STATE OF NEW YORK
DEPARTMENT OF HEALTH

REQUEST: January 10, 2018
[redacted]
AGENCY: MAP
FH #: 7681804Q

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 February 28, 2018, 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

Dr. Arnold Widman, DDS (by telephone)

ISSUE

Was the determination of the Appellant's Managed Care Plan to deny the Appellant's request for a lower partial denture 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 78, has been in receipt of Medical Assistance benefits.

2. The Appellant has been enrolled in a Managed Care Program and has received care and services through Centers Plan for Healthy Living ("Centers Plan").

3. Centers Plan has delegated the management of the dental benefit and services to

Healthplex.

4. On December 6, 2017, the Appellant's dentist requested approval for a lower partial denture for the Appellant.

5. Healthplex denied the request because this procedure is covered once every 4 years.

6. According to Healthplex's records the Appellant's previous denture was inserted on April 21, 2015 and paid for by Healthplex.

7. On January 10, 2018, the Appellant requested this hearing to review the Managed Care Provider's determination.

APPLICABLE LAW

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 care, services and supplies 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 his 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-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.

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:

The Provider Manual, page 10, states as follows:
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 radiographs; and,
 "Unbundling" of procedures

Full and/or partial dentures are covered when they are required to alleviate a serious health condition or one that affects employability. Complete dentures and partial dentures will not be replaced for a minimum of eight (8) years from initial placement except when they become they become unserviceable through trauma, disease or extensive physiological change. Dentures which are lost, stolen or broken will not be replaced.

All prosthetic appliances such as complete dentures, partial dentures, denture duplication and relining procedures include six months of post-delivery care. Placement of immediate dentures and the use of dental implants and related services are beyond the scope of the program. Complete and/or partial dentures will be approved only when existing prostheses are not serviceable or cannot be relined or rebased. Reline or rebase of an existing prostheses will not be reimbursed when such procedures are performed in addition to a new prostheses for the same arch. If a recipient's health would be adversely affected by the absence of a prosthetic replacement, and the recipient could successfully wear a prosthetic replacement, such a replacement will be considered. In the event that the recipient has a record of not successfully wearing prosthetic replacements in the past, or has gone an extended period of time (three years or longer) without wearing a prosthetic replacement, the prognosis is poor. Mitigating factors surrounding these circumstances should be included with the prior approval request. Partial dentures will be approved only when they are required to alleviate a serious health condition including one that affects employability. Eight natural or prosthetic teeth in occlusion (four maxillary and four mandibular teeth in functional contact with each other) are generally considered adequate for functional purposes. One missing maxillary anterior tooth or two missing mandibular anterior teeth may be considered a problem that warrants a prosthetic replacement.

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).

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 evidence establishes that the Appellant's dentist requested approval for a lower partial denture for the Appellant. Healthplex denied the request because this procedure is covered once every 4 years. Under NYS Dental Manual Guidelines, there is no coverage for a new denture if the previous denture is less than 8 years old. However, the Appellant is in a Plan that allows for replacement every 4 years.

At the hearing, the Appellant testified that she did have the lower partial inserted on April 21, 2015. The Appellant further testified that after two years the partial has become loose and is aggravating her gums. The Appellant further testified that her dentist told her that the denture cannot be fixed and has not tried to adjust it. The Managed Care representative testified that the clasps are made to be adjustable and no documents were submitted stating why the denture needs to be replaced.

At a hearing concerning the denial of a medical assistance request the Appellant has the burden to prove the Managed Care Plan was incorrect. The Appellant did not meet that burden. Therefore, the Managed Care Plan's determination to deny the Appellant's request for a lower partial denture must be sustained.

DECISION

The determination of the Appellant's Managed Care Provider to deny the Appellant's request for a partial lower denture was correct.

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DATED: Albany, New York
03/16/2018

NEW YORK STATE DEPARTMENT
OF HEALTH

By

Commissioner's Designee