

STATE OF NEW YORK
DEPARTMENT OF HEALTH

REQUEST: February 1, 2019

AGENCY: MAP
FH #: 7904970Y

In the Matter of the Appeal of	:
	: DECISION
	AFTER
	: FAIR
	HEARING
from a determination by the New York City	:
Department of Social Services	:

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 19, 2019, in New York City, before an Administrative Law Judge. The following persons appeared at the hearing:

For the Appellant



For the Managed Long Term Care Plan

Appearance waived by the Office of Administrative Hearings

ISSUE

Was the determination of the Appellant's Managed Long Term Care Plan to deny the Appellant's dentist's prior approval request for root canal therapy, post, cores, and crowns on teeth#5, 7, 8, 9 and 10 for the Appellant 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, age 79, has been in receipt of Medical Assistance coverage for herself.
2. The Appellant has been enrolled in a Managed Long Term Care Plan operated by Centers Plan For Healthy Living.

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3. On or about October 16, 2018, the Appellant's dentist requested prior approval by Centers Plan, for root canal therapy, posts, cores, and crowns on teeth #5, 7, 8, 9 and 10 for the Appellant.

4. By Initial Adverse Determination dated October 18, 2018, acting on behalf of Centers Plan, Healthplex notified Appellant that the prior approval request was denied, because the procedures are excluded pursuant to New York State Guidelines "Because you...need a denture...your plan will not pay to save these teeth...."

5. A request for an internal appeal was made.

6. On January 14, 2019, Healthplex issued a Final Adverse Determination in which it stated it was upholding its prior determination.

7. On February 1, 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:

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(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.

(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;

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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.

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.

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.**

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

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).

Provision of root canal therapy 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. Root canal therapy will not be approved in association with an existing or proposed prosthesis in the same arch, unless the tooth is a critical abutment, 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, root canal therapy or apical surgery 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.**

D3310 Multiple anterior pulpectomies will generally not be approved.

D3330 Molar endodontics is not approvable as a routine procedure. Prior approval requests will be considered for patients 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 patients 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.

Pursuant to the Provider Manual, codes D2710, D2720, D2721, D2722, D2740, D2750, D2751, and D2752 will only be reimbursed for anterior teeth and maxillary first bicuspid when indicated. Crowns will not be routinely approved when functional replacement of tooth contour with other restorative materials is possible, or for a molar tooth in those patients age 21 and over which has been endodontically treated without prior approval from the Department of Health. Also, crowns will not be routinely approved when there are eight natural or prosthetic bicuspid and/or molars (four maxillary and four mandibular teeth) in functional contact with each other. Acrylic (processed) jacket crowns may be approved as restorations for severely fractured anterior teeth.

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. 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 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.

Commencing in 2018, however, said policy was revoked in order for New York State to come in closer conformity with federal law, which requires the exhaustion of internal Plan appeals prior to reaching the Fair Hearing level. The change was made effective May 1, 2018. See, e.g., Spring 2018 letter from New York State Department of Health Deputy Commissioner A. Segal concerning Medicaid changes.

Volume 42 of the Code of Federal Regulations, Part 438, provides, in various parts, that Plan Members must exhaust the internal Plan appeals process before the right to a fair hearing accrues.

More specifically, 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.

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). In addition, a representative of the agency must appear at the hearing along with the case record and a written summary of the case and be prepared to present evidence in support of its determination. 18 NYCRR 358-4.3(b).

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 the Appellant, age 79, has been in receipt of Medical Assistance coverage and enrolled in a Managed Long Term Care Plan operated by Centers Plan For Healthy Living. On or about October 16, 2018, the Appellant's dentist requested prior approval by Centers Plan, for root canal therapy, posts, cores, and crowns on teeth #5,7,8,9 and 10 for the Appellant. By Initial Adverse Determination dated October 18, 2018, acting on behalf of Centers Plan, Healthplex notified Appellant that the prior approval request was denied, because the procedures are excluded pursuant to New York State Guidelines "Because you...need a denture...your plan will not pay to save these teeth..." A request for an internal appeal was made. On January 14, 2019, Healthplex issued a Final Adverse Determination in which it stated it was upholding its prior determination. The Appellant requested this hearing to challenge Healthplex's determination.

Regulations allow Managed Care Plans, Managed Long Term Care Plans, and their designees with proper expertise such as Healthplex, to make a new eligibility determination solely based on records provided, without a re-examination of the patient. Regulations also provide that if a reasonable alternative course of treatment would be extraction of the tooth (or teeth) and replacement with dentures, non-approval of treatment should occur. Additionally, if the total number of teeth which require root canal therapy are excessive or when maintenance of the teeth is not essential or appropriate in view of the overall dental status of the patient, treatment should not be covered. Healthplex's determination was based on the above stated policies.

Healthplex only presented limited documentation—its determination notices, its appeal review form, and a few X-rays. While Healthplex should have submitted more from its case file, the burden of proof here remains with Appellant. Appellant did not state or present anything which contradicted Healthplex's claims or otherwise demonstrated urgent need for the requested procedures. Appellant merely testified, "I don't want dentures," and that her "teeth hurt and are damaged."

At a fair hearing concerning a denial of services, the Appellant must establish that the denial of assistance or benefits was not correct under the applicable law and regulations. or that the Appellant is eligible for a greater amount of assistance or benefits. In the present case, Appellant did not do so. The Managed Long Term Care Organization and its designee, Healthplex, must be upheld here.

DECISION

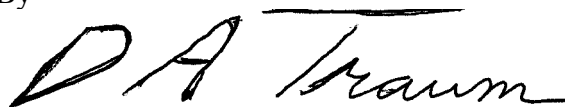
The determination of the Appellant's Managed Long Term Care Plan to deny the Appellant's request for root canal therapy, posts, cores, and crowns on teeth #5,7,8,9 and 10 for the Appellant was correct.

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DATED: Albany, New York
08/12/2019

NEW YORK STATE DEPARTMENT
OF HEALTH

By

A handwritten signature in black ink, reading "DA Traum". The signature is written in a cursive style with a horizontal line above the "A".

Commissioner's Designee