BEFORE THE
OFFICE OF ADMINISTRATIVE HEARINGS
STATE OF CALIFORNIA

In the Matter of: CLAIMANT, vs. EASTERN LOS ANGELES REGIONAL CENTER, Service Agency.	OAH No. 2017030186

DECISION

Glynda B. Gomez, Administrative Law Judge, Office of Administrative Hearings, State of California, heard this matter on April 6, 2017, in Alhambra, California.

Jacob Romero, Fair Hearings Coordinator, represented the Eastern Los Angeles Regional Center (ELARC). Claimant was not present, but was represented by his mother (Mother).

The matter was submitted on April 6, 2017.

ISSUE

Should ELARC be required to reimburse Claimant's mother for funds she borrowed to pay for dental related general anesthesia services for Claimant.

SUMMARY

Claimant contends that his parent should be reimbursed for the costs of general anesthesia needed for his dental procedure. Claimant further contends that the general

anesthesia was necessary because of his developmental disability and generic resources were explored and exhausted.

ELARC contends that it is prohibited from reimbursing parent for the costs of the general anesthesia because generic resources were available, the expenditure was not approved as part of Claimant's IPP, and it is prohibited from funding dental care costs.

For the reasons set forth below, Claimant's appeal is granted.

FACTUAL FINDINGS

1. Claimant is a 15-year-old boy who is eligible for regional center services based upon his diagnosis of Autism. Claimant is non-verbal, has aggressive behaviors and suffers from Attention Deficit Hyperactive Disorder (ADHD) and mild hearing loss. Claimant's most recent psychological assessment was in 2014 when he was 11 years old. At the time, the assessor determined that Claimant's overall cognitive functioning was equivalent to that of a 1.2 year-old child, his communication skills were that of a 1.4 year-old, his social emotional skills were at the level of a 1.4 year-old, his adaptive behavior were that of a 1.6 year-old, and his physical skills were equivalent to that of a 2.8 year-old.

2. Currently, Claimant is not attending school because of health concerns. Claimant was diagnosed with Cellulitis, Folliculitis, a staph infection (MRSA), ringworm, Psoriasis and boils. He experiences reoccurring outbreaks and bleach baths have been prescribed to control his infection. He is incontinent and must be washed each time he uses the bathroom in order to keep his genital area clean and dry according to his physician's instructions. The school district was not able to accommodate his needs and is searching for an appropriate placement for him. Presently, he is cared for at home and is not attending school.

3(a). Claimant's individual program plan (IPP), dated March 14, 2016, provides as a desired outcome that "[Claimant] will maintain stable health by having regular

medical and dental evaluations throughout the year." The IPP further provides that "Medi-Cal will continue to fund medical and dental-related services."

3(b). At the time of the IPP meeting, Claimant's mother, a registered dental assistant and dental assistant instructor, told the service coordinator that she was searching for a new dentist for Claimant and that Claimant had broken one of his permanent teeth. Mother told the service coordinator that she was having difficulty finding a dentist who would treat Claimant and accept Medi-Cal.

3(c). Mother assists Claimant with his dental hygiene including brushing his teeth and flossing. To date, Claimant has no cavities. It is likely that his tooth was broken by his constant teeth grinding.

3(d). Consistent with his diagnosis of Autism, Claimant is uncooperative and combative during dental examinations. For his safety and to conduct a thorough examination and take x-rays, it is necessary to place him under general anesthesia. Similarly, any dental procedures also require general anesthesia because Claimant is uncooperative due to his developmental disability.

4(a). Claimant's mother took him to Children's Hospital of Los Angeles (CHLA) in December of 2015 to have his tooth assessed.

4(b). Claimant refused to cooperate with the CHLA dentist. However, the CHLA team advised mother that it was necessary to document his refusal to cooperate in order to authorize general anesthesia for dental treatment.

4(c). After a visual examination, the CHLA dentist confirmed that there was a break on the distal cusp of tooth number 19 and advised mother that it would be necessary for a dentist to place Claimant under general anesthesia to determine whether a root canal treatment or an extraction was necessary.

4(d). Because Tooth number 19 was a permanent tooth and Claimant was uncooperative, CHLA did not perform a complete exam or take any x-rays.

4(e). CHLA referred Claimant to USC and UCLA dental schools for further treatment. UCLA gave Claimant an appointment for April 20, 2017. USC put Claimant on a waiting list that typically takes 18 months for an initial appointment.

5(a). In September of 2016, Mother again advised the ELARC service coordinator that Claimant had unmet dental needs and provided documentation from various dental providers. By this time, Claimant was experiencing increasing pain and discomfort.

5(b). In September and October of 2016, Mother contacted Western Dental, Loma Linda dental school, Covina surgery center, and various private dentists throughout Southern California in search of a dentist who would agree to treat claimant, was qualified to administer general anesthesia, and would accept Medi-Cal.

5(c). Mother was unable to locate someone who met all of those requirements with less than a six month wait. As Claimant's dental pain became more serious, the situation became more urgent.

5(d). Although ELARC's service coordinator was aware of Claimant's dilemma, she did not refer Claimant to an ELARC vendor dentist, advocate on Claimant's behalf or assist with any resources.

6. As a last resort, Mother purchased private dental insurance through American Association of Retired People (AARP) which commenced coverage in October 2016. Soon thereafter, Mother found a dentist that would accept Claimant as a patient using the private insurance and would use general anesthesia for his dental procedures. However, the anesthesiologist was not covered under Claimant's private insurance.

7. On October 11, 2016, Claimant's mother advised the service coordinator that Claimant's tooth had become increasingly painful and needed immediate attention. She also told the service coordinator that she intended to request reimbursement from ELARC for the cost of Claimant's general anesthesia for the dental procedure. Claimant's

mother told the service coordinator that Claimant could not wait six months or longer for a Medi-Cal provider, or the dental schools because of the increasing pain. Claimant's mother advised the service coordinator that Claimant's broken tooth was increasingly painful and he would likely lose it by waiting six months or more. Mother credibly and persuasively testified at hearing, based upon her professional experience as a dental hygienist, about the various long term consequences of tooth loss including problems eating, dry socket syndrome and loss of facial support.

8. On October 12, 2016, Dr. Seto, a dentist, and Dr. Torbiner, an anesthesiologist, performed a root canal treatment on the broken cusp of Claimant's permanent tooth number 19. Dr. Seto charged $1,400 for the procedure, x-ray and amalgam restoration. Claimant's mother paid $749.90 and the remainder was paid by the AARP dental insurance. Claimant also incurred a $1,780 charge for general anesthesia services from Dr. Torbiner, the anesthesiologist, which was not covered by insurance. Neither Dr. Seto nor Dr. Torbiner were Medi-Cal providers. Claimant's mother borrowed $1,780 for payment of the general anesthesia charges. Although Medi-Cal sometimes reimburses parents for such charges, in this case the anesthesiologist was not a Medi-Cal provider and therefore, Medi-Cal will not accept a reimbursement request for the $1,780.

9. ELARC did not provide service coordination, referral to a vendor or any other substantial assistance to Claimant in this process. Claimant was merely given a telephone number by the service coordinator for the Medi-Cal reimbursement unit of the Department of Health Services (DHS) after the expenses were incurred. Claimant's mother called the telephone number she was given and was provided with a packet of information and a reimbursement application from DHS. The accompanying instructions for submission of Claim clearly set forth, in a section entitled "Who May File a Claim?," that "If you received services on or after February 2, 2006, to get a refund for payments,

you must have paid a provider who accepts Medi-Cal." When Claimant's mother read the instructions, she knew that a reimbursement claim would be rejected and that it was futile to complete the detailed claim package because Claimant's anesthesiologist was not a Medi-Cal provider and the charge was not eligible for reimbursement under the DHS rules.

10. ELARC issued a Notice of Proposed Action to Claimant on November 22, 2016 denying Claimant's request for reimbursement on the grounds that Medi-Cal and other generic resources were available and Claimant did not seek reimbursement from Medi-Cal. ELARC does not dispute the necessity of the general anesthesia for the procedure.

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LEGAL CONCLUSIONS

1. The Lanterman Developmental Disabilities Services Act (Lanterman Act) governs this case. (Welf. & Inst. Code (Code), § 4500 et seq.) An administrative "fair hearing" to determine the rights and obligations of the parties, if any, is available under the Lanterman Act. (Code §§ 4700-4716.) Claimant requested a fair hearing to appeal ELARC's decision to deny his request for reimbursement.

2. The burden of proof is on the party seeking to terminate the service or change the status quo. In this case, that burden is on Claimant as the party seeking reimbursement. The standard of proof in this matter is a preponderance of the evidence. (See Evid. Code,
§§ 115 and 500.)

3. Cause exists to grant Claimant's appeal, as set forth in Factual Findings 1 through 10, and Legal Conclusions 4 through 15.

4. In enacting the Lanterman Act[1], the Legislature accepted its responsibility to provide for the needs of developmentally-disabled individuals and recognized that services and supports should be established to meet the needs and choices of each person with developmental disabilities. (Code, § 4501.) The Lanterman Act is intended to prevent or minimize the institutionalization of developmentally-disabled persons and their dislocation from family and community, to enable them to approximate the pattern of everyday living of nondisabled persons of the same age, and to enable them to lead more productive and independent lives in the community. (*Association for Retarded Citizens v. Department of Developmental Services* (1985) 38 Cal.3d 384, 388.)

5. The Lanterman Act was intended to ensure the rights of persons with developmental disabilities, including a right to treatment and habilitation services and supports in the least restrictive environment. Treatment and habilitation services and supports should foster the developmental potential of the person and be directed toward the achievement of the most independent, productive, and normal lives possible. (Code, §§ 4502, subd. (a) and (b), 4640.7.)

6. Code section 4512, subdivision (b), defines services and supports for persons with developmental disabilities as specialized services and supports or special adaptations of generic services and supports directed toward the alleviation of a developmental disability or toward the social, personal, physical, or economic habilitation or rehabilitation of an individual with a developmental disability, or toward the achievement and maintenance of independent, productive, normal lives. Dental care is among the listed services and supports.

7. Regional centers are responsible for developing and implementing IPPs, for taking into account consumer needs and preferences, and for ensuring service cost-

[1] Code §4500, et seq.

effectiveness. (Code §§ 4646, 4646.4, 4646.5, 4647, and 4648.) Regional Centers must ensure that the IPP and provision of services and supports by the regional center system is centered on the individual and the family of the individual with disabilities and takes into account the needs and preferences of the individual and the family, where appropriate, as well as promoting community integration, independent, productive, and normal lives, and stable and healthy environments. The provision of services to consumers and their families must be effective in meeting consumer needs, and maintain a balance between reflecting consumer and family preference on the one hand while being cost-effective on the other hand. (Code, § 4646.5.)

8. Regional Centers are responsible for coordinating services provided to consumers. "[S]ervice coordination shall include those activities necessary to implement an IPP, including, but not limited to, ...securing, through purchasing or by obtaining from generic agencies or other resources, services and supports specified in the person's IPP; coordination of service and support programs; . . . and monitoring implementation of the plan to ascertain that objectives have been fulfilled and to assist in revising the plan as necessary." (Code §4647, subd. (a).).)

9. In order to achieve the stated objectives of a consumer's IPP, the regional center shall conduct activities including, but not limited to, securing needed services and supports. A regional center may contract or issue a voucher for services and supports provided to a consumer or family. In order to ensure the maximum flexibility and availability of appropriate services and supports for persons with developmental disabilities, the department shall establish and maintain an equitable system of payment to providers of services and supports identified as necessary to the implementation of a consumers' IPP. The system of payment shall include provision for a rate to ensure that the provider can meet the special needs of consumers and provide quality services and supports in the least restrictive setting as required by law. (Welf. & Inst. Code §4648,

subd. (a)(4) and (5).).) Where there are identified gaps in the system of services and supports or where there are identified consumers for whom no provider will provide services and supports contained in his or her IPP, the regional center may provide the services and supports directly. (Welf. & Inst. Code §4648, subd. (g).)

10. Regional centers must identify and pursue all possible generic resources and other sources of funding for consumer receiving regional center services, including private insurance and may not fund services that are covered by a consumer's insurance. These sources shall include, but not be limited to, governmental or other entities or programs required to provide or pay the cost of providing services, such as Medi-Cal, Medicare, the Civilian Health and Medical Program for Uniform Services, school districts, and federal supplemental security income and the state supplementary program and private entities, to the maximum extent they are liable for the cost of services, aid, insurance, or medical assistance to the consumer. (Welf. & Inst. Code §4659, subd. (a).)

11. Effective July 1, 2009, notwithstanding any other law or regulation, a regional center shall not purchase medical or dental services for a consumer three years of age or older unless the regional center is provided with documentation of a Medi-Cal, private insurance, or a health care service plan denial and the regional center determines that an appeal by the consumer or family of the denial does not have merit. (Welf. & Inst. Code § 4659 subd. (c).) Regional centers may pay for medical or dental services while coverage is being pursued, but before a denial is made and pending an administrative decision on an appeal. (Welf. & Inst. Code § 4659, subd. (d).)

12(a). The California Supreme Court has stated that, while regional centers have 'wide discretion' in determining how to implement the IPP [citations], they have no discretion at all in determining whether to implement it: they must do so [citation]." (*Assn. for Retarded Citizens v. DDS* (1985) 38 Cal. 3d 384, 390.) Regional centers must refer consumers to available generic resources of payment, and assist consumers in their

attempts to obtain funding to which they are entitled, but regional centers must act as payers of last resort where such funding cannot be obtained. (Code § 4659, et seq.; see also Code § 4659.10 (regional centers "shall continue to be payors of last resort" in cases involving third party liability).) Regional Centers have a vendor process and rates established for services, (California Code of Regulations, Title 17, section 54326), and can contract for vendorized dental care using this process.

12(b). If a regional center does not act to provide a consumer with funding for specialized care when generic sources of funding prove intractable, the regional center must provide the services; it is authorized to pursue reimbursement under Code section 4659. Failing to do so violates the central purpose of the Lanterman Act which is to provide services to persons with developmental disabilities. (Code §§ 4502, subd. (a), 4646, subd. (a), & 4648, subd. (a).) If it chooses to do so, a regional center may also initiate legal action to pursue a funding source for consumers receiving services. (73 Ops. Cal. Atty. Gen. 156, 157 (1990).)

12(c). The Legislature's insistence on having the needs of person with developmental disabilities met by the provision of services is so significant that the Legislature directs DDS itself to provide services directly to consumers in cases where there appear to be "gaps in the system of services and support or where there are identified consumers for whom no provider will provide services and supports contained in [his] IPP." (Code §4648, subd. (g).)

13. In this case, Claimant needed a dental procedure to save his tooth and stop his pain. His mother tried unsuccessfully over a period of months to obtain dental care from a Medi-Cal provider dentist, including general anesthesia that is needed because of Claimant's developmental disability, but was unsuccessful. She contacted various private dentists, clinics, CHLA and dental schools, to no avail. Claimant's

developmental disability makes it difficult and complicated to treat him. When Claimant's pain became more severe, and his Mother knew he could no longer wait for the dental schools to care for him, she purchased additional private dental insurance to cover his care. Dr. Seto, a private dentist, agreed to treat Claimant and to obtain the services of an anesthesiologist to administer general anesthesia to Claimant during his treatment which included a root canal procedure and the placement of amalgam fillings. A large portion of Dr. Seto's charges were paid by the private insurance. However, the charges by the anesthesiologist for administration of the general anesthesia during the treatment were not covered. Mother borrowed funds to pay Dr. Seto and the anesthesiologist and is obligated to repay those funds. Clamant is not eligible for reimbursement from Medi-Cal for the funds paid because his dentist and anesthesiologist were not Medi-Cal providers. Claimant's Mother was resourceful and diligent in searching for generic resources and obtained additional insurance for Claimant to defray the costs.

14. ELARC did little to assist Claimant in locating a provider or generic resources although the service coordinator was aware of Claimant's predicament. In this instance, Claimant's need for dental care was identified in his IPP and a goal/desired outcome was fashioned to include dental health. Claimant exhausted all generic resources and the charges are not eligible for Medi-Cal reimbursement. Claimant experienced a "gap" in the system of services and supports identified in his IPP where no provider will provide services as described in Code section 4648. When this gap occurred, ELARC was responsible for service coordination including, but not limited to, securing, through purchasing, or by obtaining from generic agencies or other resources, services and supports to achieve the desired outcomes set forth in Claimant's IPP.

15. Claimant established by a preponderance of the evidence that although he had been approved for and was entitled to Medi-Cal, his needs were not met by Medi-

Cal because there was no dentist available who would meet his needs as a developmentally- disabled consumer. This was not an instance where Claimant merely decided not to use a Medi-Cal provider or his own insurance for his dental needs. When ELARC failed to provide adequate service coordination or resources, Claimant's mother did everything she could to obtain the care he needed and should be reimbursed $1780 for the cost of the general anesthesia.

ORDER

1. Claimant's request for reimbursement of dental anesthesia charges paid by his mother in the amount of $1780 is granted.

2. ELARC shall reimburse claimant’s mother within 30 days from the effective date of this Decision.

DATED:

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GLYNDA B. GOMEZ

Administrative Law Judge

Office of Administrative Hearings

NOTICE

This is the final administrative decision in this matter. Judicial review of this decision may be sought in a court of competent jurisdiction within ninety (90) days.