment by the division or fiscal agent represents full and total payment for those services authorized under the division's Medicaid program. *Under no circumstances*

---

[11] *See also* 42 CFR 447.15 ("Acceptance of State Payment as Payment in Full").

may a recipient, relative, or friend *be charged any amount to supplement fees paid by the division for services to which they are entitled under the provisions of this chapter.* (Emphasis added)

* * * * * * * * * * * *

ANALYSIS

<u>I. The Parties' Contentions and the Resulting Issues.</u>

Based on the parties' contentions, the issues in this case, stated as simply as possible, are:

1. Has DHCS paid all of the Medicaid dental benefits that it should have paid on behalf of the Claimant for fiscal years 2009 and 2010?

2. Is the Claimant himself entitled to direct reimbursement from DHCS because he paid his dentist $1,000.00 of his own money?

These issues will be addressed below in the order stated. The Claimant bears the burden of proof on both issues by a preponderance of the evidence (see Principles of Law, above).

<u>II. Did DHCS Satisfy Its Obligation To Claimant For Fiscal Year 2009?</u>

Pursuant to 7 AAC 43.625(b), the Claimant is entitled to a maximum of $1,150.00 in dental benefits for fiscal year 2009, and another $1,150.00 in dental benefits for fiscal year 2010, *assuming that all other applicable Medicaid criteria have been met*. If all other applicable criteria have been met, then, pursuant to 7 AAC 43.625(b)(6), the Claimant is entitled to obtain dentures. Accordingly, did the Claimant satisfy all Medicaid criteria prerequisite to the Division's obligation to pay for a denture in fiscal year 2009?

7 AAC 43.025(a) states two of the three criteria applicable in this case. It provides as follows:

> (a) The division will be responsible for payment for service rendered to a recipient only when *the patient was eligible for Medicaid coverage* and when *the service was properly authorized by the division* if it was a service which requires prior authorization.

Thus, in order for DHCS to be responsible for medical services pursuant to 7 AAC 43.025(a), a Claimant must (1) be eligible for Medicaid coverage; and (2) receive prior (or retroactive) authorization from DHCS for the services requested. In this case, both of these criteria were met. Specifically, the Claimant was Medicaid-eligible during the period of time relevant to this decision (see Findings of Fact at paragraph 1, above). In addition, it is clear from the record that payment for the Claimant's upper and lower dentures was authorized by the Division either before or after the procedures (i.e. were either pre-authorized or retroactively authorized). See Findings of Fact at paragraphs 7, 8, 12, and 18, above). Accordingly, there is no question that the Claimant satisfied the criteria of 7 AAC 43.025(a).

There is, however, one additional Medicaid payment requirement critical to this case. This requirement is found in 7 AAC 43.625(b), a regulation specific to the Medicaid dental program. 7 AAC 43.625(b) provides in relevant part that "the department will pay for dental claims under this section that are applied toward a recipient's annual limit *for service dates from July 1 to June 30 of that year."* [Emphasis added]. In other words, the Medicaid dental program clearly requires that the Division pay only those claims for dental services which were *actually performed* ("service dates") *within the fiscal year.*

In this case, the apparent intent of the Claimant and his dentist was that the upper denture (D5110) be both preauthorized *and completed* by June 30, 2009 so that the Claimant's 2009 Medicaid dental benefits could be used to pay for it (see Findings of Fact at paragraphs 4 and 7-12, above). The Claimant's dentist initially billed Medicaid for the upper denture (D5110) using the "prep" date (May 12, 2009) in an apparent effort to accomplish this. However, because of delays, the upper denture (D5110) was not "seated" (i.e. work on it was not completed) until July 21, 2009 (Ex. G-1; undisputed hearing testimony). Thus, the denture was "seated" or completed after fiscal year 2009, which ended on June 30, 2009. Accordingly, because work was not *completed* until fiscal year 2010, the Division could not pay for the D5110 using the Claimant's fiscal year 2009 Medicaid benefits without violating 7 AAC 43.625(b). [12]

In summary, 7 AAC 43.625(b) did not allow the Division to pay for an upper denture completed in fiscal year 2010 using the Claimant's fiscal year 2009 Medicaid dental benefits. Accordingly, the Division did not err when it effectively denied payment for the Claimant's upper denture (D5110).

III. Did DHCS Satisfy Its Obligation To Claimant For Fiscal Year 2010?

The Division asserts that Medicaid paid for the Claimant's upper denture (testimony of [redacted] and [redacted]). However, the Claimant's dentist's own account history clearly shows a zero balance owing for the D5110 (upper denture) as of July 21, 2009 (Ex. I-2). The Claimant's $1,000.00 payment of July 21, 2009 was not applied by the Claimant's dentist until *after* the Claimant's account showed a zero balance for the D5110.

The Claimant's account showed a zero balance on July 21, 2009 because the Claimant's dentist had applied Medicaid's payment of $1,070.00 for the D5110 (upper denture) on May 26, 2009 (Ex. I-2), and the Claimant's dentist did not void that transaction and return the $1,070.00 for the D5110 (upper denture) to Medicaid until either August 18, 2009 (Ex. G-1) or August 25, 2009 (Ex. I-2). Thus, the Claimant's July 21 payment of $1,000.00 was applied in payment of his lower denture (D5214).

Medicaid's fiscal year begins on July 1 of a calendar year and ends on June 30 of the next calendar year ([redacted] testimony; see also footnote 4, above). There is a cap for each fiscal year for dental benefits. *Id.* Regulation 7 AAC 43.625(b) requires that the Division pay only those claims for dental services which were *actually performed* ("service dates') *within the fiscal year.*

---

[12] On either August 18, 2009 (Ex. G-1) or August 25, 2009 (Ex. I-2) the Claimant's dentist voided his May 14, 2009 payment claim ($1,070.00) for the D5110 (upper denture), and returned the money to Medicaid, because the procedure had incorrectly been billed on the "prep" date rather on the later "seat" (completion) date (Ex. G-1) and was therefore not in compliance with Medicaid billing requirements ([redacted] testimony). See Findings of Fact at paragraph 14, above.

In this case, the lower denture (D5214) was not seated / completed until July 21, 2009 (Ex. G-1). Thus, pursuant to 7 AAC 43.625(b) (discussed in Analysis Section II, above), the lower denture (D5214) could only be paid for by Medicaid using fiscal year 2010 dental benefits, which became available on July 1, 2009.

Medicaid pays a maximum of $910.00 for lower dentures ([redacted] testimony). On either October 20, 2009 (Ex. G-1) or October 27, 2009 (Ex. I-2), Medicaid paid $910.00 toward the Claimant's lower denture (D5214). Accordingly, the Claimant exhausted his fiscal year 2010 Medicaid dental benefits when DHCS paid for his lower denture.

IV. Is Claimant Entitled To Reimbursement By DHCS For Payments He Made to His Dentist?

As discussed above, the Claimant paid his dentist $1,000.00 of his own funds. The next question is, does he have any right to direct reimbursement of these funds *from DHCS?*

It appears that the dentist's *intent* was to apply the Claimant's $1,000.00 to the upper denture, because it appears that he knew that the upper denture had been completed too late to be paid for by Medicaid from FY2009 funds. See dentist's letter to the Division's contractor (First Health Services Corporation) dated July 14, 2009 (Ex. E-1). However, the dentist's billing history clearly shows that the payments were applied differently, as explained below.

As discussed in Analysis Section III, above, the Claimant's account showed a zero balance on July 21, 2009 because the Claimant's dentist had applied Medicaid's payment of $1,070.00 for the D5110 (upper denture) on May 26, 2009 (Ex. I-2), and the Claimant's dentist did not void that transaction and return the $1,070.00 for the D5110 (upper denture) to Medicaid until either August 18, 2009 (Ex. G-1) or August 25, 2009 (Ex. I-2). Thus, the Claimant's July 21 payment of $1,000.00 was clearly applied in payment of his lower denture (D5214). Subsequently, the Claimant's dentist billed Medicaid for the lower denture (D5214) (Ex. G-1). Finally, on either October 20, 2009 (Ex. G-1) or October 27, 2009 (Ex. I-2) Medicaid paid the Claimant's dentist $910.00 for the lower denture (D5214) (Ex. G-1).

As discussed in Sections II – III of the above Analysis, 7 AAC 43.625(b) does not allow the Division to pay for an upper denture completed in fiscal year 2010 using the Claimant's fiscal year 2009 Medicaid dental benefits, which ended on June 30, 2009. Accordingly, the Division did not err when it effectively denied payment for the Claimant's upper denture (D5110).

Further, the Claimant exhausted the portion of his 2010 Medicaid dental benefits that was allocable to dentures pursuant to AS 47.07.067 and 7 AAC 43.625. Thus, DHCS paid out all fiscal year 2010 dental benefits to which the Claimant is entitled for his lower denture. Moreover, the Claimant paid the $1,000.00 payment which he seeks to recover here *directly to his dentist, not to DHCS*.

In summary, the Claimant does not have any right to direct reimbursement of funds *from DHCS* because DHCS does not possess or retain any monies from which the Claimant could possibly be entitled to direct reimbursement. Accordingly, it is not necessary to discuss the specific requirements for direct reimbursement set forth in the state and federal regulations and policy manuals. [13]

---

[13] These provisions are 42 CFR 447.25(c), Section 4.20 of the Alaska State Plan, and Section 6320 of the State Medicaid Manual.

It is clear that, pursuant to 7 AAC 43.615, a provider is not entitled to collect anything from a recipient if the claim is totally paid by Medicaid. However, Exhibits G-1 and I-2 clearly show that the Claimant's dentist applied *both* the Claimant's $1,000.00 payment of July 21, 2009, *and* Medicaid's $910.00 payment of October 27, 2009, to pay for the Claimant's lower denture. Thus, although it may not have been intentional, *the Claimant's dentist ultimately received no money for the upper denture, but was paid twice for the Claimant's lower denture.*

With regard to payment issues between the Claimant and his dentist, it must be noted that, in Fair Hearing cases like this one, this Office only has jurisdiction to decide issues arising between the various divisions/offices of the State of Alaska Department of Health and Social Services (DHSS), and the applicants and recipients of the benefit programs administered by DHSS. See 7 AAC 49.010 and 7 AAC 49.170. This Office *does not* have jurisdiction over third parties (i.e. parties other than a claimant and the particular state DHSS division/office involved). [14]

CONCLUSIONS OF LAW

1. Pursuant to Medicaid regulation 7 AAC 43.625(b), the Claimant is entitled to a maximum of $1,150.00 in dental benefits for fiscal year 2009, and another $1,150.00 in dental benefits for fiscal year 2010.

2. The Claimant's upper denture was not seated, and thus was not completed, until July 21, 2009 (during fiscal year 2010). 7 AAC 43.625(b) does not allow the Division to pay for an upper denture completed in fiscal year 2010 using the Claimant's fiscal year 2009 Medicaid dental benefits. Accordingly, the Division did not err when it effectively denied payment for the Claimant's upper denture (D5110).

3. The Division was correct and did not err when it paid $910.00 for a lower denture completed in fiscal year 2010 using the Claimant's fiscal year 2010 Medicaid dental benefits.

4. The Claimant is not entitled to direct reimbursement from the Division of any sums that Claimant paid to his dentist.

5. This Office does not have jurisdiction to resolve claims that may exist between the Claimant and his dentist.

---

[14] Further, even if this Office had such jurisdiction, due process requires that a third party be given notice of a proceeding, and the opportunity to participate in that proceeding, before the third party's rights can be determined in that proceeding. Accordingly, should a claimant in a Fair Hearing case have a dispute which cannot be resolved without the participation of a third party, it may be necessary for the claimant to have that dispute resolved by an authority (such as a court) which has broader jurisdiction than does this Office.

DECISION

The Division was correct when it effectively denied the Claimant's request to disburse his fiscal year 2009 Medicaid dental benefits for an upper (maxillary) denture which was not completed during fiscal year 2009.

The Division was correct when it paid $910.00 of the Claimant's fiscal year 2010 Medicaid dental benefits toward the Claimant's lower (mandibular) denture which was completed during fiscal year 2010.

The Claimant is not entitled to direct reimbursement from DHCS of any sums that the Claimant paid to his dentist.

This Office does not have jurisdiction to resolve claims that may exist between the Claimant and his dentist.

APPEAL RIGHTS

If for any reason the Claimant is not satisfied with this decision, the Claimant has the right to appeal by requesting a review by the Director. To do this, send a written request directly to:

Director of the Division of Senior and Disabilities Services
Department of Health and Social Services
PO Box 110680
Juneau, AK 99811-0680

If the Claimant appeals, the request must be sent within 15 days from the date of receipt of this Decision. Filing an appeal with the Director could result in the reversal of this Decision.

DATED this [22nd] day of January, 2010.

_____/signed/______________________
Jay Durych
Hearing Authority

CERTIFICATE OF SERVICE

I certify that on this [22nd] day of January 2010
copies of the foregoing document were sent to the
Claimant via USPS certified mail, and to the remainder
of the service list by e-mail, as follows:
Claimant - via USPS Certified Mail, Return Receipt Requested
[redacted], Director
[redacted], Policy & Program Development
[redacted], Policy & Program Development
[redacted], Staff Development & Training
[redacted], Fair Hearing Representative

____
J. Albert Levitre, Jr., Law Office Assistant I