**STATE OF NEW YORK**
**DEPARTMENT OF HEALTH**

**REQUEST:** December 9, 2016
[redacted]
**AGENCY:** MAP
**FH #:** 7433774Y

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 January 4, 2017, in New York City, before an Administrative Law Judge. The following persons appeared at the hearing:

For the Appellant

[redacted]

For the Managed Care Plan (Centers Plan for Healthy Living)

Centers Plan for Healthy Living appearance waived by the Office of Administrative Hearings – written submissions only

## ISSUE

Was the Appellant's Managed Care Plan's determination of November 9, 2016 to deny the Appellant's dentist's request for coverage for a root canal, post, core and crown for tooth number 15 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 sixty-nine, has been in receipt of Medical Assistance benefits provided through a Medicaid Managed Care Plan known as Centers Plan for Healthy Living.

2. The Appellant's dentist requested coverage for a root canal, post, core and crown for

tooth number 15 for the Appellant.

3. By written notice dated November 9, 2016, the Managed Care Plan determined to deny the Appellant's dentist's request for coverage for a root canal, post, core and crown for tooth number 19 for the Appellant because the service was not covered according to New York State Medicaid guidelines.

4. On December 9, 2016, the Appellant requested this fair hearing.

**APPLICABLE LAW**

Section 358-5.9 of the Regulations provide in part:

(a) At a fair hearing concerning the adequacy of Medical Assistance, the Appellant must establish that the Agency's benefits was not correct or that the Appellant is eligible for a greater amount of assistance or benefits.

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.

Section 438.210 of 42 CFR Subpart D provides, in pertinent 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....

Section 438.236 of 42 CFR Subpart D provides, in pertinent part:

(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 438.400 of 42 CFR Subpart F provides in part:

(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:

In the case of an MCO or PIHP-"Action" means--

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

Article 49 of the Public Health Law pertains to Utilization Review and External Appeal.

The New York State Medicaid Dental Provider Manual provides, in pertinent part, as follows:

Molar endodontic treatment, retreatment or apical surgery is not approvable as a routine procedure. Prior approval requests will be considered for beneficiaries 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 beneficiaries 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 and when the tooth cannot be extracted and replaced with a new prosthesis.

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).

**DISCUSSION**

The record establishes that the Appellant has been in receipt of Medical Assistance benefits provided through a Medicaid Managed Care Plan known as the Centers Plan for Healthy Living. The record further establishes that the Appellant's dentist requested coverage for a root canal, post, core and crown for tooth number 15 for the Appellant. The Appellant's dentist also included clinical notes and x-rays with the prior approval request. It further establishes that on

November 9, 2016, the Managed Care Plan determined to deny the Appellant's dentist's request for coverage for a root canal, post, core and crown for tooth number 15 for the Appellant because the service was not covered according to New York State Medicaid guidelines.

At the hearing, the Appellant testified that she does not have an existing dental prosthesis, such as a denture or a bridge. The Appellant further testified there is no medical condition that prevents the extraction of tooth 19. The Appellant also testified that tooth 19 is painful. The Appellant testified he is unable to chew due to the pain radiating from tooth 15.

The New York State Medicaid Dental Provider Manual provides, in pertinent part, that for 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 and when the tooth cannot be extracted and replaced with a new prosthesis. Based thereon, the record sustains the Managed Care Plan's determination as the Appellant is over age 21 and tooth number 19 is a molar that does not serve as an abutment for an existing functional dental prosthesis. Furthermore, the record sustains the Managed Care Plan's determination as there is no evidence that Appellant's tooth number 15 cannot be extracted and replaced with a new prosthesis.

The Appellant failed to establish that the determination of the Appellant's Managed Care Plan to deny the Appellant's dentist's request for coverage for a root canal, post, core and crown for tooth number 15 for the Appellant is not correct under the guidelines of the New York State Medicaid Dental Provider Manual.

Therefore, the determination of the Appellant's Managed Care Plan to deny the Appellant's dentist's request for coverage for a root canal, post, core and crown for tooth number 15 for the Appellant must be sustained.

**DECISION**

The Appellant's Managed Care Plan's determination of November 9, 2016 to deny the Appellant's dentist's request for coverage for a root canal, post, core and crown for tooth number 15 for the Appellant is correct.

FH# 7433774Y

DATED: Albany, New York
01/23/2017

NEW YORK STATE DEPARTMENT
OF HEALTH

By

Commissioner's Designee