STATE OF NEW YORK
DEPARTMENT OF HEALTH

REQUEST: July 17, 2017
[redacted]
AGENCY: MAP
FH #: 7571972Z

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 14, 2017, 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

Evidence waiver packet – appearance on paper only

ISSUE

Was the Managed Long-Term Care Plan's determination to deny the Appellant's dentist's prior authorization request for a porcelain crown (D2751), a prefabricated post and core (D2954), and root canal therapy (D3320) for the Appellant's tooth number 29 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 50, is enrolled in a partially-capitated managed long-term care plan operated by Centers Plan for Healthy Living (hereinafter, the "MLTC Plan").

2. On March 13, 2017, the Appellant's dentist submitted a prior authorization request to the MLTC Plan on the Appellant's behalf for a porcelain crown (D2751), a

prefabricated post and core (D2954), and root canal therapy (D3320) for the Appellant's tooth number 29.

3. By notice dated March 15, 2017, the MLTC Plan advised the Appellant of its determination to deny the requested services because "there are 8 points of teeth (4 top and 4 bottom) in biting contact".

4. On April 20, 2017, the Appellant requested fair hearing number 7518107K to review the Plan's March 15, 2017 determination.

5. On May 22, 2017, fair hearing number 7518107K was held, which included as evidence the Plan's explanation that the Appellant does not have 8 posterior teeth in functional contact, but will have 8 posterior teeth in functional contact if she receives a partial upper denture.

6. On June 20, 2017, a decision after fair hearing number 7518107K was issued, whereby the Plan's determination was affirmed because the "Appellant did not establish [that] she had fewer than 8 points of occlusal contact without tooth number 29".

7. On July 12, 2017, the Appellant's dentist submitted a new prior authorization request to the MLTC Plan on the Appellant's behalf for a porcelain crown (D2751), a prefabricated post and core (D2954), and a root canal (D3320) for the Appellant's tooth number 29. The request included images of the Appellant's teeth.

8. By notice dated July 12, 2017, the MLTC Plan determined to deny the Appellant's dentist's prior authorization request for root canal therapy, a porcelain crown, and a prefabricated post and core for the Appellant's tooth number 29 "because there are 8 points of teeth (4 top and 4 bottom) in biting contact".

9. On July 17, 2017, the Appellant requested this fair hearing.

APPLICABLE LAW

Social Services Law section 365-a 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.

> 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.

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, . . .

* * *

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. The NYS Department of Health has entered into a contract with VNS Choice.

Section 438.210 of 42 CFR Subpart D provides in part:

Section 438.210 Coverage and authorization of services.

(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 438.236 of 42 CFR Subpart D provides in part:

Section 438.236 Practice guidelines.

(a) Basic rule: The State must ensure, through its contracts, that each MCO and, when applicable, each PIHP and PAHP meets the requirements of this section.

(b) Adoption of practice guidelines. Each MCO and, when applicable, each PIHP and PAHP adopts practice guidelines that meet the following requirements:

(1) Are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field.

(2) Consider the needs of the MCO's, PIHP's, or PAHP's enrollees.

(3) Are adopted in consultation with contracting health care professionals.

(4) Are reviewed and updated periodically as appropriate.

(c) Dissemination of guidelines. Each MCO, PIHP, and PAHP disseminates the guidelines to all affected providers and, upon request, to enrollees and potential enrollees.

(d) Application of guidelines. Decisions for utilization management, enrollee education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines.

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 4403-f of the Public Health Law pertains to Managed Long Term Care Plans.

Subsection 1 of said statute, definitions, states, in part:

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 which the plan is authorized to enroll.

Subsection 5 of said statute states, in part:

Applicability of other laws. (a) A managed long term care plan or approved managed long term care demonstration shall be subject to the provisions of the insurance law and regulations applicable to health maintenance organizations, this article and regulations promulgated pursuant thereto. To the extent that the provisions of this section are inconsistent with the provisions of this chapter or the provisions of the insurance law, the provisions of this section shall prevail.

Article V of the Managed Long-Term Care Model Contract for New York State provides:

A. Provision of Benefits

1. The Contractor agrees to provide covered services set forth in Appendix G in accordance with the coverage and authorization requirements of 42 CFR 438.210; comply with professionally recognized standards of health care and implement practice guidelines consistent with 42 CFR 438.236; and comply with the requirements of 438.114 regarding emergency and post-stabilization services to the extent that services required to treat an emergency medical condition are within the scope of covered services in Appendix G.

2. Benefit package services provided by the Contractor under this Contract shall comply with all standards of the State Medicaid Plan established pursuant to State Social Services Law Section 363-a and shall satisfy all applicable requirements of the State Public Health and Social Services Law. Non-covered services for which the Enrollee is eligible under the Medicaid Program will be paid by the Department on a fee-for-service basis directly to the provider of service.

3. The Contractor agrees to allow each Enrollee the choice of Participating Provider of covered service to the extent possible and appropriate.

4. The Contractor agrees to maintain and demonstrate to the Department's satisfaction, a sufficient and adequate network for the delivery of all covered services either directly or through subcontracts. The Contractor shall meet the standards required by 42CFR 438.206 for availability of services; and 42CFR 438.207 for assurances of adequate capacity; and applicable sections of Public Health Law and regulations. If the network is unable to provide necessary services under this Contract for a particular Enrollee, the Contractor agrees to adequately and timely furnish these services outside of the Contractor's network for as long as the Contractor is unable to provide them within the network.

According to Appendix G of the just-cited Model Contract, one of the services for which the State will pay a Plan as part of capitation payments, if the Plan elects to provide such service, is dentistry.

Appendix K of the just-cited Model Contract summarizes the participant's statutory rights to appeal determinations of the Managed Long-Term Care Plan, including the right to a fair hearing. Pursuant to the New York State Department of Health Office of Health Insurance Programs MLTC Policy 15.03, for all MLTC partial capitation plan decisions made on or after July 1, 2015 that deny, reduce or discontinue enrollees' services, enrollees may request a State fair hearing from the NYS Office of Temporary and Disability Assistance ("OTDA") immediately without first requesting an internal appeal of the determination.

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

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…

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

Pursuant to the New York State Medicaid Dental Manual, the following services are considered outside 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 use of panoramic images along with intraoral complete series of images (D0210).

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 its replacement by addition to an existing 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 patient, treatment will not be covered.

Pursuant to the Provider Manual, 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 post-treatment 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.

Regulation 358-5.9(a) provides, in part:

> 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.

DISCUSSION

By notice dated July 12, 2017, the MLTC Plan advised the Appellant of its determination to deny her dentist's prior authorization request for root canal therapy (D3320), a porcelain crown (D2751), and a prefabricated post and core (D2954) for the Appellant's tooth number 29 "because there are 8 points of teeth (4 top and 4 bottom) in biting contact".

At the outset, it must be noted that the Plan's medical necessity standard for authorizing dental treatment is inconsistent with New York State Medicaid Guidelines. Whereas Centers Plan deems four upper teeth in contact with four bottom teeth sufficient for chewing purposes, New York State Medicaid Guidelines make that clear a person is considered able to chew if they have 8 posterior teeth in functional occlusion (i.e., 4 upper posterior teeth in functional contact with 4 lower posterior teeth).

Almost as interesting is the explanation contained in the narrative accompanying the Plan's evidence waiver packet. The narrative confirms that the Appellant does not have 8 posterior teeth in functional contact since, according to Centers Plan, she is missing the following upper teeth: 1, 2, 3, 4, 13, 14, 15 & 16. Nevertheless, the Plan asserts that the Appellant "should be eligible" (signifying perhaps that such is not guaranteed) for a partial upper

denture which will then provide the Appellant with 8 teeth in biting contact. Tooth charting enclosed in the Plan's evidence packet also confirms that the Appellant currently has less than 8 posterior teeth in functional occlusion. In fact, she only has four posterior teeth in functional occlusion on the date of this hearing, information which the Appellant confirmed at the hearing.

The Appellant also explained that extraction of this tooth, and use of a removable prosthesis such as a denture, will be useless for her because she will not be able to place and remove the denture from her mouth. She stated that she is diagnosed with Friedreich's ataxia, a disease causing progressive damage to the nervous system, which causes, among other things, poor coordination, muscle weakness in the arms and legs, and osteoarthritis in the spine, all of which limit her fine motor abilities. Along with muscle weakness, the Appellant has severe, chronic pain (neuropathy) in her extremities and spine. For these reasons, the Appellant contended, she cannot utilize a device that must be inserted and removed from her mouth regularly.

The Plan has also asserted that decision after fair hearing number 7518107K affirmed an earlier, identical, determination rendered by the Plan with respect to an earlier prior authorization request submitted by the Appellant's dentist and that therefore, this decision should adhere to similar reasoning contained therein. The decision after fair hearing number 7518107K has been reviewed, as has the information contained in that fair hearing record. Upon review of the information contained in that hearing record, the decision after fair hearing number 7518107K is held to be incorrect and does not support the Plan's continued denial of the requested dental services. Issuance of an amended decision or other novation related to the prior hearing can be arranged if absolutely necessary.

The decision after fair hearing number 7518107K incorrectly found that the Appellant has 8 teeth in occlusal contact and that, therefore, she cannot qualify for the requested root canal and crown. However, as already explained, under Medicaid Guidelines, analysis of medical necessity for dental procedures requires a review of whether an individual has 8 posterior points in functional occlusion. The record in that hearing did not reflect that the Appellant had 8 posterior points in functional contact (a fact which Centers Plan had also acknowledged in its evidence waiver submission for fair hearing number 7518107K), nor was the Appellant ever asked why a removable prosthesis is not feasible. As such, Centers Plan's reliance on this prior fair hearing decision has not advanced its position in this current fair hearing regarding its July 12, 2017 determination.

The evidence has been considered. At a hearing regarding the inadequacy of Medical Assistance, the Appellant must establish that the determination made by the Managed Care Plan was incorrect. For all of the reasons previously stated, the record clearly shows that the Appellant has less than 8 posterior teeth in functional contact, and due to medical reasons, cannot utilize a removable prosthesis. Therefore, the Plan's determination is not sustained.

DECISION AND ORDER

The Managed Long-Term Care Plan's determination to deny the Appellant's dentist's prior authorization request for a porcelain crown (D2751), a prefabricated post and core (D2954), and root canal therapy (D3320) for the Appellant's tooth number 29 was not correct and is reversed.

The Managed Long-Term Care Plan is directed to:

1. Authorize the Appellant to receive a porcelain crown (D2751), a prefabricated post and core (D2954), and root canal therapy (D3320) for the Appellant's tooth number 29.

2. Notify the Appellant and her dentist in writing when it has complied with this directive.

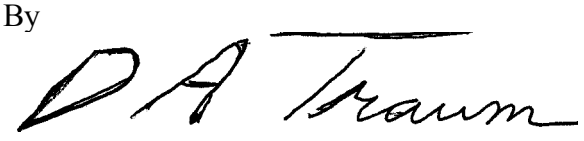
Should the Managed Long-Term Care Plan need additional information from the Appellant in order to comply with the above directives, it is directed to notify the Appellant promptly in writing as to what documentation is needed. If such information is requested, the Appellant must provide it to the Managed Long-Term Care Plan promptly to facilitate such compliance.

As required by 18 NYCRR 358-6.4, the Agency must comply immediately with the directives set forth above.

DATED: Albany, New York
12/22/2017

NEW YORK STATE
DEPARTMENT OF HEALTH

By



Commissioner's Designee