STATE OF NEW YORK
DEPARTMENT OF HEALTH

REQUEST: April 26, 2019
[redacted]
AGENCY: MAP
FH #: 7951469Q

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 30, 2019, in New York City, before an Administrative Law Judge. The following persons appeared at the hearing:

For the Appellant

[redacted]

For the Medicaid Managed Long Term Care Plan

On papers only – Plan appearance waived by the Office of Administrative Hearings

ISSUE

Was the determination of the Appellant's Medicaid Managed Long Term Care Plan, Centers Plan for Healthy Living (by Healthplex, Inc.), to deny the Appellant's dentist's prior approval request for Debridement and Contouring (D6102) for tooth number 30 for the Appellant correct?

FACT FINDING

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 80, has been in receipt of Medical Assistance benefits provided through a Medicaid Managed Long Term Care Plan, Centers Plan for Healthy Living (hereinafter, the "Plan").

2. The Plan has delegated the management of dental benefits and services to its dental vendor, Healthplex, Inc.

3. The Appellant's dentist requested prior approval for Debridement and Contouring (D6102) for tooth number 30 for the Appellant.

4. By Initial Adverse Determination dated March 18, 2018, the Plan (by Healthplex, Inc.) determined to deny said request, reasoning as follows: "You asked for implants because you are missing teeth…Based on documentation/x-rays, implant not covered under plan guidelines."

5. The Plan upheld its Initial Adverse Determination on internal appeal and so advised the Appellant by Final Adverse Determination of April 26, 2019, reasoning as follows:

"You asked for a surface cleaning of exposed implant surfaces (debridement and contouring) for tooth #30 because you want to replace your missing teeth...To approve this service, the following criteria must be met:

- Your physician submitted a letter to explain how implants will alleviate your medical condition.
- Your dentist submitted a letter to explain why other covered functional alternatives for prosthetic replacement will not correct your dental condition and why you require implants.

These criteria are not met because:

- Based on the documentation and x-rays submitted by your dentist, implants and implant related services are not covered under your managed care benefits.
- Healthplex, Inc. on behalf of Centers Plan of Healthy Living did not receive a letter from your physician or dentist explaining why you require implants.
- Please talk to your dentist about other options to solve the problems with your teeth."

6. On April 26, 2019, the Appellant requested this fair hearing.

APPLICABLE LAW

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.

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.

Federal Regulations (Title 42) state, in pertinent part:

§ 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 § 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 [emphasis added]; 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.

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.

18 NYCRR 506.2 provides

(a) 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**. [Emphasis added].

(b) Definition of preventive, prophylactic and other routine dental care, services and supplies. Preventive, prophylactic and other routine dental care, services and supplies shall mean dental care, services and supplies **deemed essential to maintain an adequate level of dental health** [Emphasis added] and shall include but need not be limited to:

(1) dental services required for emergency care and/or the relief of pain or acute infection;
(2) oral examination, including treatment plan, if necessary;
(3) periapical, bitewing, occlusal and extraoral radiographs, as required;
(4) oral prophylaxis, including cleaning, supra and subgingival scaling, and polishing of teeth;

(5) subgingival curettage and root planing;
(6) topical fluoride applications for persons 13 years of age and under;
(7) restoration of carious permanent and primary teeth with:
(i) silver amalgam;
(ii) silicate cement;
(iii) plastic materials; or
(iv) stainless steel crowns;
(8) pulpotomy for permanent or primary teeth;
(9) endodontic therapy for incisor or cuspid teeth;
(10) extraction of infected or nonrestorable teeth; and
(11) repair of full or partial dentures, recementing crowns and fixed bridges, or replacing facings on bridges.

The New York State Medicaid Dental Policy and Procedure Code Manual states that services provided must conform to acceptable standards of professional practice and provides, in pertinent part, that 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 Manual further provides as follows:

SERVICES NOT WITHIN THE SCOPE OF THE MEDICAID PROGRAM
…

Molar root canal therapy for members 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;
…

3. “ESSENTIAL” SERVICES:
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.

…

VIII. IMPLANT SERVICES D6000 - D6199

Dental implants will be covered by Medicaid when medically necessary. Prior approval requests for implants must have supporting documentation from the patient's physician and dentist. A letter from the patient's physician must explain how implants will alleviate the patient's medical condition. A letter from the patient's dentist must explain why other covered functional alternatives for prosthetic replacement will not correct the patient's dental condition and why the patient requires implants.

General Guidelines:

➢ A complete treatment plan addressing all phases of care is required and should include the following:

- Accurate pretreatment charting;
- Complete treatment plan addressing all areas of pathology;
- Inter-arch distances;
- Number, type and location of implants to be placed;
- Design and type of planned restoration(s);
- Sufficient number of current, diagnostic radiographs and/or CT scans allowing for the evaluation of the entire dentition.

➢ If bone graft augmentation is needed there must be a 4 to 6-month healing period before a dental implant can be placed

➢ Dental implant code D6010 will be re-evaluated via intraoral radiographs or CT scans prior to the authorization of abutments, crowns, or dentures four to six months after dental implant placement.

➢ Treatment on an existing implant / implant prosthetic will be evaluated on a case-

by-case basis.

➢ Implant and implant related codes not listed will be considered on a case-by-case basis.

➢ Physician's documentation must include a list of all medications currently being taken and all conditions currently being treated.

➢ All cases will be considered based upon supporting documentation and current standard of care.

…

CODE	**DESCRIPTION**	
…		
For procedure codes D6101 – D6103 the following must be submitted:		
➢ Pre-operative radiographic image of defect		
➢ Detailed narrative		
➢ Intra-oral photograph of defect area		
…		
D6102	**Debridement and osseous contouring of a peri-implant defect or defects surrounding a single implant and includes surface cleaning of the exposed implant surfaces, including flap entry and closure** (TOOTH) (PA REQUIRED) (POST OPERATIVE CARE: 30 DAYS)	$400.00
…		

See New York State Medicaid Dental Policy and Procedure Code Manual (Version 2019, effective 1/1/2019).

DISCUSSION

At issue is the Plan's determination to deny the Appellant's dentist's prior approval request for Debridement and Contouring (D6102) for tooth number 30 for the Appellant.

Section 358-5.9(a) of the Regulations provides, in part, that at a fair hearing concerning the denial of services, the Appellant must establish that such denial was not correct. It is found that in this case the Appellant failed to establish that the subject Plan's determination to deny the requested procedures is not correct under the applicable Regulations and the guidelines set forth in the New York State Medicaid Dental Policy and Procedure Code Manual (hereinafter, the "Manual").

Pursuant to the Manual, Debridement and Contouring (D6102) is listed as an implant-related service, described as "[d]ebridement and osseous [consisting of bone] contouring of a peri-implant defect or defects surrounding a single implant surfaces, including flap entry and closure". In accordance with the Manual, the service requires prior approval, including the

submission of a "detailed narrative" in support thereof. Appellant's dentist submitted a letter dated March 12, 2019 to the Plan stating that Appellant had undergone a surgical removal of a cyst (cystectomy) in the left lower quadrant of Appellant's mouth on January 9, 2019; that his #21 implant is left without "distal bony support" and that in order to save this implant, "chemical, mechanical treatment is planning[sic] with simultaneously[sic] bone graft LLQ [left lower quadrant])."

At the hearing, Appellant submitted another letter from his dentist, dated April 2, 2019, which indicates that the removal of the cyst included distal surface of tooth #20 and that after the removal, there was significant bony defect left which does not allow to restore the lower left quadrant with denture or implant to compensate for normal masticatory function of the lower left quadrant and that ridge augmentation is indicated to support the #20 implant and create a condition for possible surgical placement of "implant #21, 19 on removable denture."

Although Appellant's testimony at the hearing was consistent with his dentist's narratives, these narratives are incompatible with the prior approval claim form the dentist submitted to the Plan, which form states that the subject procedure is to be done to tooth #30. However, tooth #30 is located in the right lower quadrant of the Appellant's mouth, not the left lower quadrant, where cystectomy was performed and teeth ##19, 20 and 21 discussed by the dentist are located.

Given the nature of the procedure, which involves treatment of defects surrounding implant surfaces, the record fails to establish how this service on tooth #30 located in the right lower quadrant of the Appellant's mouth is medically necessary in this case.

For the reasons set forth above, the Plan's determination must be sustained.

DECISION

The determination of the Appellant's Medicaid Managed Long Term Care Plan, Centers Plan for Healthy Living (by Healthplex, Inc.), to deny the Appellant's dentist's prior approval request for Debridement and Contouring (D6102) for tooth number 30 for the Appellant is correct.

DATED: Albany, New York
06/21/2019

NEW YORK STATE DEPARTMENT
OF HEALTH

By

Commissioner's Designee

FH# 7951469Q