STATE OF NEW YORK
DEPARTMENT OF HEALTH

REQUEST: January 8, 2019
[redacted]
AGENCY: MAP
FH #: 7891371L

In the Matter of the Appeal of

[redacted]

from a determination by the New York City Department of Social Services

DECISION AFTER FAIR HEARING

JURISDICTION

Pursuant to Section 22 of the New York State Social Services Law (hereinafter Social Services Law) and Part 358 of Title 18 NYCRR, (hereinafter Regulations), a fair hearing was held on April 2, 2019, in New York City, before an Administrative Law Judge. The following persons appeared at the hearing:

For the Appellant

[redacted]

For the Managed Long Term Care Plan

Appearance waived by the Office of Administrative Hearings

ISSUE

Was the determination of the Appellant's Managed Lon Term Care Plan to deny the Appellant's request for fixed bridgework for teeth numbered 3,4,5,6,7, 8,9, 10, 11, 12, 13, 14, and 15 correct?

FACT FINDINGS

An opportunity to be heard having been afforded to all interested parties and evidence having been taken and due deliberation having been had, it is hereby found that:

1. The Appellant, currently age 69, has been enrolled in a Managed Long Term Care Plan operated by Centers Plan for Healthy Living,

2. On or about November 7, 2018, the Appellant's dentist requested prior approval by the MLTCP for fixed bridgework for teeth numbered 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, and 15.

3. By initial adverse determination notice dated November 7, 2018, Healthplex, acting on behalf of Centers Plan, determined to deny the request for fixed bridgework. The bridgework was denied because "….there is no coverage for fixed bridgework(unless required for cleft palate stabilization or if a removable denture is not feasible). Because no evidence of these conditions was submitted, this service is denied…."

4. On or about November 14, 2018, a request for an internal appeal was made by Appellant.

5. On November 15, 2018, Healthplex issued a Final Adverse Determination in which it stated "we are not changing our decision to deny your request…."

6. On January 8, 2019, the Appellant requested this fair hearing.

APPLICABLE LAW

Social Services Law section 365-a(2) states, in part, that the amount, nature and manner of providing medical assistance for needy persons shall be determined by the public welfare official with the advice of a physician and in accordance with the local medical plan, this title, and the regulations of the department.

1. "Benchmark coverage" shall mean payment of part or all of the cost of medically necessary medical, dental, and remedial care, services, and supplies described in subdivision two of this section, and to the extent not included therein, any essential benefits as defined in 42 U.S.C. 18022(b), with the exception of institutional long term care services; such care, services and supplies shall be provided consistent with the managed care program described in section three hundred sixty-four-j of this title.

2. "Standard coverage" shall mean payment of part or all of the cost of medically necessary medical, dental and remedial care, services and supplies, as authorized in this title or the regulations of the department, which are necessary to prevent, diagnose, correct or cure conditions in the person that cause acute suffering, endanger life, result in illness or infirmity, interfere with such person's capacity for normal activity, or threaten some significant handicap and which are furnished an eligible person in accordance with this title and the regulations of the department.

Part 438 of 42 Code of Federal Regulations (CFR) pertains to the provision of Medicaid medical care, services and supplies through Managed Care Organizations (MCOs), Prepaid Inpatient Health Plans (PIHPs), Prepaid Ambulatory Health Plans (PAHPs) and Primary Care Case Managers (PCCMs), and the requirements for contracts for services so provided.

Section 438.400 of 42 CFR Subpart F provides in part:

(a) Statutory basis. This subpart is based on sections 1902(a)(3), 1902(a)(4), and 1932(b)(4) of the Act.

(1) Section 1902(a)(3) requires that a State plan provide an opportunity for a fair hearing to any person whose claim for assistance is denied or not acted upon promptly.

(2) Section 1902(a)(4) requires that the State plan provide for methods of administration that the Secretary finds necessary for the proper and efficient operation of the plan.

(3) Section 1932(b)(4) requires Medicaid managed care organizations to establish internal grievance procedures under which Medicaid enrollees, or providers acting on their behalf, may challenge the denial of coverage of, or payment for, medical assistance.

(b) Definitions. As used in this subpart, the following terms have the indicated meanings:

Action means-- In the case of an MCO or PIHP--

(1) The denial or limited authorization of a requested service, including the type or level of service;

(2) The reduction, suspension, or termination of a previously authorized service;

(3) The denial, in whole or in part, of payment for a service...

Section 438.402 of 42 CFR Subpart F provides in part:

(a) The grievance system. Each MCO [Managed Care Organization] and PIHP [Prepaid Inpatient Health Plan] must have a system in place for enrollees that includes a grievance process, an appeal process, and access to the State's fair hearing system...

Section 438.402 of 42 CFR Subpart F provides in part:

(a) Coverage. Each contract with an MCO, PIHP, or PAHP must do the following:

(1) Identify, define, and specify the amount, duration, and scope of each service that the MCO, PIHP, or PAHP is required to offer.

(2) Require that the services identified in paragraph (a)(1) of this section be furnished in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services furnished to beneficiaries under fee-for-service Medicaid, as set forth in Sec. 440.230.

(3) Provide that the MCO, PIHP, or PAHP--

(i) Must ensure that the services are sufficient in amount, duration, or scope to reasonably be expected to achieve the purpose for

which the services are furnished.

(ii) May not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the beneficiary;

(iii) May place appropriate limits on a service--

(A) On the basis of criteria applied under the State plan, such as medical necessity; or

(B) For the purpose of utilization control, provided the services furnished can reasonably be expected to achieve their purpose, as required in paragraph (a)(3)(i) of this section; and

(4) Specify what constitutes ``medically necessary services'' in a manner that--

(i) Is no more restrictive than that used in the State Medicaid program as indicated in State statutes and regulations, the State Plan, and other State policy and procedures; and

(ii) Addresses the extent to which the MCO, PIHP, or PAHP is responsible for covering services related to the following:

(A) The prevention, diagnosis, and treatment of health impairments.

(B) The ability to achieve age-appropriate growth and development.

(C) The ability to attain, maintain, or regain functional capacity.

(b) Authorization of services. For the processing of requests for initial and continuing authorizations of services, each contract must require--

(1) That the MCO, PIHP, or PAHP and its subcontractors have in place, and follow, written policies and procedures.

(2) That the MCO, PIHP, or PAHP--

(i) Have in effect mechanisms to ensure consistent application of review criteria for authorization decisions; and

(ii) Consult with the requesting provider when appropriate.

(3) That any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, be made by a health care professional who has appropriate clinical expertise in treating the enrollee's condition or disease.

(c) Notice of adverse action. Each contract must provide for the MCO, PIHP, or PAHP to notify the requesting provider, and give the enrollee written notice of any decision by the MCO, PIHP, or PAHP to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. For MCOs and PIHPs, the notice must meet the requirements of Sec. 438.404, except that the notice to the provider need not be in writing.

(d) Timeframe for decisions. Each MCO, PIHP, or PAHP contract must provide for the following decisions and notices:

(1) Standard authorization decisions. For standard authorization decisions, provide notice as expeditiously as the enrollee's health condition requires and within State-established timeframes that may not

exceed 14 calendar days following receipt of the request for service, with a possible extension of up to 14 additional calendar days, if--

(i) The enrollee, or the provider, requests extension; or

(ii) The MCO, PIHP, or PAHP justifies (to the State agency upon request) a need for additional information and how the extension is in the enrollee's interest.

(2) Expedited authorization decisions.

(i) For cases in which a provider indicates, or the MCO, PIHP, or PAHP determines, that following the standard timeframe could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function, the MCO, PIHP, or PAHP must make an expedited authorization decision and provide notice as expeditiously as the enrollee's health condition requires and no later than 3 working days after receipt of the request for service.

(ii) The MCO, PIHP, or PAHP may extend the 3 working days time period by up to 14 calendar days if the enrollee requests an extension, or if the MCO, PIHP, or PAHP justifies (to the State agency upon request) a need for additional information and how the extension is in the enrollee's interest.

(e) Compensation for utilization management activities. Each contract must provide that, consistent with Sec. 438.6(h), and Sec. 422.208 of this chapter, compensation to individuals or entities that conduct utilization management activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any enrollee.

Section 438.406 of 42 CFR Subpart F provides in part:

(a) General requirements. In handling grievances and appeals, each MCO and each PIHP must meet the following requirements:

(1) Give enrollees any reasonable assistance in completing forms and taking other procedural steps. This includes, but is not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability.

(2) Acknowledge receipt of each grievance and appeal.

(3) Ensure that the individuals who make decisions on grievances and appeals are individuals--

(i) Who were not involved in any previous level of review or decision-making; and

(ii) Who, if deciding any of the following, are health care professionals who have the appropriate clinical expertise, as determined by the State, in treating the enrollee's condition or disease.

(A) An appeal of a denial that is based on lack of medical

necessity.

(B) A grievance regarding denial of expedited resolution of an appeal.

(C) A grievance or appeal that involves clinical issues.

(b) Special requirements for appeals. The process for appeals must:

(1) Provide that oral inquiries seeking to appeal an action are treated as appeals (to establish the earliest possible filing date for the appeal) and must be confirmed in writing, unless the enrollee or the provider requests expedited resolution.

(2) Provide the enrollee a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing. (The MCO or PIHP must inform the enrollee of the limited time available for this in the case of expedited resolution.)

(3) Provide the enrollee and his or her representative opportunity, before and during the appeals process, to examine the enrollee's case file, including medical records, and any other documents and records considered during the appeals process.

(4) Include, as parties to the appeal--

(i) The enrollee and his or her representative; or

(ii) The legal representative of a deceased enrollee's estate.

Public Health Law Section 4403-f provides in pertinent part as follows concerning eligibility for managed long term care:

1. Definitions. As used in this section:

(a) "Managed long term care plan" means an entity that has received a certificate of authority pursuant to this section to provide, or arrange for, health and long term care services, on a capitated basis in accordance with this section, for a population, age eighteen and over, which the plan is authorized to enroll.

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(c) "Operating demonstration" means the following entities: the chronic care management demonstration programs authorized by chapter five hundred thirty of the laws of nineteen hundred eighty-eight, chapter five hundred ninety-seven of the laws of nineteen hundred ninety-four and chapter eighty-one of the laws of nineteen hundred ninety-five as amended.

(d) "Health and long term care services" means services including, but not limited to home and community-based and institution-based long term care and ancillary services (that shall include medical supplies and nutritional supplements) that are necessary to meet the needs of persons whom the plan is authorized to enroll. The managed long term care plan may also cover primary care and acute care if so authorized.

Section 506.2(a) of 18 NYCRR provides that dental care in the Medical Assistance program shall include only preventive, prophylactic and other routine dental care, services and supplies, and dental prosthetic and orthodontic appliances required to alleviate a serious health condition including one which affects employability.

According to the dental provider manual, services provided must conform to acceptable standards of professional practice. Dental care provided under the Medicaid program must meet as high standards of quality as can reasonably be provided to the community-at-large. All materials and therapeutic agents used or prescribed must meet the minimum specifications of the American Dental Association, and must be acceptable to the State Commissioner of Health. Experimental procedures are not reimbursable in the Medicaid program.

The dental provider manual provides that dental care provided under the Medicaid Program includes only *essential services* (rather than "comprehensive" services), and further provides:

Services Not Within the Scope of the Medicaid Program

Dental implants and related services;

Fixed bridgework, except for cleft palate stabilization, or when a removable prosthesis would be contraindicated;

Immediate full or partial dentures;

Molar root canal therapy for beneficiaries 21 years of age and over, except when extraction would be medically contraindicated or the tooth is a critical abutment for an existing serviceable prosthesis provided by the NYS Medicaid program;

Crown lengthening;

Replacement of partial or full dentures prior to required time periods unless appropriately documented and justified as stated in the Manual;

Dental work for cosmetic reasons or because of the personal preference of the recipient or provider;

Periodontal surgery, except for procedure D4210 – gingivectomy or gingivoplasty, for the sole correction of severe hyperplasia or hypertrophy associated with drug therapy, hormonal disturbances or congenital defects;

Adult orthodontics, except in conjunction with, or as a result of, approved orthognathic surgery necessary in conjunction with an approved course of orthodontic treatment or the on-going treatment of clefts;

Placement of sealants for beneficiaries under 5 or over 15 years of age;

Improper usage of panoramic images (D0330) along with intraoral complete series of images (D0210).

Services Which Do Not Meet Existing Standards of Professional Practice
Partial dentures provided prior to completion of all Phase I restorative treatment which includes necessary extractions, removal of all decay and placement of permanent restorations;

Extraction of clinically sound teeth;

Teeth left untreated;

Treatment done without clinical indication. Procedures should not be performed without documentation of clinical necessity. Published "frequency limits" are general reference points on the anticipated frequency for that procedure. Actual frequency must be based on the clinical needs of the individual recipient;

Restorative treatment of teeth that have a hopeless prognosis and should be extracted;

Taking of unnecessary or excessive radiographic images; and,

"Unbundling" of procedures.

As per the provider manual, fixed bridgework is only allowed for one upper anterior tooth or two lower anterior teeth in qualifying individuals.

Section 358-5.9 of the Regulations provide in part:

(a) At a fair hearing concerning the denial of an application for or the adequacy of public assistance, medical assistance, HEAP, SNAP benefits or services, the appellant must establish that the agency's denial of assistance or benefits was not correct or that the appellant is eligible for a greater amount of assistance or benefits.

DISCUSSION

The record discloses that Appellant, currently age 69, has been enrolled in a Medicaid Managed Long Term Care Plan operated by Centers Plan for Healthy Living. On or about November 7, 2018, the Appellant's dentist requested prior approval by the MLTCP for fixed bridgework for teeth numbered 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, and 15. By initial adverse determination notice dated November 7, 2018, Healthplex, acting on behalf of Centers Plan, determined to deny the request for fixed bridgework. On or about November 14, 2018, a request for an internal appeal was made by Appellant. On November 15, 2018, Healthplex issued a

Final Adverse Determination in which it stated "we are not changing our decision to deny your request…."The Appellant has requested this fair hearing for review.

The dental provider manual states that "Fixed bridgework is generally considered beyond the scope of the NYS Medicaid program." Limited exceptions exist for individuals with cleft palates and when a removable prosthesis would otherwise be contraindicated. However, even then, regulations and policy only allow fixed bridgework for *one upper anterior tooth or two lower anterior teeth*. Appellant here wants fixed bridgework for a total of 13 teeth, way too many.

Additionally, the record meanwhile did not set forth clear reasons why a removable prosthesis would be counter-indicated in the first place. Appellant produced two notes from his dentist. The dentist, in a letter dated April 2, 2019, stated fixed bridgework provides "increased strength as a fundamental physics design principle….[and] food more readily travels beneath a removable denture and …may more readily become displaced…." In short, the dentist made arguments why fixed bridgework is superior, *but did not make arguments why Appellant just could not handle removable dentures instead*. With too many teeth involved and without evidence Appellant can not have removable dentures, Healthplex's decision to deny on behalf of Centers Plan therefore must be upheld.

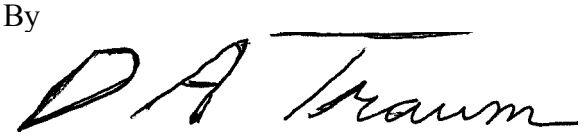
DECISION

The determinations of the Appellant's Managed Long Term Care Provider to deny the Appellant's request for fixed bridgework for teeth numbered 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, and 15 for the Appellant was correct.

DATED: Albany, New York
06/07/2019

NEW YORK STATE DEPARTMENT
OF HEALTH

By



Commissioner's Designee