STATE OF NEW YORK
DEPARTMENT OF HEALTH

REQUEST: June 30, 2017
[redacted]
AGENCY: MAP
FH #: 7565111L

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 7, 2017, in New York City, before an Administrative Law Judge. The following persons appeared at the hearing:

For the Appellant

[redacted]

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

MLTCP appearance waived by the Office of Administrative Hearings
Healthplex, dental benefit manager for MLTCP (on papers)

ISSUE

Was the MLTCP's determination dated June 20, 2017 to deny the Appellant's dentist's prior approval request for a root canal, post and cores, and a crown for tooth number 15 and a partial lower denture 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 60, has been in receipt of Medical Assistance benefits provided through his MLTCP.

2. On June 19, 2017, Healthplex, the dental benefit manager for the MLTCP, received a prior approval request from the Appellant's dentist for root canal treatment, post, core and crown for tooth number 15 (lower left 2nd molar), and for a lower partial denture.

3. The Appellant's dentist indicated on the undated prior approval "ADA Dental Claim Form", request's dental charting that the Appellant was missing teeth numbers 2, 12, 18, 30, and 31, thus leaving the following six pairs of posterior teeth in occlusion: 1/32, 4/29, 5/28, 13/20, 14/19, and 16/17.

4. On June 20, 2017, Healthplex notified the Appellant's dentist in a "Predetermination" letter of its determination to deny the root canal for tooth number 15 because

> 7J-Program Dental Guidelines will not cover root canal therapy because the service is for a molar in a patient 21 or over and the tooth is not necessary to support an existing bridge or denture.

The post and core, and crown were concurrently denied because "7Z- other treatment associated with this service has been denied…." And, Healthplex notified the Appellant and his dentist of its determination to deny the prior approval request for the partial lower denture because "7Y – Program Dental Guidelines will not cover this service because there are 8 points of teeth (4 top and 4 bottom) in biting contact."

5. On June 20, 2017, in concurrent "MLTC Initial Adverse Deuteriation" and "Managed Long Term Care Action Taken Denial, Reduction or Termination of Benefits" notices, the MLTCP notified the Appellant of its determination to deny the Appellant's dentist's prior approval request, reiterating the reasons specified in the concurrent Predetermination letter.

6. On June 30, 2017, the Appellant requested this fair hearing.

APPLICABLE LAW

At a fair hearing concerning the denial of an application for or the adequacy of Public Assistance, Medical Assistance, HEAP, Supplemental Nutrition Assistance Program 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. Except where otherwise established by law or regulation, in fair hearings concerning the discontinuance, reduction or suspension of Public Assistance, Medical Assistance, Supplemental Nutrition Assistance benefits or services, the social services agency must establish that its actions were correct. 18 NYCRR 358-5.9(a).

Section 4403-f of the New York State Public Health Law pertains to Managed Long Term Care Plans.

Article 49 of the New York State Public Health Law pertains to Utilization Review and

External Appeal.

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. CENTERS FOR MEDICARE & MEDICAID SERVICES SPECIAL TERMS AND CONDITIONS, NUMBER: 11-W-00114/2, TITLE: Partnership Plan Medicaid Section 1115 Demonstration, AWARDEE: New York State Department of Health

Partnership Plan - Approval Period: August 1, 2011 – December 31, 2014; as Amended April 14, 2014.

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In 2012, New York added to the demonstration an initiative to improve service delivery and coordination of long term care services and supports for individuals through a managed care model. Under the Managed Long Term Care (MLTC) program, eligible individuals in need of more than 120 days of community-based long term care are enrolled with managed care providers to receive long term services and supports as well as other ancillary services. Other covered services are available on a fee-for-service basis to the extent that New York has not exercised its option to include the individual in the Mainstream Medicaid Managed Care Program (MMMC). Enrollment in MLTC was phased in geographically and by group. The state's goal specific to managed long term care (MLTC) are as follows:
• Expanding access to managed long term care for Medicaid enrollees who are in need of long term services and supports (LTSS);
• Improving patient safety and quality of care for enrollees in MLTC plans;
• Reduce preventable inpatient and nursing home admissions; and
• Improve satisfaction, safety and quality of life.
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Page 8-9:

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IV. POPULATIONS AFFECTED BY AND ELIGIBILITY UNDER THE DEMONSTRATION

1. Demonstration Components. The Partnership Plan includes five distinct components, each of which affects different populations, some of which are eligible under the state plan and some of which are eligible only as an expansion population under the demonstration.
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b. Managed Long Term Care (MLTC). This component provides a limited set of Medicaid state plan benefits including long term services and supports through a managed care delivery system to individuals eligible through the state plan who require more than 120 days of community based long term care services.

Services not provided through the MLTC program are provided on a fee-for-service basis. The state has authority to expand mandatory enrollment into MLTC to all individuals identified in Table 3 (except those otherwise excluded or exempted as outlined in STC 10 of this section) with initial mandatory enrollment starting in any county in New York city and then expanding statewide based on the enrollment plan outlined in Attachment F. When the state intends to expand into a new county outside of New York City, it must notify CMS 90 days prior to the effective date of the expansion and submit a revised assessment of the demonstration's budget neutrality agreement along with all other required materials as outlined in STC 6 in Section V.
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Page 101, ATTACHMENT B, Managed Long Term Care Benefits, states that dental is an included benefit.

Per May 29, 2015 letter the Centers for Medicare & Medicaid Services (CMS) granted a temporary extension of New York's Partnership Plan section 1115 demonstration (Project No. 11-W- 00114/2). The temporary extension is effective through July 31, 2015.

Part 438 of 42 Code of Federal Regulations (CFR) pertains to the 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 438.400 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.

(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:

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

(1) The denial or limited authorization of a requested service, including the type or level of 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 438.210 of 42 CFR Subpart D provides in 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.

(c) Notice of adverse action. Each contract must provide for the MCO, PIHP, or PAHP to notify the requesting provider, and give the enrollee written notice of any decision by the MCO, PIHP, or PAHP to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. For MCOs and PIHPs, the notice must meet the requirements of Sec. 438.404, except that the notice to the provider need not be in writing.

(d) Timeframe for decisions. Each MCO, PIHP, or PAHP contract must provide for the following decisions and notices:

(1) Standard authorization decisions. For standard authorization decisions, provide notice as expeditiously as the enrollee's health condition requires and within State-established timeframes that may not exceed 14 calendar days following receipt of the request for service, with a possible extension of up to 14 additional calendar days, if--

(i) The enrollee, or the provider, requests extension; or

(ii) The MCO, PIHP, or PAHP justifies (to the State agency upon request) a need for additional information and how the extension is in the enrollee's interest.

(2) Expedited authorization decisions.

(i) For cases in which a provider indicates, or the MCO, PIHP, or PAHP determines, that following the standard timeframe could seriously jeopardize the

> enrollee's life or health or ability to attain, maintain, or regain maximum function, the MCO, PIHP, or PAHP must make an expedited authorization decision and provide notice as expeditiously as the enrollee's health condition requires and no later than 3 working days after receipt of the request for service. (ii) The MCO, PIHP, or PAHP may extend the 3 working days [sic] time period by up to 14 calendar days if the enrollee requests an extension, or if the MCO, PIHP, or PAHP justifies (to the State agency upon request) a need for additional information and how the extension is in the enrollee's interest.

Section 438.406 of 42 CFR Subpart F provides in part:

(a) General requirements. In handling grievances and appeals, each MCO and each PIHP must meet the following requirements:

> (1) Give enrollees any reasonable assistance in completing forms and taking other procedural steps. This includes, but is not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability.
>
> (2) Acknowledge receipt of each grievance and appeal.
>
> (3) Ensure that the individuals who make decisions on grievances and appeals are individuals--
>
> > (i) Who were not involved in any previous level of review or decision-making; and
> >
> > (ii) Who, if deciding any of the following, are health care professionals who have the appropriate clinical expertise, as determined by the State, in treating the enrollee's condition or disease.
> >
> > > (A) An appeal of a denial that is based on lack of medical necessity.
> > >
> > > (B) A grievance regarding denial of expedited resolution of an appeal.
> > >
> > > (C) A grievance or appeal that involves clinical issues.

(b) Special requirements for appeals. The process for appeals must:

> (1) Provide that oral inquiries seeking to appeal an action are treated as appeals (to establish the earliest possible filing date for the appeal) and must be confirmed in writing, unless the enrollee or the provider requests expedited resolution.
>
> (2) Provide the enrollee a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing. (The MCO or PIHP must inform the enrollee of the limited time available for this in the case of expedited resolution.)

(3) Provide the enrollee and his or her representative opportunity, before and during the appeals process, to examine the enrollee's case file, including medical records, and any other documents and records considered during the appeals process.

(4) Include, as parties to the appeal--

(i) The enrollee and his or her representative;

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.

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.

Title 18 Section 513.6 (e) provides, in part:

> When the opinion of the ordering or treating practitioner is on matters within the ordering or treating practitioner's professional expertise and within the range of commonly accepted medical practice for the profession, it is entitled to significant weight in reaching a determination and cannot be outweighed solely by the opinions of nonmedical personnel or persons not within the same medical profession as the ordering or treating practitioner.

Article V.A. of the Managed Long Term Care Contract provides in part:

OBLIGATIONS OF THE CONTRACTOR

A. Provision of Benefits

1. The Contractor agrees to provide covered services set forth in Appendix G in accordance with the coverage and authorization requirements of 42 CFR 438.210; comply with professionally

recognized standards of health care and implement practice guidelines consistent with 42 CFR 438.236; and comply with the requirements of 438.114 regarding emergency and post-stabilization services to the extent that services required to treat an emergency medical condition are within the scope of covered services in Appendix G.

2. Benefit package services provided by the Contractor under this Contract shall comply with all standards of the State Medicaid Plan established pursuant to State Social Services Law Section 363-a and shall satisfy all applicable requirements of the State Public Health and Social Services Law. Non-covered services for which the Enrollee is eligible under the Medicaid Program will be paid by the Department on a fee-for-service basis directly to the provider of service.

3. The Contractor agrees to allow each Enrollee the choice of Participating Provider of covered service to the extent possible and appropriate.

4. The Contractor agrees to maintain and demonstrate to the Department's satisfaction, a sufficient and adequate network for the delivery of all covered services either directly or through subcontracts. The Contractor shall meet the standards required by 42 CFR 438.206 for availability of services; and 42 CFR 438.207 for assurances of adequate capacity; and applicable sections of Public Health Law and regulations. If the network is unable to provide necessary services under this Contract for a particular Enrollee, the Contractor agrees to adequately and timely furnish these services outside of the Contractor's network for as long as the Contractor is unable to provide them within the network.

APPENDIX G, Managed Long-Term Care Covered/Non-Covered Services states that dentistry is provided as medically necessary.

APPENDIX J, DEFINITIONS
Terms used in this Contract, which are not otherwise defined, shall have the meanings set forth below.
Definitions of covered services are intended to provide general information about the level of care available through the Medical Assistance Program. The full description and scope of services specified herein are established by the Medical Assistance Program as set forth in the applicable eMedNY Provider Manual. Managed care organizations may not define covered services more restrictively than the Medicaid Program. Contractors are expected to provide services for individual Enrollees as described in each Enrollee's plan of care. Services may be provided either directly or through a sub-contract.

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Dentistry includes but shall not be limited to preventive, prophylactic and other dental care, services and supplies, routine exams, prophylaxis, oral surgery, and dental prosthetic and orthotic appliances required to alleviate a serious health condition including one which affects employability.

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Dental Policy and Procedure Code Manual Version 2017 (effective 1/1/2017) Page 24:

"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.

Dental Policy and Procedure Code Manual Version 2017 (effective 1/1/2017) Pages 9-10:

The dental provider manual provides that dental care provided under the Medicaid Program includes only *essential services* (rather than "comprehensive" services), and further provides:

Services Not Within the Scope of the Medicaid Program
 Dental implants and related services;
 Fixed bridgework, except for cleft palate stabilization, or when a removable prosthesis would be contraindicated;

 Immediate full or partial dentures;
 Molar root canal therapy for beneficiaries 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 provided by the NYS Medicaid program;
 Crown lengthening;
 Replacement of partial or full dentures prior to required time periods unless appropriately documented and justified as stated in the Manual;
 Dental work for cosmetic reasons or because of the personal preference of the recipient or provider;
Periodontal surgery, except for procedure D4210 – gingivectomy or gingivoplasty, for the sole correction of severe hyperplasia or hypertrophy associated with drug therapy, hormonal disturbances or congenital defects;
 Adult orthodontics, except in conjunction with, or as a result of, approved orthognathic surgery necessary in conjunction with an approved course of orthodontic treatment or the on-going treatment of clefts;
 Placement of sealants for beneficiaries under 5 or over 15 years of age;
 Improper usage of panoramic images (D0330) along with intraoral complete series of images (D0210).

Services Which Do Not Meet Existing Standards of Professional Practice Are Not Reimbursable These services include but are not limited to:
 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;
 Other dental services rendered when teeth are left untreated;
 Extraction of clinically sound teeth;
 Treatment provided when there is no clinical indication of need noted in the treatment record. 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 member;
 Restorative treatment of teeth that have a hopeless prognosis and should be extracted;
 Taking of unnecessary or excessive radiographic images;
 Services not completed and,
 "Unbundling" of procedures.
...

Dental Policy and Procedure Code Manual Version 2017 (effective 1/1/2017) Page 36,
CROWNS - SINGLE RESTORATIONS ONLY
The materials used in the fabrication of a crown (e.g. all-metal, porcelain, ceramic, resin) is at the discretion of the provider. The crown fabricated must correctly match the procedure code approved on the Prior Approval.
Crowns will not be routinely approved for a molar tooth in those members age 21 and over which has been endodontically treated without prior approval from the Department of Health. Crowns include any necessary core buildups.
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Dental Policy and Procedure Code Manual Version 2017 (effective 1/1/2017) Page 43,
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 premature replacement will not be reviewed without supporting documentation of medical necessity. Dentures which are lost, stolen or broken will not be replaced unless there exists a serious health condition that has been verified and documented.
General Guidelines for All Removable Prosthesis:
 Complete and/or partial dentures will be approved only when the existing prosthesis is not serviceable or cannot be relined or rebased. Reline or rebase of an existing prosthesis will not be reimbursed when such procedures are performed in addition to a new prosthesis for the same arch within 6 months of the delivery of a new prosthesis. Only “tissue conditioning” (D5850 or D5851) is payable within six (6) months prior to the delivery of a new prosthesis;
 Six (6) months of post-delivery care from the date of insertion is included in the reimbursement for all newly fabricated prosthetic appliances. This includes rebasing, relining, adjustments and repairs.
 Cleaning of removable prosthesis or soft tissue not directly related to natural teeth is not a covered service. Prophylaxis and/or scaling and root planing is only payable when performed on natural dentition;
 "Immediate" prosthetic appliances are not a covered service. An appropriate length of time for healing should be allowed before taking any final impressions. Generally, it is expected that tissues will need a minimum of four (4) to six (6) weeks for healing. Claims for denture insertion occurring within four (4) weeks of extraction(s) will pend for professional review;
 The use of dental implants and implant related prosthetic services are considered beyond the scope of the program;
 Claims are not to be submitted until the denture(s) are completed and delivered to the member. The "date of service" used on the claim is the date that the denture(s) are delivered. If the prosthesis cannot be delivered or the member has lost eligibility following the date of the "decisive appointment," claims should be submitted following the guidelines for "Interrupted Treatment";
 Medicaid payment is considered payment in-full. Except for members with a "spend down," members cannot be charged beyond the Medicaid fee. Deposits, down-payments or advance payments are prohibited;
 All treatment notes, radiographic images, laboratory prescriptions and laboratory invoices should be made part of the member's treatment record to be made available upon request in support of any treatment provided, and;
 The total cost of repairs should not be excessive and should not exceed 50% of the cost of a new prosthesis. If the total cost of repairs is to exceed 50% of the cost of a new prosthesis, a prior approval request for a new prosthesis should be submitted with a detailed description of the existing prosthesis and why any replacement would be necessary per Medicaid guidelines and would be more appropriate than repair of the existing prosthesis.

DISCUSSION

The uncontested evidence establishes that the Appellant has been in receipt of Medical Assistance benefits provided through his MLTCP.

Review of the evidence establishes that on June 19, 2017, Healthplex, the dental benefit manager for the MLTCP, received a prior approval request from the Appellant's dentist for root canal treatment, post, core and crown for tooth number 15 (lower left 2nd molar), and for a lower partial denture. On June 20, 2017, Healthplex notified the Appellant and his dentist about its determination to deny the root canal for tooth number 15 because the service is for a molar in a patient 21 or over and the tooth is not necessary to support an existing bridge or denture; to deny the post, core and crown because the root canal was denied; and to deny the partial lower denture because there are 8 points of teeth (4 top and 4 bottom) in biting contact."

As part of the prior approval request, the Appellant's dentist submitted an undated ADA Dental Claim Form, and a set of radiographs. Review of the dental charting made by the Appellant's dentist as part of the ADA Dental Claim Form establishes that there were 12 points of occlusion: 1/32, 4/29, 5/28, 13/20, 14/19, and 16/17. In a letter titled "Request for Waiver of Personal Appearance/Evidence Packet", dated August 2, 2017, the MLTCP relied upon the occlusion of teeth pairs 4/29, 5/28, 13/20, 14/19 to form the 8 points of occlusion to support its determination. Review of the evidence establishes convergence of evidence between the MLTCP and the Appellant's dentist regarding 8 points of occlusion. Per the Dental Provider Manual, 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. Therefore, where there is no dispute that that the Appellant has 8 points of occlusion, the Appellant's contention, as it pertains the partial lower denture, that the MLTCP's decision was "arbitrary and capricious and amount to gross negligence and deliberate indifference" is not supported by the evidence.

As to the root canal, the Appellant is 21 years of age and over, did not present evidence that tooth 15's extraction would be medically contraindicated, nor did the Appellant present evidence that the tooth is a critical abutment for an existing serviceable prosthesis provided by the NYS Medicaid program, all elements set forth in the Dental Provider Manual. Chronic pain, kidney issues, tinnitus, and teeth infections, conditions asserted by the Appellant, are not among the criteria set forth in the Dental Provider Manual as basis for endodontic therapy. Again, the Appellant's contention that the MLTCP's determination was arbitrary and capricious is not supported by the evidence in the record.

There is no evidence to establish that Healthplex, on behalf of the MLTCP, failed to make its determination in accordance with applicable regulations and guidelines. The Appellant failed to establish that the MLCTP's denial of the prior approval request was erroneous.

Based on the foregoing, the determination by the MLTCP is affirmed.

DECISION

The MLTCP's determination dated June 20, 2017 to deny the Appellant's dentist's prior approval request for a root canal, post and cores, and a crown for tooth number 15 and a partial lower denture was correct.

DATED: Albany, New York
09/12/2017

NEW YORK STATE
DEPARTMENT OF HEALTH

By

Commissioner's Designee