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

[redacted] 2017
Signature Confirmation

Client ID # [redacted]
Request # 813549

NOTICE OF DECISION

[redacted]

PROCEDURAL BACKGROUND

On [redacted] 2017, BeneCare Dental Health Plans ("BeneCare") sent [redacted] (the "Appellant") a notice of action denying a request for prior authorization of the replacement of existing upper partial dentures, indicating that the replacement is not medically necessary under state law.

On [redacted] 2017, the Appellant requested an administrative hearing to contest BeneCare's denial of a prior authorization request for existing upper partial dentures.

On [redacted] 2017, the Office of Legal Counsel, Regulations, and Administrative Hearings ("OLCRAH") issued a notice scheduling the administrative hearing for [redacted] 2017.

On [redacted] 2017, OLCRAH, at the Appellant's request, issued a notice rescheduling the administrative hearing for [redacted] 2017.

On [redacted] 2017, 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 by telephone at the hearing:

[redacted], Appellant
Kate Nadeau, BeneCare's Representative

Dr. Greg Johnson, BeneCare's Dental Consultant
Marci Ostroski, Hearing Officer

The Hearing Record was left open for BeneCare to investigate the status of the Appellant's referral on his lower complete dentures. BeneCare provided additional exhibits and on [redacted] 2017, the record closed.

STATEMENT OF THE ISSUE

The issue is whether BeneCare's denial of prior authorization for the replacement of the Appellant's existing upper partial denture for lack of medical necessity was correct and in accordance with state law.

FINDINGS OF FACT

1. The Appellant is a participant in the Medicaid program, as administered by the Department of Social Services (the "Department"). (Hearing summary)

2. The Appellant is fifty-four (54) years old (D.O.B. [redacted]/62). (Exhibit 1: Dental Claim Form)

3. BeneCare is the Department's contractor for reviewing dental providers' requests for prior authorization of partial or full dentures. (Hearing record)

4. [redacted] is the Appellant's treating provider (the "treating dentist"). (Exhibit :1 Dental Claim Form; Hearing summary)

5. On [redacted] 2014, Medicaid paid for an upper partial denture for the Appellant. (Exhibit 6: CT Medicaid Archived Claim History Record)

6. On [redacted] 2017, BeneCare received a prior authorization request and a panoramic X-ray from the Appellant's treating provider requesting approval of Medicaid coverage for an existing upper partial denture and a full lower denture. (Exhibit: 1: Dental Claim Form, Exhibit 2: Panoramic X-ray)

7. On [redacted] 2017, BeneCare approved the prior authorization request for the payment of a lower complete denture. (Exhibit 10: Email from BeneCare; Approval Print screen)

8. On [redacted] 2017, BeneCare denied the prior authorization request for approval of payment for the replacement of upper partial dentures. The reason specified is that Medicaid has paid for full or partial dentures within the last seven years and the primary care or attending physician did not provide any evidence that meets the medically necessary criteria set forth by the Department. (Exhibit 8: Dental Consultant Review Record)

9. On [redacted] 2017, the Appellant's treating dentist reported to BeneCare that the Appellant's "upper partial does not fit properly, it's way off bite". (Hearing Summary)

10. On [redacted] 2017, BeneCare reviewed the Appellant's prior authorization request for an upper denture during a second level review and determined that the Department had paid for partial dentures for the Appellant on [redacted] 2014, and replacement of that denture was not medically necessary. (Exhibit 6: Medicaid Archived Claim History Record)

11. On [redacted] 2017, BeneCare sent the Appellant a second notice advising him that after an appeal review of the request for an upper denture, the denial was upheld. (Exhibit 8: Determination Letter, [redacted]/17)

12. The Appellant does not have any medical conditions related to the condition of his dentures and has not provided any medical documentation supporting the positon that replacement of the upper partial dentures is medically necessary. (Appellant's testimony)

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. Regulations of the Connecticut State Agencies ("Conn. Agencies Regs.") §17b-262-863(6) provides that denture or denture prosthesis means artificial structures made by or under the direction of a dentist to replace a full or partial set of teeth.
3. Section 184B(VI) of the Medical Services Policy provides that dentures means artificial structures made by or under the direction of a dentist to replace a full or partial set of teeth.

4. Connecticut General Statutes §17b-259b provides (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.

5. 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 assistance 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.

6. 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 that apply to these services.

7. 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.

8. Conn. Agencies Regs. 17b-262-864 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.

9. Conn. Agencies Regs. 17b-262-864(b)(2) provides that coverage of non-emergency dental services provided to all adults twenty-one years of age and older shall be limited as follows: Prosthodontics:

    A. Coverage of complete and removable partial dentures for functional purposes when there are fewer than 8 posterior teeth in occlusion or missing anterior teeth is subject to prior authorization requirements in section 17b-262-866 of the Regulations of Connecticut State Agencies.
    B. Coverage of removable partial dentures when there are more than 8 posterior teeth in occlusion and no missing anterior teeth is allowed on a case-by-case basis conditioned upon a demonstration of medical necessity and subject to prior authorization requirements in section 17b-262-866 of the Regulations of Connecticut State Agencies;
    C. 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; and
    D. 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 because of misuse, abuse or negligence.

10. BeneCare correctly determined that Medicaid paid for upper partial and lower partial dentures for the Appellant within the last seven years.

11. BeneCare was correct to deny prior authorization because the Appellant does not meet the medical necessity criteria for replacement of his upper partial and lower partial dentures, in accordance with state statutes and regulations.

DISCUSSION

The Appellant previously received partial dentures paid for by Medicaid on [redacted] 2014. He is not eligible to receive another upper partial 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 criteria.

The Appellant testified that his upper partial denture and his lower partial denture do not match each other preventing him from chewing properly. The Appellant's treating dentist submitted a treatment plan which included the extraction of teeth and a complete lower denture which was approved by BeneCare. The Clinical consultant present at the administrative hearing suggested that if the Appellant chose to pursue the complete lower denture his treating dentist could articulate the new complete lower denture to the existing upper partial denture to resolve his issues with the alignment.

DECISION

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

Marci Ostroski
Hearing Officer

Cc: Diane D'Ambrosio, BeneCare
Rita LaRosa, BeneCare

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, law, and 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 06105-3725.

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, if 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 06105-3725. 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.