STATE OF NEW YORK
DEPARTMENT OF HEALTH

REQUEST: March 22, 2017
[redacted]
AGENCY: MAP
FH #: 7497975Z

In the Matter of the Appeal of [redacted]	:	**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 April 13, 2017, in New York City, before an Administrative Law Judge. The following persons appeared at the hearing:

For the Appellant

[redacted]

For the Managed Long Term Care Plan ("Centers Plan for Healthy Living")

Agency appearance waived by the Office of Administrative Hearings

ISSUE

Was the determination of the Appellant's Managed Long Term Care Plan, Centers Plan for Healthy Living, to deny the Appellant's dentist's request for prior authorization for a root canal (D3320) and crowns (D2752 x 2), correct?

FINDINGS OF FACT

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 58, has been enrolled in a Managed Care Program and has received care and services, through a Medicaid Managed Long Term Care ("MLTC") Health Plan ("the Plan") operated by Centers Plan for Healthy Living whose dental plan administrator is HealthPlex.

2. On March 2, 2017, the Plan received a request for prior authorization for a root canal (D3320) and crowns (D2752 x 2) from the Appellant's dentist.

3. By Notice of Denial dated January 19, 2017, the Plan informed the Appellant of its determination to deny the Appellant's dentist's request for prior authorization for a root canal (D3320) and crowns (D2752 x 2) because the Appellant had 8 teeth in biting contact; because the teeth were not a critical abutment; and because extraction was not medically contraindicated.

4. On October 3, 2016, the Appellant requested this fair hearing to contest the Plan'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.

The Medicaid Managed Care Model Contract delineates the terms by which Managed Care Plans must provide healthcare services available to enrollees under the New York State Medicaid Guidelines, and as such services are specified in the Model Contract. Chapter 10 of the Medicaid Managed Care Model Contract states, in part:

10.1 Contractor Responsibilities

a) Contractor must provide or arrange for the provision of all services set forth in the Benefit Package for MMC Enrollees and FHPlus Enrollees subject to any exclusions or limitations imposed by Federal or State Law during the period of this Agreement. SDOH shall assure that Medicaid services covered under the Medicaid fee-for-service program but not covered in the Benefit Package are available to and accessible by MMC Enrollees.

10.2 Compliance with State Medicaid Plan, Applicable Laws and Regulations

a) All services provided under the Benefit Package to MMC Enrollees must comply with all the standards of the State Medicaid Plan established pursuant to Section 363-a of the SSL and shall satisfy all other applicable requirements of the SSL and PHL.

b) Benefit Package Services provided by the Contractor through its FHPlus product shall

comply with all applicable requirements of the PHL and SSL.

c) Pursuant to 42 CFR 438.210, the Contractor may establish appropriate limits on a service for utilization control and/or medical necessity. The Contractor must ensure that Covered Services are provided in sufficient amount, duration and scope to reasonably be expected to achieve the purpose for which the services are furnished. The Contractor will not define medically necessary services in a manner that limits the scope of benefits provided in the SSL, the State Medicaid Plan, State regulations or the Medicaid Provider Manuals.

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.

According to the New York State Medicaid Program Dental Provider Manual ("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 further provides, in pertinent part, as follows:

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.

The Dental Provider Manual further provides, in pertinent part, as follows:

VI. PROSTHODONTICS (Removable) D5000 - D5899

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 unserviceable through trauma, disease or extensive physiological change. Prior approval requests for replacements will not be reviewed without supporting documentation of medical necessity. Dentures which are lost, stolen or broken will not be replaced.

18 NYCRR 358-5.9(a) provides:

At a fair hearing concerning the denial of an application for or the adequacy of public assistance, medical assistance, HEAP, SNAP benefits or services; or an exemption from work activity requirements the appellant must establish that the agency's denial of assistance or benefits or such an exemption was not correct or that the appellant is eligible for a greater amount of assistance or benefits.

DISCUSSION

The record establishes the following relevant facts. The Appellant, age 58, has been enrolled in a Managed Care Program and has received care and services, through a Medicaid Managed Long Term Care ("MLTC") Health Plan ("the Plan") operated by Centers Plan for Healthy Living whose dental plan administrator is HealthPlex. On March 2, 2017, the Plan received a request for prior authorization for a root canal (D3320) and crowns (D2752 x 2) from the Appellant's dentist. By Notice of Denial dated January 19, 2017, the Plan informed the Appellant of its determination to deny the Appellant's dentist's request for prior authorization for a root canal (D3320) and crowns (D2752 x 2) because the Appellant had 8 teeth in biting contact; because the teeth were not a critical abutment; and because extraction was not medically contraindicated.

The Dental Manual specifically notes: "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. *** 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)."

The Appellant's tooth #29 is not a critical abutment and extraction is not medically dangerous. Teeth #13 and #31 are not critical abutments and extraction is not medically dangerous. The Appellant would have in excess of 8 teeth in biting contact despite the extraction of #29, #13, and #31.

The Plan's determination, supported by the lack of any evidence to the contrary, must be sustained.

It is noted that the Plan indicated the likelihood of its prior approval of a partial upper denture that would provide for teeth #13 and #9 that are in the same upper arc. The Appellant is informed of the right to request that the dentist seek prior approval for the same. The Appellant is also informed of the right to request that the dentist seek prior approval for a lower denture for the other extracted teeth in the same lower arc.

DECISION

The determination of the Appellant's Managed Long Term Care Plan, Centers Plan for Healthy Living, to deny the Appellant's dentist's request for prior authorization for a root canal (D3320) and crowns (D2752 x 2) is correct.

DATED: Albany, New York
04/18/2017

NEW YORK STATE
DEPARTMENT OF HEALTH

By

Commissioner's Designee