STATE OF NEW YORK
DEPARTMENT OF HEALTH

REQUEST: October 12, 2018
[redacted]
AGENCY: MAP
FH #: 7842032H

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 November 2, 2018, 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 (Centers Plan for Healthy Living)

On Papers Only – Appearance Waived by the Office of Administrative Hearings

ISSUE

Does the Appellant's October 12, 2018 fair hearing request to review the determination of her managed care plan, which denied the Appellant's request for osseous surgery on four quadrants, raise an issue to be decided by the Commissioner?

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, age 42, has been in receipt of authorization for Medical Assistance.

2. The Appellant has been enrolled in a Medicaid managed long term care plan operated by Centers Plan for Healthy Living (Centers Plan). Healthplex is the dental plan administrator for Centers Plan.

3. On September 7, 2018, Healthplex received an electronic request from Dr. [redacted] for osseous surgery on all four quadrants for the Appellant.

4. On September 7, 2018, Healthplex issued a determination denying the request for osseous surgery on four quadrants for the Appellant.

5. On October 12, 2018, the Appellant requested this fair hearing.

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...

Section 364.2 of the Social Services Law provides in part, as follows:

The Department of Health shall be responsible for . . .

(b) establishing and maintaining standards for all non-institutional health care and services rendered pursuant to this title, . . .

* * *

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.

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.

Pursuant to regulations at 18 NYCRR 513.0, where prior approval of medical, dental and remedial care, services or supplies is required under the MA program, such prior approval will be granted when the medical, dental and remedial care, services or supplies are shown to be medically necessary to prevent, diagnose, correct or cure a condition of the recipient which: (1) causes acute suffering; (2) endangers life; (3) results in illness or infirmity; (4) interferes with the

capacity for normal activity; or (5) threatens to cause a significant handicap. Pursuant to 18 NYCRR 513.6, the determination to grant, modify or deny a request initially must be made by qualified Department of Health professional staff exercising professional judgment based upon objective criteria and the written guidelines of the Department of Health and regulations, and commonly accepted medical practice.

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.

Part 438 of 42 Code of Federal Regulations (CFR) pertains to 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.

42 CFR 438.402 provides, in part, that:

(a)The grievance and appeal system. Each MCO, PIHP, and PAHP must have a grievance and appeal system in place for enrollees. Non-emergency medical transportation PAHPs, as defined in § 438.9, are not subject to this subpart F.

(b)Level of appeals. Each MCO, PIHP, and PAHP may have only one level of appeal for enrollees.

(c)Filing requirements -

(1)Authority to file.

(i) An enrollee may file a grievance and request an appeal with the MCO, PIHP, or PAHP. An enrollee may request a State fair hearing after receiving notice under § 438.408 that the adverse benefit determination is upheld.

(A)Deemed exhaustion of appeals processes. In the case of an MCO, PIHP, or PAHP that fails to adhere to the notice and timing requirements in § 438.408, the enrollee is deemed to have exhausted the MCO's, PIHP's, or PAHP's appeals process. The enrollee may initiate a State fair hearing.

42 CFR 438.408 provides, in part, that:

(f)Requirements for State fair hearings -

> (1)Availability. An enrollee may request a State fair hearing only after receiving notice that the MCO, PIHP, or PAHP is upholding the adverse benefit determination.
>
> > (i)Deemed exhaustion of appeals processes. In the case of an MCO, PIHP, or PAHP that fails to adhere to the notice and timing requirements in § 438.408, the enrollee is deemed to have exhausted the MCO's, PIHP's, or PAHP's appeals process. The enrollee may initiate a State fair hearing.

18 NYCRR Section 358-5.9(a) provides 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.

DISCUSSION

The record establishes that the Appellant, age 42, has been in receipt of authorization for Medical Assistance. The Appellant has been enrolled in a Medicaid managed long term care plan operated by Centers Plan for Healthy Living (Centers Plan). Healthplex is the dental plan administrator for Centers Plan. On September 7, 2018, Healthplex received an electronic request from Dr [redacted] for osseous surgery on all four quadrants for the Appellant. On September 7, 2018, Healthplex issued a determination denying the request for osseous surgery on four quadrants for the Appellant.

Pursuant to the above-cited federal rules at 42 CFR Part 438.402 which took effect on May 1, 2018, the Appellant was required to request an internal appeal of the September 7, 2018 determination before requesting this hearing. The second page of the September 7, 2018 notice advised that if the Appellant did not agree with the plan's decision, she had to ask for an internal appeal with the plan, and the third page of the notice advised that a State Fair Hearing could be requested *after* she asked for a plan appeal and had received a Final Adverse Determination.

At the hearing, the Appellant did not establish that she had asked for an internal appeal of the September 7, 2018 determination prior to requesting this hearing. Thus, the Commissioner does not have jurisdiction to decide any issue related to this hearing request. The Appellant's provider may submit a new prior approval request to Centers Plan on behalf of the Appellant, if appropriate.

DECISION

The Appellant's October 12, 2018 fair hearing request to review the determination of her managed care plan, which denied the Appellant's request for osseous surgery on four quadrants does not raise an issue to be decided by the Commissioner at this time.

DATED: Albany, New York
01/03/2019

NEW YORK STATE
DEPARTMENT OF HEALTH

By

Allyson Sacky

Commissioner's Designee