STATE OF NEW YORK
DEPARTMENT OF HEALTH

REQUEST: March 18, 2019
[redacted]
AGENCY: MAP
FH #: 7928392R

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 May 28, 2019, in New York City, before an Administrative Law Judge. The following persons appeared at the hearing:

For the Appellant

[redacted]

For the Managed Care Plan ([redacted])

Appearance waived by the Office of Administrative Hearings

ISSUE

Was the Managed Care plan's determination of April 1, 2019 to deny the Appellant's request for crowns, D2750, consultations, D9310, and fillings, D2393, correct?

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 54, has been in receipt of Medicaid benefits through a Managed Care Plan, Centers Plan for Healthy Living, which delegates dental care and services to the dental vendor, [redacted].

2. On March 18, 2019, the Appellant requested this fair hearing.

3. On March 29, 2019, [redacted] received a request from Union Square Dental on behalf of the Appellant for consultation, full mouth rehab under general anesthesia, crown for tooth #4 and filing on tooth #5.

4. By Initial Adverse Determination, dated April 1, 2019, the Managed Care Plan determined to deny the request on the grounds that the "*service is not covered by your managed care benefits*." With regard to the request for Crowns, the Plan determined that, "*Denial Code 7y Tooth 04, Under Program Dental Guidelines, there is no coverage for this service if you have or will have 8 points (4 top and 4 bottom natural or prosthetic teeth in biting contact. Because you will have 8 points of biting contact without this service, it is denied. This decision was based on a review of the dental records submitted by your dentist."*

With regard to the request for Filings, (resin-based composite) the Plan determined, "*Denial Code K5 Tooth 05, Requested service is considered within the scope of the general dentist";*

With regard to Consultation, "*Denial Code K5, Requested service is considered within the scope of the general dentist…These decisions were based on a review of [Appellant's] radiographs and narrative as submitted by his dentist,* [redacted]

5. The Initial Adverse Determination dated April 1, 2019 also advised the Appellant that he had 60 calendar days from the date of that Notice to ask for a Plan Appeal.

6. The Appellant did not file a Plan Appeal.

7. The Appellant requested this Fair Hearing on March 18, 2019.

APPLICABLE LAW

Section 365-a of the Social Services Law provides in part:

2. "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 by this title or the regulations..., 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....

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"), or, if applicable, from a mental health special needs plan or a comprehensive HIV special needs plan.

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.

The United State Department of Health and Human Services (Health Care Finance Administration) has granted the State of New York a waiver under Section 1115 of the Social Security Act to permit the operation of a demonstration waiver program for Managed Care Programs in which certain eligible Medicaid recipients are subject to mandatory enrollment.

Dental Provider Manual, 1/1/13, page 9, Services Not Within the Scope of the Medicaid Program:
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...
Dental work for cosmetic reasons or because of the personal preference of the recipient or provider;
....
Page 14, Prior Approval / Prior Authorization Requirements
...
Procedures that require prior approval, or where a DVS over-ride is required, must not begin until the provider has received approval from the DOH. When any portion of a treatment plan requires prior approval, the complete treatment plan listing all necessary procedures, whether or not they require prior approval, must be listed and coded on the prior approval request form. Any completed treatment which is not evident on submitted images should be noted. No treatment other than provision of symptomatic relief of pain and/or infection is to be instituted until such time as cases have been reviewed and a prior approval determination made.
All prior approval requests should include accurate pretreatment charting clearly depicting all existing restorations and missing natural teeth. Any existing fixed or removable prosthetic appliances should be noted and their current conditions described and the date of initial placement noted. If applicable, a complete medical history, nutritional assessment, certification of employment and any other pertinent information that will assist in determining the necessity and appropriateness of the proposed treatment plan should be submitted.
....
Page 22, 3. “ESSENTIAL” SERVICES
...
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.

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.

Dental Policy and Procedure Code Manual, Version 2013 (effective 1/1/13), page 32:
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CROWNS - SINGLE RESTORATIONS ONLY
Crowns will not be routinely approved for a molar tooth in those beneficiaries age 21 and over which has been endodontically treated without prior approval from the Department of Health. The use of esthetic veneers is at the discretion of the provider as to when they are clinically indicated.
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D2751 Crown – porcelain fused to predominately base metal (TOOTH)
****
OTHER RESTORATIVE SERVICES

Model Contract (August 1, 2011), Appendix K, page K-28
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25. Dental Services
a) Dental care includes preventive, prophylactic and other routine dental care, services, supplies and dental prosthetics required to alleviate a serious health condition, including one which affects employability. Orthodontic services are not covered.

The DentaQuest Provider Office Reference Manual

14.02 Criteria for Cast Crowns … Permanent molar teeth must have pathologic destruction to the tooth by caries or trauma and should involve four or more surfaces and two or more cusps. Permanent bicuspid teeth must have pathologic destruction to the tooth by caries or trauma and should involve three or more surfaces and at least one cusp….

A request for a crown following root canal therapy must meet the following criteria:
Request should include a dated post-endodontic radiograph.
Tooth should be filled sufficiently close to the radiological apex to ensure that an apical seal is achieved, unless there is a curvature or calcification of the canal that limits the ability to fill the canal to the apex.
The filling must be properly condensed/obturated. Filling material does not extend excessively beyond the apex.

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"), or, if

applicable, from a mental health special needs plan or a comprehensive HIV special needs plan.

Denial of clinical treatment and/or benefits: When the MCO denies services or benefits that have been requested by a physician, the MCO must send the recipient a notice of adverse determination and a notice containing fair hearing rights. The MA recipient may elect to pursue the matter by requesting a state fair hearing, filing a grievance through the MCO's internal process, filing a complaint with the SDOH, seeking a utilization review appeal and/or any combination of these procedures. For denials without a physician's order, meaning the MCO supports or confirms the decision of a treating physician to deny services and/or benefits, the MA recipient must complete the internal grievance and appeals process or utilization review process prior to obtaining a notice containing fair hearing rights. The MCO would be required to issue a notice of adverse determination. At the conclusion of the internal process, the MCO must provide the enrollee a notice containing fair hearing rights. The enrollee may then request an external review from the state, file a complaint with the SDOH, request a fair hearing, or any combination of these procedures.

When the dispute involves MCO adverse determinations, the MCOs must appear at the hearings to present justification for their determination or submit a written summary of the justification and evidence for the adverse determination. SDOH will inform the MCO of the date of the scheduled hearing. If the MCO is not going to attend the hearing, the information must be provided to the hearing officer at least 3 business days before the scheduled hearing. If the hearing is scheduled less than 3 business days after the request, the MCO must deliver the evidence to the hearing site no later than 1 business day prior to the hearing, otherwise they must appear in person. If the MCO has reversed the initial determination and provided the service to the member, they may request a waiver from personal appearance and in submitted papers explain that they have withdrawn their initial determination and are providing the service or treatment. Only the beneficiary may withdraw his/her request for a fair hearing, even if the MCO claims that it has reversed its initial determination and is providing the service to the beneficiary.

According to the dental provider manual, dental care in the Medicaid Program shall include only **essential services** rather than comprehensive care. The provider should use this Manual to determine when the Medicaid program considers dental services "essential". The application of standards related to individual services is made by the DOH when reviewing individual cases.

The New York State Dental Provider Manual provides, in pertinent part, as follows:

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.

D9310 Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician

The consulted provider must be enrolled in one of the dental specialty areas recognized by the NYS Medicaid program and the claim must include the NPI of the referring provider. The referring provider cannot be from the same group as the consulting provider.

The following records must be retained in the recipient's permanent record and provided upon request:
• A copy of the written request from the referring provider; and,
• A copy of the written evaluation to the referring provider with the findings and recommendations.

If the consultant provider assumes the management of the recipient after the consultation, subsequent services rendered by that provider will not be reimbursed as consultation. Referral for diagnostic aids (including radiographic images) does not constitute consultation but is reimbursable at the listed fees for such services. Consultation will not be reimbursed if claimed by a provider within ninety days of an examination or an office visit for observation (D9430).

Section 358-5.9(a) of the Regulations provide in part that at a fair hearing concerning the denial of an application for or the adequacy of medical assistance or services, the appellant must establish that the agency's denial of assistance was not correct or that the appellant is eligible for a greater amount of assistance.

Regulations at 18 NYCRR 358-3.7(a) provide that an appellant has the right to examine the contents of the case record at the fair hearing. At the fair hearing, the agency is required to provide complete copies of its documentary evidence to the hearing officer. In addition, such documents must be provided to the appellant and appellant's authorized representative where such documents were not provided otherwise to the appellant or appellant's authorized representative in accordance with 18 NYCRR 358-3.7. 18 NYCRR 358-4.3(a).

DISCUSSION

The evidence establishes that the Appellant, age 54, has been in receipt of Medicaid benefits through a Managed Care Plan, Centers Plan for Healthy Living, which delegates dental care and services to the dental vendor, [redacted].

At the hearing, an evidence packet was introduced into evidence on behalf of the Plan, which establishes that on March 29, 2019, [redacted] received a request from Union Square Dental on behalf of the Appellant for consultation, full mouth rehab under general anesthesia, crown for tooth #4 and filing on tooth #5.

By Initial Adverse Determination, dated April 1, 2019, the Managed Care Plan determined to deny the request on the grounds that the "*service is not covered by your managed care benefits*." With regard to the request for Crowns, the Plan determined that, "*Denial Code 7y Tooth 04, Under Program Dental Guidelines, there is no coverage for this service if you have or will have 8 points (4 top and 4 bottom natural or prosthetic teeth in biting contact. Because you will have 8 points of biting contact without this service, it is denied. This decision was based on a review of the dental records submitted by your dentist."* With regard to the request for Filings, (resin-based composite) the Plan determined, "*Denial Code K5 Tooth 05, Requested service is considered within the scope of the general dentist";* With regard to Consultation, "*Denial Code K5, Requested service is considered within the scope of the general dentist…These decisions*

were based on a review of [Appellant's] radiographs and narrative as submitted by his dentist, Union Square Dental.

The Initial Adverse Determination, dated April 1, 2019, also advised the Appellant that he had 60 calendar days from the date of that Notice to ask for a Plan Appeal.

A review of the evidence indicates that the Appellant did not file a Plan Appeal before requesting this hearing.

A review of the records at the NYS Office of Temporary and Disability Assistance, shows that on March 18, 2019, the Appellant requested this fair hearing. The Appellant actually requested this fair hearing prior to the Initial Adverse Determination.

At the Fair Hearing, the Appellant did not establish that he filed an internal appeal with regard to the Plan's April 1, 2019 determination.

Therefore, the application of law to uncontroverted facts establishes that the Commissioner lacks jurisdiction to provide review of said determination within the fair hearing process.

DECISION

There is no issue to be decided regarding the Managed Care Plan's determination of April 1, 2019 to deny the Appellant's request for crowns, D2750, consultations, D9310, and fillings, D2393.

DATED: Albany, New York
08/27/2019

NEW YORK STATE
DEPARTMENT OF HEALTH

By H. Cooper Gregory

Commissioner's Designee