**STATE OF CONNECTICUT**
**DEPARTMENT OF SOCIAL SERVICES**
**OFFICE OF LEGAL COUNSEL, REGULATIONS, AND ADMINISTRATIVE HEARINGS**
**55 FARMINGTON AVENUE**
**HARTFORD, CT 06105-3730**

[redacted] **2016**
**Signature Confirmation**

**Client ID #**[redacted]
**Request #748023**

## NOTICE OF DECISION
## PARTY

[redacted]

## PROCEDURAL BACKGROUND

On [redacted] 2016, Benecare Dental Plans ("Benecare") sent [redacted] ("Appellant") a Notice of Action ("NOA") denying a prior authorization request for approval of Medicaid coverage for an upper and lower complete (full) denture.

On [redacted] 2016, the Appellant requested an administrative hearing to contest the Department's denial of prior authorization of upper and lower complete (full) denture.

On [redacted] 2016, the Office of Legal Counsel, Regulations, and Administrative Hearings ("OLCRAH") issued a notice scheduling the administrative hearing for [redacted] 2016.

On [redacted] 2016, the Office of Legal Counsel, Regulations, and Administrative Hearings ("OLCRAH") issued a notice rescheduling the administrative hearing for [redacted] 2016.

On [redacted] 2016, in accordance with sections 17b-60, 17b-61 and 4-176e to 4-189, inclusive, of the Connecticut General Statutes, OLCRAH held an administrative hearing.

The following individuals were present at the hearing:

[redacted], Appellant via telephone
Katie Nadeau, Benecare Dental Plan Representative
Lenny Colon, Interpreter, ITI
Dr. Susan Lieb, Clinical Consultant for Benecare via telephone
Miklos Mencseli, Hearing Officer

Benecare requested the hearing record be held open for the submission of additional evidence. On [redacted] 2016, the hearing record was closed.

## STATEMENT OF THE ISSUE

The issue is whether Benecare's denial of the Appellant's request for prior authorization for payment under Medicaid coverage for an upper and lower complete (full)l denture was correct.

## FINDINGS OF FACT

1. [redacted] is a participant in the Medicaid program, as administered by the Department of Social Services through Benecare, its contractor.

2. On [redacted] 2011, Medicaid paid for dentures for the Appellant. (Department's Dental Claim History – Dept. Ex. 4A & 4B)

3. [redacted] is the Appellant's treating dentist ("the treating dentist"). (Dept. Ex. 1A)

4. On [redacted] 2015, the treating dentist completed a prior Authorization request for an upper and lower complete (full) denture. (Summary, Dept. Ex. 1A, 1B)

5. On [redacted] 2016, Benecare denied the prior authorization request for approval of payment for an upper and lower complete (full) denture as not medically necessary because Medicaid has paid for both within the last seven years. (Dept. Exhibit 2A, 2B, 2C & 2D: Notice of Action [redacted]15)

6. On [redacted] 2016, the Appellant filed a request for an administrative hearing. (Dept. Ex. 3A, 3B)

7. On [redacted] 2016, Benecare phoned the Appellant and to discuss the Appeals/Hearing process. The Appellant stated his dentures were stolen and he would provide a note from his Doctor and fax it to Benecare. (Summary)

8. Benecare did not receive a medical note from the Appellant. (Summary, Testimony)

9. On [redacted] 2016, having not received a Doctor's note Benecare reviewed the Appellant's x-rays and records and determined that the patient had a history of plan payments within the time limitations set and had not presented evidence by a physician that the dental treatment is medically necessary. (Dept. Ex. 5: Dental Consultant Grievance Review Record[redacted]16)

10. On [redacted] 2016, Benecare issued a determination letter to the Appellant, upholding the decision to deny his request for complete (full) denture replacement procedures. (Dept. Ex. 6A, 6B, 6C & 6D, 6E, 6F: Notices dated [redacted]16, [redacted]-16)

11. There is no medical evidence on the record to support a finding that replacement of the upper and lower complete (full) denture is medically necessary for the Appellant.

12. There is no medical evidence on the record to support a finding that replacement of the upper and lower complete (full) denture meets the medical necessity care conditions criteria.

13. On [redacted] 2016, Benecare received a letter from the Appellant's primary care physician. The letter states: "The acquisition of dentures would greatly improve this person's health status and provide the ability to eat healthier food choices". (Dept. Ex. 8: letter signed by Alicia M. Dodson, MD, FAAP)

14. Benecare determined that the letter from the Appellant's physician does not meet the criteria of medical necessity. (Dept. Ex. 9: email dated [redacted] 2016)

## CONCLUSIONS OF LAW

1. State statute provides that the Department may make such regulations as are necessary to administer the medical assistance program. [Conn. Gen. Stat. §17b-262]

2. "Medically necessary" and "medical necessity" defined. Notice of denial of services. Regulations. (a) For purposes of the administration of the medical assistance programs by the Department of Social Services, "medically necessary" and "medical necessity" mean those health services required to prevent, identify, diagnose, treat, rehabilitate or ameliorate an individual's medical condition, including mental illness, or its effects, in order to attain or maintain the individual's achievable health and independent functioning provided such services are: (1) Consistent with generally-accepted standards of medical practice that are defined as standards that are based on (A) credible scientific evidence published in peer-reviewed medical literature that is generally recognized by the relevant medical community, (B) recommendations of a physician-specialty society, (C) the views of physicians practicing in relevant clinical areas, and (D) any other relevant factors; (2) clinically appropriate in terms of type, frequency, timing, site, extent and duration and considered effective for the individual's illness, injury or disease; (3) not primarily for

the convenience of the individual, the individual's health care provider or other health care providers; (4) not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the individual's illness, injury or disease; and (5) based on an assessment of the individual and his or her medical condition.

(b) Clinical policies, medical policies, clinical criteria or any other generally accepted clinical practice guidelines used to assist in evaluating the medical necessity of a requested health service shall be used solely as guidelines and shall not be the basis for a final determination of medical necessity.

(c) Upon denial of a request for authorization of services based on medical necessity, the individual shall be notified that, upon request, the Department of Social Services shall provide a copy of the specific guideline or criteria, or portion thereof, other than the medical necessity definition provided in subsection (a) of this section, that was considered by the department or an entity acting on behalf of the department in making the determination of medical necessity.

3. Section 184 of the Medical Services Policy provides that for the purposes of this section, dental services are diagnostic, preventive, or restorative procedures, performed by a licensed dentist in a private or group practice or in a clinic; a dental hygienist, trained dental assistant or, or other dental professionals employed by the dentist, group practice or clinic, providing such services are performed within the scope of their profession in accordance with State law. These services relate to:

    I. The teeth and other structures of the oral cavity; and
    II. Disease, injury, or impairment of general health only as it relates to the oral health of the recipient.

4. Section 184D of the Medical Services Policy provides that payment for Dental Services is available for all persons eligible for Medicaid, subject to the conditions and limitations, which apply to these services.

5. Section 184E of the Medical Services Policy provides that except for the limitations and exclusions listed below, the Department will pay for the professional services of a licensed dentist or dental hygienist which conform to accepted methods of diagnosis and treatment, but will not pay for anything of an unproven, experimental or research nature or for services in excess of those deemed medically necessary by the Department to treat the recipient’s diagnosis, symptoms or medical history.

6. Section 17b-10 of the Connecticut General Statutes provides that the department shall adopt as a regulation in accordance with the provisions of chapter 54, any new policy necessary to conform to a requirement of an approved federal waiver application initiated in accordance with section 17b-8 and any new policy necessary to conform to a requirement of a federal or joint state and federal program administered by the department, including, but not limited to, the state supplement program to the Supplemental Security Income Program, but the department may operate under such policy while it is in the process of adopting the policy as a regulation, provided the Department of Social Services prints notice of intent to adopt the regulation in the Connecticut Law Journal within twenty days after adopting the policy. Such policy shall be valid until the time final regulations are effective.

7. Section 17b-262-865 of the Regulations of Connecticut State Agencies provides that coverage of the following non-emergency dental services is limited when provided to clients twenty-one years of age and older. Each of the limitations on coverage described below are subject to exception on a case-by-case basis based upon demonstration of medical necessity and any other factors specified below. Prior authorization is required for medical payment to be available as an exception to any of the following limitations on coverage.

8. Section 17b-262-865(d)(1) of the Regulations of Connecticut State Agencies discusses prosthodontics and states complete and partial denture prosthesis construction shall be limited to one per seven (7) year period.

9. Section 17b-262-865(d)(3) of the Regulations of Connecticut State Agencies states, replacement of denture prosthesis more than once in the seven (7) year period shall be limited to replacement for reasons of medical necessity. Replacement will not be made for cosmetic reasons. Replacement will not be made if the prosthesis was lost, stolen or destroyed as a result of misuse, abuse, or negligence.

10. Benecare correctly determined that the Appellant's condition does not meet the criteria for Medicaid coverage for an upper and lower complete (full) denture because Medicaid paid for both for the Appellant within the last seven years.

11. Benecare correctly determined that the Appellant's condition does not meet the criteria to authorize payment for replacement dentures because there is no medical evidence that the absence of dentures would jeopardize his medical health. Replacement dentures have not been shown to be medical necessary or to meet the medical necessity care condition criteria.

12. Benecare correctly denied the Appellant's request for authorization of payment for replacement dentures

## DISCUSSION

The Appellant previously received dentures paid for by Medicaid on [redacted] 2011. He is not eligible to receive another upper and lower complete (full) denture to be paid for by Medicaid unless it is medically necessary. No medical evidence was provided to support a finding that the requested dentures are medically necessary or meet the medical necessity care condition criteria.

The Appellant had his dentures stolen 5(five) years ago when he was in a convalescent home. The Appellant indicated he has medical issues of diabetes, high cholesterol and anxiety. He is on a special diet due to his diabetes. The Appellant thought his medical provided had faxed over documentation to Benecare back in [redacted]. The Appellant was provided an opportunity to provide documentation to Benecare. Benecare received a letter from the Appellant's physician. Benecare determined it does not meet the medical necessity care condition criteria. The letter is a general form letter. Benecare is sending the Appellant's physician a follow-up letter. At this time there is no medical documentation on file for the Appellant that demonstrates dentures are medically necessary or meet the medical necessity care condition criteria.

Benecare denied the Appellant's request for approval of payment for an upper and lower complete (full) denture in accordance with the governing state regulations.

## DECISION

The Appellant's appeal is **DENIED**.

Miklos Mencseli
Hearing Officer

C: Phil Ober, Operation Manager, DSS R.O. # 52 New Britain
Diane D'Ambrosio, Connecticut Dental Health Partnership, P.O. Box 486, Farmington, CT 06034

## RIGHT TO REQUEST RECONSIDERATION

The appellant has the right to file a written reconsideration request within **15** days of the mailing date of the decision on the grounds there was an error of fact or law, new evidence has been discovered or other good cause exists. If the request for reconsideration is granted, the appellant will be notified within 25 days of the request date. No response within 25 days means that the request for reconsideration has been denied. The right to request a reconsideration is based on §4-181a (a) of the Connecticut General Statutes.

Reconsideration requests should include specific grounds for the request: for example, indicate what error of fact or law, what new evidence, or what other good cause exists.

Reconsideration requests should be sent to: Department of Social Services, Director, Office of Administrative Hearings and Appeals, 55 Farmington Avenue Hartford, CT 06105.

## RIGHT TO APPEAL

The appellant has the right to appeal this decision to Superior Court within 45 days of the mailing of this decision, or 45 days after the agency denies a petition for reconsideration of this decision, provided that the petition for reconsideration was filed timely with the Department. The right to appeal is based on §4-183 of the Connecticut General Statutes. To appeal, a petition must be filed at Superior Court. A copy of the petition must be served upon the Office of the Attorney General, 55 Elm Street, Hartford, CT 06106 or the Commissioner of the Department of Social Services, 55 Farmington Avenue Hartford, CT 06105. A copy of the petition must also be served on all parties to the hearing.

The 45 day appeal period may be extended in certain instances if there is good cause. The extension request must be filed with the Commissioner of the Department of Social Services in writing no later than 90 days from the mailing of the decision. Good cause circumstances are evaluated by the Commissioner or the Commissioner's designee in accordance with §17b-61 of the Connecticut General Statutes. The Agency's decision to grant an extension is final and is not subject to review or appeal.

The appeal should be filed with the clerk of the Superior Court in the Judicial District of New Britain or the Judicial District in which the appellant resides.