STATE OF NEW YORK
DEPARTMENT OF HEALTH

REQUEST: July 11, 2016
[redacted]
AGENCY: Fullint Dual Adv
FH #: 7339877N

In the Matter of the Appeal of

[redacted]

from a determination by the Fullint Dual Adv County 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 July 26, 2016, in Fullint Dual Adv County, before an Administrative Law Judge. The following persons appeared at the hearing:

For the Appellant

[redacted]

For Centers Plan for Healthy Living

[redacted], FIDA Plan Representative
Dr. Susan Weiss, Associate Dental Director

ISSUE

Was the MCO's May 24, 2016 determination to deny the Appellant's dentist's prior approval request for a referral for endodontic treatment for Appellant's tooth number 28, correct?

PROCEDURAL HISTORY AND FINDINGS OF FACT

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, age 92, receives Medicare and Medicaid benefits.

2. The Appellant has been enrolled in Centers Plan for Healthy Living ("Centers Plan"), a Fully Integrated Duals Advantage ("FIDA") Managed Care Organization ("MCO") since April, 2015.

3. Appellant's dentist submitted a prior approval request for a root canal therapy referral for tooth number 28. Thereafter, by Notice dated May 24, 2016, the MCO determined to deny the request on the grounds "Program Dental Guidelines will not cover root canal therapy unless it is needed and the overall dental health of the patient is excellent". See MCO Exhibit "A"

4. On May 26, 2015, Appellant orally requested an internal appeal with the MCO. See MCO Exhibit "B"

5. By letter dated May 27, 2016, the MCO requested additional information from Appellant's dental provider including dental charts, medical history and radiographs. See MCO Exhibit "D".

6. By notice dated June 24, 2016, the MCO advised Appellant of its intention to extend the deadline for the appeal decision by 14 days. See MCO Exhibit "E".

7. Thereafter, Appellant's dental provider submitted to the MCO a dental chart with treatment notes, a patient registration and health history form and 3 radiographs. See MCO Exhibit "F".

8. On July 8, 2016, Healthplex, the dental administrator for the MCO, completed an Appeal Review Form including a dental chart. See MCO Exhibit "G".

9. By Notice dated July 8, 2016, the MCO upheld its determination to deny Appellant's dentist's prior approval request for a root canal therapy referral for Appellant 's tooth number 28 on the grounds that "Program Dental Guidelines will not cover root canal therapy unless it is needed and the overall dental health of the patient is excellent. This decision was based on a review of the dental records submitted by your dentist." See MCO Exhibit "H".

6. On July 11, 2016, the MCO filed an automatic Integrated Appeal on behalf of the Appellant.

APPLICABLE LAW

The Centers for Medicare & Medicaid Services ("CMS") is an agency of the United States, Department of Health and Human Services, responsible for the administration of the Medicare, Medicaid, and State Children's Health Insurance Programs under Title XVIII, Title IX, Title XI, and Title XXI of the Social Security Act.

The New York State Department of Health ("NYSDOH"), pursuant to Article 44 of the New York State Public Health Law (PHL), the State of New York, Department of Health (State/NYSDOH), is authorized to issue Certificates of Authority to establish Health Maintenance Organizations (HMOs), PHL §4400 et seq., Managed Long Term Care Plans (MLTCPs), PHL §4403-f, and Article Seven, Section 364-j(27) of the Social Services Law.

The Fully Integrated Duals Advantage ("FIDA") Plans provide medical services to enrolled beneficiaries.

Pursuant to the Memorandum of Understanding ("MOU"), executed on August 26, 2013, CMS and NYSDOH agreed to purchase medical services from FIDA Plans in accordance with the terms and conditions of MOU and in compliance with all Federal and State laws and regulations. The MOU and consequent contracts were executed to test a Capitated Financial Alignment Model ("Demonstration") for Medicare-Medicaid Enrollees in order to better serve individuals eligible for both Medicare and Medicaid ("Medicare-Medicaid Enrollees"). These Medicare-Medicaid Plans ("MMPs") provide integrated benefits to those Medicare-Medicaid Enrollees who reside in certain targeted geographic areas and who choose to participate in the Demonstration ("Participants").

Key objectives of the initiative are to improve the participant experience in accessing care, deliver person-centered care, promote independence in the community, improve quality, eliminate cost shifting between Medicare and Medicaid, and achieve cost savings for the State and Federal government through improvements in care and coordination.

Section 1.109 ("Definition of Terms," p.20) provides that "Medically Necessary Items and Services (Also **Medical Necessity**) — Those items and services necessary to prevent, diagnose, correct, or cure conditions in the Participant that cause acute suffering, endanger life, result in illness or infirmity, interfere with such Participant's capacity for normal activity, or threaten some significant handicap. Notwithstanding this definition, the FIDA Plan will provide coverage in accordance with the more favorable of the current Medicare and NYSDOH coverage rules, as outlined in NYSDOH and Federal rules and coverage guidelines."

Part 438 of 42 Code of Federal Regulations (hereinafter, "CFR") pertains to provision of Medicaid medical care, services and supplies through Managed Care Organizations (hereinafter, "MCOs"), Prepaid Inpatient Health Plans (hereinafter, "PIHPs"), Prepaid Ambulatory Health Plans (hereinafter, "CAHPs"), and Primary Care Case Managers (hereinafter, "PCCMs"), and the requirements for contracts for services so provided. 42 CFR parts 422 and 460 (PACE specifically) also establish requirements for services provided.

Section 438.210 of 42 CFR Subpart D provides, in pertinent 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....

Section 4403-f of the New York State Public Health Law (hereinafter, "NYSPHL") authorizes managed long term care (hereinafter, "MLTC") plans and the New York State Department of Health (hereinafter "NYSDOH") and the Centers for Medicare and Medicaid (hereinafter, "CMS") require certain Medicaid beneficiaries to join a MLTC. As set forth in, Medical Redesign Team (hereinafter, "MRT") #90 and pursuant to 364-j of the Social Services Law (hereinafter, "SSL"), Dual Eligible (Medicare and Medicaid) beneficiaries ages 21 and older, who require more than 120 days of home and community based long term services and are safely able to stay home, are mandated to enroll in a MLTC program.

There are four operating MLTC programs in New York State: Medicaid Plans (hereinafter "MAP"), Medicaid Advantage Plus Plans (hereinafter, "MAP'), Programs of All-Inclusive Care for the Elderly (hereinafter, "PACE"), and the Fully Integrated Duals Advantage Program (hereinafter, "FIDA").

Article 5, Title 11, Section 364-j (c) of the Social Services Law defines a **managed care program** as "[a] statewide program in which medical assistance recipients enroll on a voluntary or mandatory basis to receive medical assistance services, including case management, directly and indirectly (including by referral) from a managed care provider…"

Section 364-j (b) defines a **managed care provider** as "[a]n entity that provides or arranges for the provision of medical assistance services and supplies to participants directly or indirectly (including by referral), including case management…"

Section 364-j (1)(c) of the Social Services Law defines "Managed Care Program" as a program in a social services district in which Medicaid recipients enroll on a voluntary or mandatory basis to receive Medicaid services, including case management, directly or indirectly (including by referral) from a managed care provider ("Medicaid Managed Care Health Plan"), and as applicable, from a mental health special needs plan or a comprehensive HIV special needs plan.

10 NYCRR 98-1.2 and 18 NYCRR 360-10.3 define a **managed care organization ("MCO")** as a health maintenance organization ("HMO"); prepaid health services plan (PHSP); comprehensive HIV special needs plan ("HIV SNP"); and, where specified in this Subpart, a primary care partial capitation provider ("PCPCP"); and managed long-term care provider ("MLTCP").

Social Services Law §365-a(2) provides that "Medical assistance" 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.

Social Services Law §365-a(2)(k) provides that such care, services and supplies shall include care and services furnished by an entity offering a comprehensive health services plan, including an entity that has received a certificate of authority pursuant to sections forty-four

hundred three, forty-four hundred three-a or forty-four hundred eight-a of the public health law (as added by chapter six hundred thirty-nine of the laws of nineteen hundred ninety-six) or a health maintenance organization authorized under article forty-three of the insurance law, to eligible individuals residing in the geographic area served by such entity, when such services are furnished in accordance with an agreement approved by the department which meets the requirements of federal law and regulations.

With regard to endodontics, the New York State Medicaid Program Dental Manual Procedure Code Section V (IV) provides, in pertinent part, as follows:

All radiographs taken during the course of root canal therapy and all post-treatment radiographs are included in the fee for the root canal procedure. At least one pre-treatment radiograph demonstrating the need for the procedure, and one posttreatment radiograph that demonstrates the result of the treatment, must be maintained in the patient's record.

Surgical root canal treatment or apicoectomy may be considered appropriate and covered when the root canal system cannot be acceptably treated non-surgically, there is active root resorption, or access to the canal is obstructed. Treatment may also be covered where there is gross over or under extension of the root canal filling, periapical or lateral pathosis persists, or there is a fracture of the root.

* * * * * * *

Molar endodontics treatment, retreatment or apical surgery is not approvable as a routine procedure. Prior approval requests will be considered for beneficiaries under age 21 who display good oral hygiene, have healthy mouths with a full complement of natural teeth with a low caries index and/or who may be undergoing orthodontic treatment. In those beneficiaries age 21 and over, molar endodontic therapy will be considered only in those instances where the tooth in question is a critical abutment for an existing functional prosthesis.

* * * * * * *

The Dental Manual Procedure Code Section V under “Essential Services” provides:

When reviewing requests for services the following guidelines will be used:

Treatment will not be routinely approved when functional replacement with less costly restorative materials, including prosthetic replacement, is possible.

Caries index, periodontal status, recipient compliance, dental history, medical history and the overall status and prognosis of the entire dentition, among other factors, will be taken into consideration. Treatment is not considered appropriate when the prognosis of the tooth is questionable or when a reasonable alternative course of treatment would be extraction of the tooth and replacement. Treatment such as endodontics or crowns will not be approved in association with an existing or proposed prosthesis in the same arch, unless the tooth is a critical abutment for a prosthesis provided through the NYS Medicaid program, or unless replacement by addition to an existing prosthesis or new prosthesis is not feasible. If the total number of teeth which require, or are likely to require treatment would be considered excessive or when maintenance of the tooth is not considered essential or appropriate in view of the overall dental status of the recipient, treatment will not be covered. Treatment of deciduous teeth when

exfoliation is reasonably imminent will not be routinely reimbursable. Claims submitted for the treatment of deciduous cuspids and molars for children ten (10) years of age or older, or for deciduous incisors in children five (5) years of age or older will be pended for professional review. As a condition for payment, it may be necessary to submit, upon request, radiographic images and other information to support the appropriateness and necessity of these restorations. Extraction of deciduous teeth will only be reimbursed if injection of a local anesthetic is required.

Eight (8) posterior natural or prosthetic teeth (molars and/or bicuspids) in occlusion (four (4) maxillary and four (4) mandibular teeth in functional contact with each other) will be considered adequate for functional purposes. Requests will be reviewed for necessity based upon the presence/absence of eight (8) points of natural or prosthetic occlusal contact in the mouth (bicuspid/molar contact).

One (1) missing maxillary anterior tooth or two (2) missing mandibular anterior teeth may be considered an esthetic problem that warrants a prosthetic replacement.

The "three way contract" between CMS, the Department and the MCO defines Referral as an authorization provided by a PCP to enable a Participant to seek medical care from another Provider. Referrals are not required for Covered Items and Services under the FIDA Demonstration. Referrals from PCPs or other Providers are not necessary and may not be required by the FIDA Plan or any of its Participating Providers when a Participant is obtaining Covered Items or Services under the FIDA Demonstration.

Additionally, 18 NYCRR Section 358-5.9(a) provides, in relevant part, that at a fair hearing concerning the denial of an application for or the adequacy of medical assistance, 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.

ANALYSIS AND CONCLUSIONS OF LAW

The record establishes that Appellant has been enrolled in Centers Plan for Healthy Living ("Centers Plan"), a Fully Integrated Duals Advantage ("FIDA") Managed Care Organization ("MCO") since April, 2015. The record further establishes that by Coverage Determination Notice dated May 24, 2016, the MCO determined to deny Appellant's dentist's prior approval request for a root canal therapy referral for Appellant's tooth number 28 on the grounds "Program Dental Guidelines will not cover root canal therapy unless it is needed and the overall dental health of the patient is excellent". The record establishes that the MCO later upheld its denial on identical grounds indicating it had reviewed the dental records submitted by Appellant's dentist. A second level appeal was filed by the MCO on July 11, 2016.

The "three way contract" between CMS, the Department and the MCO defines Referral as an authorization provided by a PCP [primary care provider] to enable a Participant to seek medical care from another Provider. Referrals are not required for Covered Items and Services under the FIDA Demonstration. Referrals from PCPs or other Providers are not necessary and may not be required by the FIDA Plan or any of its Participating Providers when a Participant is obtaining Covered Items or Services under the FIDA Demonstration. Dental Services are covered, so a referral would not be needed. However, the real issue is whether this particular

dental service for this particular Appellant is a covered service.

At the hearing, the associate dental director for Healthplex, the dental administrator for the MCO, testified that review of the radiographs and dental chart provided by Appellant's dentist revealed Appellant suffered from significant bone loss and was missing many teeth. Accordingly, the MCO contended that Appellant's overall poor dental health rendered her inappropriate for the requested endodontic treatment based on Medicaid guidelines. The dental director testified that the appropriate alternative treatment would be extraction and replacement with a partial denture.

At the hearing, Appellant's son and representative testified that Appellant was not seeking root canal therapy for tooth number 28. The representative testified that he did not believe the dentist that submitted the prior approval request did a thorough job. The representative testified that he did not want to put his mother through a root canal or extraction. Instead, he testified that he brought his mother to another dentist who recommended periodontal treatment to alleviate the pain Appellant was experiencing in her lower jaw. The representative testified that he wanted his mother treated at this new dentist and conceded that he was not contesting the MCO's denial of root canal therapy for Appellant's tooth number 28. The dental director explained to the representative that that the new dentist would have to submit a new prior authorization request for any recommended treatment which the MCO would then make a coverage determination on. The representative testified that he would proceed in the manner suggested by the dental director.

Pursuant to the Dental Manual Section cited above, the Medicaid Program provides coverage for only "essential services" rather than comprehensive care. Treatment will not be routinely approved when functional replacement with less costly restorative materials, including prosthetic replacement, is possible. Specifically, treatment will not be covered when maintenance of the tooth is not considered essential or appropriate in view of the overall dental status of the recipient.

In the present case, the record, including dental charts prepared by Appellant's dentist and a dental reviewer for the MCO, establishes that Appellant is missing at least 21 teeth. Additionally, the dental director testified that the radiographs submitted established Appellant also suffered from significant bone loss in her mouth. This testimony was credible and uncontested and is therefore accepted. Accordingly, the evidence establishes that Appellant suffers from poor overall dental health. Pursuant to the above cited NYS Medicaid Dental Guidelines, the root canal treatment requested in this case is not covered because maintenance of Appellant's tooth number 28 is not considered essential or appropriate in view of her overall dental status.

However, it is noted that Appellant appears to have abandoned the request for root canal treatment to tooth number 28 and is seeking alternative treatment with another dental provider. Appellant is advised that her new dental provider is free to submit a new prior authorization request for any treatment plan created by the new dental provider to the MCO for a coverage determination.

DECISION

The determination of the MCO dated May 24, 2016 to deny Appellant's dentist's request for a referral for root canal treatment for Appellant's tooth number 28 was correct.

DATED: Albany, New York
09/06/2016

NEW YORK STATE
DEPARTMENT OF HEALTH
FULLY INTEGRATED DUALS ADVANTAGE PROGRAM

By:

Commissioner's Designee