STATE OF CONNECTICUT
DEPARTMENT OF SOCIAL SERVICES
OFFICE OF LEGAL COUNSEL, REGULATIONS, AND ADMINISTRATIVE HEARINGS
55 FARMINGTON AVENUE
HARTFORD, CT 06105-3725

[redacted] **2016**
SIGNATURE CONFIRMATION

HEARING ID #: 757662
CLIENT ID #: [redacted]

NOTICE OF DECISION

PARTY

[redacted]

PROCEDURAL BACKGROUND

On [redacted] 2016, Connecticut Dental Health Partnership ("CTDHP") sent [redacted] ("Appellant") a Notice of Action ("NOA") denying a prior authorization request for approval of Medicaid coverage for a partial upper denture.

On [redacted] 2016, the Appellant requested an administrative hearing to contest CTDHP's denial of his prior authorization request.

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

On [redacted] 2016, in accordance with sections 17b-60, 17-61 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
Awilda Maldonado, BeneCare Dental Plan Representative
Dr. Greg Johnson, Dental Consultant for CTDHP, telephone participation
Pamela J. Gonzalez, Hearing Officer

STATEMENT OF THE ISSUE

The issue is whether CTDHP's denial of the Appellant's request for prior authorization for payment under Medicaid coverage for a partial upper denture was correct.

FINDINGS OF FACT

1. The Appellant is a recipient of medical assistance under the Medicaid program. (Hearing record)

2. On [redacted] 2011, Medicaid paid for a partial upper denture for the Appellant. (CTDHP's Dental Claim History – CTDHP exhibit 5)

3. On [redacted] 2016, CTDHP received a prior authorization request from the Appellant's treating dentist for the replacement of an existing upper partial denture. (Prior Authorization Claim Form – CTDHP exhibit 1)

4. On [redacted] 2016, CTDHP issued a notice of denial to the Appellant indicating that the program will pay for a new full or partial denture only once every seven years. (Notice dated [redacted] 2016 – CTDHP exhibit 2)

5. On [redacted] 2016, in a telephone conversation, the Appellant reported to CTDHP that his denture could no longer be repaired. (CTDHP's representative's testimony)

6. On [redacted] 2016, CTDHP advised the Appellant to have his treating dentist take a photograph of the denture and submit it for review. (CTDHP's representative's testimony)

7. The Appellant lost his upper partial denture and therefore did not take it to his dentist to be photographed. (Appellant's testimony)

8. On [redacted] 2016, CTDHP contacted the Appellant's treating dentist to inquire whether they had photographed the denture. The treating dentist informed CTDHP that the Appellant had not come in to the office with the denture. (CTDHP representative's testimony)

9. On [redacted] 2016, CTDHP reviewed its records with respect to the request for prior authorization to pay for a replacement upper partial denture and found that the State of CT had paid for an upper partial denture for the Appellant within the last seven years and there was no evidence of medical necessity provided to justify authorization of payment. (CTDHP's testimony)

10. On [redacted] 2016, CTDHP issued a Determination Letter to the Appellant to advise him that the request for prior authorization was denied. (Letter dated [redacted] 2016 – CTDHP exhibit 7)

CONCLUSIONS OF LAW

1. Section 17b-2(6) of the Connecticut General Statutes states that the Department of Social Services is designated as the state agency for the administration of the Medicaid program pursuant to Title XIX of the Social Security Act.

2. Section 17b-259b of the Connecticut General Statutes defines "medically necessary" and "medical necessity". 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(b) of the Connecticut General Statutes provides in part that pursuant to section 17b-10, the Commissioner of Social Services may implement policies and procedures necessary to administer the provisions of sections 3-114r, 17b-321, 17b-340a and 17b-340b, while in the process of adopting such policies and procedures in regulation form, provided the commissioner prints notice of intent to adopt regulations in the Connecticut Law Journal not later than twenty days after the date of implementation. Such policies and procedures shall remain valid for three years following the date of publication in the Connecticut Law Journal unless otherwise provided for by the General Assembly.

7. Section 17b-262-864 of the Regulations of Connecticut State Agencies provides that the limitations on coverage of certain non-emergency dental services in subsection (a) of this section apply to healthy adults. The limitations on non-emergency dental services in subsection (b) of this section apply to all adults twenty-one years of age and older and are subject to the prior authorization requirements in section 17b-262-866 of the Regulations of Connecticut State Agencies.

8. Section 17b-262-864(b)(C) of the Regulations of Connecticut State Agencies provides that coverage of non-emergency dental services provided to all adults twenty-one years of age and older shall be limited as follows: One complete and

partial denture prosthesis construction is covered per seven-year period. Clients shall sign an acceptance form upon receipt of a new denture prosthesis acknowledging that the prosthesis is acceptable and that he or she understands the department's replacement policy as described in subsection (d) of this section.

9. Section 17b-262-864(b)(D) of the Regulations of Connecticut State Agencies provides that replacement of denture prosthesis more than once in a seven-year period shall be limited to replacement for reasons of medical necessity. Replacement shall not be made for cosmetic reasons. Replacement shall not be made if the prosthesis was lost, stolen or destroyed as a result of misuse, abuse or negligence.

10. Section 17b-282d of the Connecticut General Statutes states, in part, for purposes of this section, "healthy adult" means a person twenty-one years of age or older for whom there is no evidence indicating that dental disease is an aggravating factor for the person's overall health condition.

11. No evidence was presented that dental disease is an aggravating factor for the Appellant's overall health condition.

12. The Appellant is considered to be a "healthy adult" for purposes of this decision.

13. CTDHP correctly determined that the Appellant's condition does not meet the criteria for Medicaid coverage for a partial upper denture because Medicaid paid for a partial upper denture for the Appellant within the last seven years.

14. CTDHP correctly determined that the Appellant's condition does not meet the criteria to authorize payment for replacement dentures within the seven year period 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.

15. CTDHP correctly denied the Appellant's request for authorization of payment for replacement dentures.

DISCUSSION

The Appellant received a partial upper denture paid for by Medicaid in [redacted] 2011. He is not eligible to receive another partial upper denture within seven years of the date paid for by Medicaid unless it is medically necessary. Although the Appellant described that the condition of his mouth has changed and that he is afflicted with diabetes, no medical evidence was provided to support a finding that the requested dentures are medically necessary or meet the medical necessity care condition criteria.

CTDHP denied the Appellant's request for approval of payment for an upper partial denture in accordance with the governing state regulations.

The Appellant may submit another prior authorization claim at any time.

DECISION

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

Pamela J. Gonzalez
Hearing Officer

Copy: Diane D'Ambrosio, CTDHP
Rita Larosa, CTDHP
Awilda Maldonado, CTDHP

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 Legal Counsel, Regulations, and Administrative Hearings, 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 his 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.