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

[redacted] 2018
Signature Confirmation

Client ID # [redacted]
Request # 121610

NOTICE OF DECISION

PARTY

[redacted]

PROCEDURAL BACKGROUND

On [redacted], 2018, Connecticut Dental Health Partnership/Benecare Dental 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] 2018, the Appellant requested an administrative hearing to contest Benecare's denial of a prior authorization request for an upper partial denture.

On [redacted] 2018, the Office of Legal Counsel, Regulations, and Administrative Hearings ("OLCRAH") issued a notice scheduling the administrative hearing for [redacted] 2018.

On [redacted] 2018, the Appellant requested a continuance which OLCRAH granted.

On [redacted] 2018, the OLCRAH issued a notice scheduling the administrative hearing for [redacted] 2018.

On [redacted] 2018, the Appellant requested a continuance which OLCRAH granted.

On [redacted] 2018, the OLCRAH issued a notice scheduling the administrative hearing for [redacted] 2018.

On [redacted] 2018, 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
Kate Nadeau, Benecare's Representative
Dr. Brett Zanger, Benecare's Dental Consultant, participated via telephone
Lisa Nyren, Hearing Officer

The hearing record remained open for the submission of additional evidence. On [redacted] 2018, the record closed.

STATEMENT OF THE ISSUE

The issue to be decided is whether Benecare's denial of prior authorization through the Medicaid program for the Appellant's replacement of his existing upper partial denture was 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 Record)

2. The Appellant is [redacted] years old, born on [redacted]. (Hearing Record)

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

4. On [redacted] 2017, the Appellant received an upper partial denture from [redacted] for which Medicaid paid for. (Exhibit 6: Claims Information, Exhibit 7: Acknowledgement of Receipt, and Appellant's Testimony)

5. On [redacted] 2018, Benecare received a prior authorization request from [redacted] (the "treating dentist") requesting approval of Medicaid coverage for a replacement of an upper partial denture on behalf of the Appellant. (Exhibit 1: Dental Claim Form)

6. On [redacted] 2018, Benecare denied the treating dentist's request for prior authorization for the replacement of an upper partial denture and issued a

notice of action. Benecare determined that the replacement of the upper partial dentures is not medically necessary under the factors set forth in State Statute and Departmental Medical Service Policies. Specifically, Medicaid has paid for full or partial dentures within the last seven years and there was no additional medical evidence provided by your primary care or attending physician indicating that being without the dentures worsens an existing medical condition and being without the denture(s) creates a condition where the patient cannot complete activities of daily living if it worsens a an existing medical condition. (Exhibit 3: Notice of Action)

7. On [redacted] 2018, the Appellant requested an administrative hearing to contest Benecare's denial of the prior authorization request for the replacement of his upper partial dentures. (Exhibit 4: Administrative Hearing Request)

8. On [redacted] 2018, Benecare completed an administrative review. Benecare determined that the patient had received an upper partial denture paid for by Medicaid within the time limitations set by state law. Benecare determined the Appellant had not presented any evidence by a physician stating that upper partial denture is expected to use for mastication on a daily basis. Benecare determined the Appellant presented no evidence by a physician that the denture is needed for medical reasons or that the denture will improve a specific medical condition. Benecare determined the replacement of the upper partial denture does not meet the medically necessary criteria set forth by the Department. (Exhibit 6: Claims Information, Exhibit 9: Dental Consultant Grievance Review Record, Exhibit 10: Notice of Action)

9. On [redacted] 2018, Benecare denied the request for the replacement of the denture and notified the Appellant. The letter states, "Coverage for the replacement of existing partial or full dentures is not paid by the plans more than once in a 7 year period from the date for which benefits for this service were previously paid, unless deemed medically necessary and medically appropriate by the Department. Evidence was provided that [redacted] 2017 was the initial placement for an upper partial denture. No evidence of medical necessity was provided from the attending physician." (Exhibit 10: Notice of Action)

10. On [redacted], 2018, OLCRAH held an administrative hearing. (Hearing Record)

11. On [redacted] 2018, Benecare completed a third review of dental records, reversed their decision to deny the replacement of upper partial dentures, and approved the replacement of existing upper partial dentures. (Exhibit 13: Letter of Approval)

12. On [redacted] 2018, Benecare issued the Appellant a notice of action. The notice stated, "Benecare has determined from this third review of the dental records that the previously denied request for replacement of existing upper partial dentures is now approved." (Exhibit 13: Letter of Approval)

CONCLUSIONS OF LAW

1. The 2018 Supplement to the Connecticut General Statutes § 17b-2(a)(6) 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. State statute provides that 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 [Conn. Gen. Stats. § 17-259b(a)]

3. Regulations of Connecticut State Agencies § 17b-262-527 provides that the department shall review the medical appropriateness and medical necessity of medical goods and services provided to Medical Assistance Program clients both before and after making payment for such goods and services.

4. State regulation § 17b-262-528(a) provides that prior authorization, to determine medical appropriateness and medical necessity, shall be required as a condition of payment for certain Medical Assistance Program goods or services as set forth in the regulations of the department governing specific provider types and specialties. The

department shall not make payment for such goods and services when such authorization is not obtained by the provider of the goods or services.

5. State regulation 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. [Conn. Agency Regs. § 17b-262-864]

6. State regulation provides that 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. [Conn. Agency Regs. § 17b-262-864(b)(2)(C)]

7. State regulation 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. [Conn. Agency Regs. § 17b-262-864(b)(2)(D)]

8. State regulation provides that if the department denies a request for prior authorization, the recipient may request an administrative hearing with the department in accordance with section 17b-60 of the Connecticut General Statutes. [Conn. Agency Regs. § 17b-262-866(e)]

9. Statute provides in part an aggrieved person authorized by law to request a fair hearing on a decision of the Commissioner of Social Services or the conservator of any such person on his behalf may make application for such hearing in writing over his signature to the commissioner and shall state in such application in simple language the reasons why he claims to be aggrieved. [Conn. Gen. Stats. § 17b-60]

10. Uniform Policy Manual ("UPM") § 1570.25(C)(2)(c) provides that the Fair Hearing Official: determines the issue of the hearing.

11. UPM § 1570.25(C)(2)(k) provides that the Fair Hearing Official renders a Fair Hearing decision in the name of the Department, in accordance with the criteria in this chapter, to resolve the dispute.

12. Benecare voided the action that led to the Appellant's request for an administrative hearing.

13. Benecare has approved the prior authorization request for the replacement of the Appellant's upper partial dentures; thus, the Appellant has not experienced any loss of benefits.

14. The Appellant's hearing issue has been resolved; therefore, there is no issue on which to rule. "When the actions of the parties themselves cause a settling of their differences, a case becomes moot." McDonnell v. Maher, 3 Conn. App. 336 (Conn. App. 1985), citing, Heitmuller v. Stokes, 256 U.S. 359, 362-3, 41 S.Ct. 522, 523-24, 65 L.Ed. 990 (1921).

15. The issue for which the Appellant had originally requested the hearing has been approved; there is no practical relief that can be afforded through an administrative hearing.

DECISION

The Appellant's appeal is dismissed as moot**.**

Lisa A. Nyren
Hearing Officer

PC: 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 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.