STATE OF NEW YORK
DEPARTMENT OF HEALTH

REQUEST: August 4, 2015
[redacted]
AGENCY: MAP
FH #: 7095838J

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 September 20, 2018, in New York City, before an Administrative Law Judge. The following persons appeared at the hearing:

For the Appellant

[redacted]

For the Office of Health Insurance Programs

Appearance by evidence packet

ISSUES

Did the Appellant establish a good cause reason for failing to attend a hearing that was scheduled for December 29, 2015 to review the denial of the Appellant's dentist's request for root canal therapy on tooth #23 for the Appellant?

If so, was the Agency's determination of January 15, 2015 to deny the Appellant's dentist's request for root canal therapy on tooth #23 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 62, has been in receipt of Medical Assistance benefits. From September 1, 2013 through May 31, 2017, Appellant's Medical Assistance was fee-for-service, with no kind of Plan enrollment.

2. On December 29, 2014, the Appellant's dentist requested approval for root canal therapy on tooth #23 for Appellant.

3. By notice dated January 15, 2015, the New York State Department of Health – Office of Health Insurance Programs, the Agency advised the Appellant of its determination to deny the Appellant's dentist request for root canal therapy on tooth #23 for the Appellant on the following grounds: " This tooth is not a critical abutment. A reasonable alternative would be extraction and replacement with an existing or proposed prosthesis. ".

4. On August 4, 2015, the Appellant requested a fair hearing to review the Agency's determination and a hearing was scheduled for December 29, 2015.

5. The Appellant did not attend the fair hearing that was scheduled for December 29, 2015, either in person or by representative, and at no time before the hearing did the Appellant request that such hearing be rescheduled.

3. Effective June 1, 2017, Appellant was enrolled into the Centers Plan for Healthy Living partially capitated Managed Long-Term Care Plan.

6. Based upon the settlement of a class action law suit regarding abandoned Medical Assistance fair hearings, the Office of Administrative Hearings of the New York State Office of Temporary and Disability Assistance, on June 5, 2018, issued a letter to the Appellant's address of record asking if the fair hearing request had been abandoned and advising that if the Appellant requested that such hearing be reopened, the Appellant would be required to provide a good cause reason for defaulting the hearing.

7. On June 8, 2018, the Office of Administrative Hearings received a response from the Appellant, requesting that the hearing be rescheduled.

8. The present hearing has been scheduled in response to such request for rescheduling.

APPLICABLE LAW

Section 22 of the Social Services Law provides that applicants for and recipients of Public Assistance, Emergency Assistance to Needy Families with Children, Emergency Assistance for Aged, Blind and Disabled Persons, Veteran Assistance, Medical Assistance and for any services authorized or required to be made available in the geographic area where the person resides must request a fair hearing within sixty days after the date of the action or failure to act complained of.

As per Matter of Bryant v. Perales, 161 A.D.2d 1186 (4th Dept.1990), the 60 day Statute of Limitations starts from the Appellant's receipt of the pertinent notice.

OTDA Transmittal 18-07 states:

> This Transmittal establishes the handling procedures for hearings and hearing requests involving members of the Fishman retroactive class and their authorized representatives, comprised of all Medicaid appellants who should have, but did not receive a Fishman Default Letter (Letter 18) during the period of January 1, 2012 through March 28, 2017.
> The Office of Administrative Hearings (OAH) will mail a letter dated June 5, 2018 ("Retroactive Letter") to the 76,019 appellants and 6,445 authorized representatives described above, advising them to contact OAH within ten (10) calendar days of the postmark if they wish to reopen the fair hearing on Medicaid issues only. When the Retroactive Letters are sent, the Comment field on the Fair Hearing Information Screen (FHIS) for each hearing will be updated to include the following language: "FISHMAN RETROACTIVE LETTER SENT 06/05/2018." Each Retroactive Letter will contain an "**R**" located near the bottom right-hand corner to assist appellants and staff in identifying the document.
>
> If an appellant or authorized representative requests rescheduling within ten (10) calendar days of the Retroactive Letter's postmark, Legal Specialties Unit staff (LSU) shall reopen the hearing in FHIS by entering "REOP 76" in the Disposition/Reason field….
>
> Under no circumstances shall Aid to Continue be granted or restored prior to the completion of a hearing….
>
> At the new or reopened hearing, the explanation for the failure to appear on the prior hearing date will be addressed by the Hearing Officer. If the request to reopen the prior hearing had been made within ten calendar days of Retroactive Letter's postmark, the Hearing Officer shall treat the Medicaid issue(s) consistent with hearing requests that have been reopened pursuant to NYCRR § 358-5.5 (a). Otherwise, the Hearing Officer shall treat the issues (all non-Medicaid issues, and all Medicaid issues included in a hearing that was denied reopening) consistent with reopening requests that have been denied pursuant to 18 NYCRR § 358-5.5 (d).

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.

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, . . .

* * *

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.

Section 506.3(b) of the Regulations requires prior approval for all dental prosthetic appliances which shall be furnished only if 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:

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, 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 Provider Manual, 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. Pulp capping is not reimbursable.

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).

The following Regulations contain pronouncements concerning evaluation of prior approval requests by the New York State Department of Health:

18 NYCRR section 513.6(d)

The assigned staff of the Department of Health must consider:

(1) the opinions of the ordering or treating practitioners, if given, and all other information submitted by or on behalf of a recipient; and

(2) any other information it has available.

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.

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.

DISCUSSION

By notice dated January 15, 2015, the New York State Department of Health – Office of Health Insurance Programs,(the Agency herein) advised the Appellant of its determination to deny the Appellant's dentist request for root canal therapy on tooth #23 for the Appellant on the following grounds: " This tooth is not a critical abutment. A reasonable alternative would be extraction and replacement with an existing or proposed prosthesis. ".

The Appellant did not attend the fair hearing that was scheduled for December 29, 2015, either in person or by representative. In accordance with the above-cited terms of the judgment in the case of Fishman v. Daines, on June 5, 2018, the Office of Administrative Hearings therefore sent a letter to the Appellant's address of record asking if the fair hearing request had been abandoned and advising that if the Appellant requested that such hearing be reopened, the Appellant would be required to provide a good cause reason for defaulting the hearing that was scheduled for December 29, 2015.

On June 8, 2018, the Office of Administrative Hearings received a response from the Appellant, requesting that the hearing be rescheduled. Based upon such request, the present hearing was scheduled.

Under OTDA Policy Memo 18-07, because OTDA did not send reminder letters to certain defaulting Appellants, such as the now Appellant, OTDA will review Appellant's reason for default under established standards employed with regard to 18 NYCRR section 358-5.5. The Appellant contended at the hearing that the failure to attend the original fair hearing was because she had not received the State letter scheduling the December 29, 2015 Fair Hearing.

The Appellant's testimony that she did not receive the State Letter scheduling the December 29, 2015 Fair Hearing was found to be credible. As the Appellant has established a good cause reason for failing to attend the December 29, 2015 fair hearing, the hearing requested by the Appellant on August 4, 2015 may be reviewed at this time.

The Agency submitted at the hearing a brief on the Appellant's fair hearing request which in pertinent part states as follows; " Appellant's dentist [redacted] requested approval for A. Perform root canal treatment (procedure code D3310) on tooth #22, lower left cuspid. B. Perform root canal treatment (procedure code D3310) on tooth #23, lower left lateral incisor. 2. Summary of Findings and Review: C. Tooth #22 was approved for root canal treatment, procedure code D3310, as a critical abutment for an existing or proposed lower partial denture. Tooth #23 would not be considered a critical abutment and in view of the overall dental status, a reasonable alternative course of treatment would be to extraction of tooth #23 and replace with the existing or proposed lower partial denture. The provision of root canal treatment for tooth #23 would be considered non-essential under the Medicaid program and was therefore denied. ".

The Agency's contentions are in accordance with the dental provider manual and the Appellant's dental records and the evidence developed in this hearing.

It is noted, that at the hearing, the Appellant presented a medical statement from [redacted] stating in part as follows: " Patient requires: #22 – Post Crown; #23 Root Canal therapy or Complete Denture. ". Also, at the hearing the Appellant presented a medical statement from [redacted] and dated August 30, 2018 stating in part as follows: " (Appellant) is under my psychiatric care. She has undergone a complete psychiatric evaluation by me in October 2017 and I have been seeing her monthly since. I can attest that (Appellant's) problems with her dentition have impacted her self-esteem greatly, which is worsening her depression. Having access to dental care to repair her smile would greatly improve her self-image, mood and quality of life. ".

The record developed herewith shows that the evidence presented by the Appellant at the hearing corresponds to the Appellant's current dental or mental condition and it does not reflect the Appellant's dental or mental condition existed at the time (August 4, 2015) when the Appellant's original dentist requested root canal therapy for Appellant on tooth #23.

Therefore, and inasmuch as the Appellant did not establish at the hearing that the Agency's original determination of January 15, 2015 to deny root canal treatment for Appellant on tooth #23 was improper, the Agency's determination is therefore sustained pursuant to applicable laws.

It is noted that Appellant is currently a Member of a Managed Long-Term Care Plan. Appellant should see dentists that participate with her Plan (Centers Plan for Healthy Living). If any service requiring prior approval is required, the participating dentist will send any such prior approval request to the Managed Long-Term Care Plan.

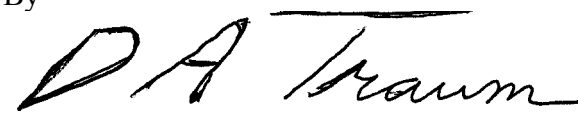
DECISION

The Agency's determination of January 15, 2015 to deny the Appellant's request for root canal treatment for tooth #23, was correct.

DATED: Albany, New York
11/09/2018

NEW YORK STATE
DEPARTMENT OF HEALTH

By



Commissioner's Designee