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

[redacted] **2018**
Signature Confirmation

Client ID #[redacted]
Request # 127780

NOTICE OF DECISION

PARTY

[redacted]

PROCEDURAL BACKGROUND

On [redacted], BeneCare Dental Plans ("BeneCare") issued a notice of action ("NOA") to [redacted] (the "Appellant") denying her dental provider's request for prior authorization for replacement of an existing upper partial denture, for the reasons that her plan paid for a partial denture within the past 7 years, and that no evidence was provided that replacement of the denture was medically necessary.

On [redacted], the Appellant requested an administrative hearing to contest the Department's denial of prior authorization to replace her partial denture.

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

On [redacted], 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
Magdalena Carter, BeneCare's representative
Dr. Greg Johnson, BeneCare's Dental Consultant, via telephone
James Hinckley, Hearing Officer

The Appellant provided a document at the hearing showing that she had voluntarily been appointed a conservator of estate on [redacted]. On [redacted] after the hearing had concluded, the hearing officer scheduled the hearing to reconvene

on [redacted], and notified [redacted], Esq. On [redacted] at the scheduled time for the reconvened hearing, the Appellant did not appear and Ms. [redacted], who was available by telephone, explained that she was conservator of estate but not conservator of person for the Appellant, and was unable to participate without her presence. The hearing did not reconvene but the hearing officer reopened the record until [redacted] to allow Ms. [redacted] an opportunity to consult with the Appellant, and for any additional information that might be provided as a result. No additional information was provided and on [redacted], the hearing record closed.

STATEMENT OF THE ISSUE

The issue is whether BeneCare's denial of prior authorization for replacement of the Appellant's partial denture was in accordance with state statute and regulations.

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 (D.O.B [redacted]). (Hearing Record)

3. On [redacted], the Probate Court voluntarily appointed a conservator of estate for the Appellant. (Ex. A-1: Probate Decree/Appointment of Conservator/Voluntary Appointment)

4. BeneCare is the Department's contractor for reviewing providers' requests for prior authorization for dental treatment. (Hearing Record)

5. [redacted] Inc. is the Appellant's dental provider (the "dental provider"). (Ex. 1: Prior Authorization Claim Form)

6. On [redacted], the Appellant's Medicaid plan paid a claim on her behalf for the construction of an upper partial denture. (Ex. 4: Claims Information)

7. On [redacted], BeneCare received from the Appellant's dental provider a prior authorization request for the construction of an upper partial denture accompanied by an x-ray of the Appellant's mouth. (Summary, Ex. 1: Dental Claim Form/Prior Authorization Request)

8. The Department identifies teeth using a standardized numbering system. (Hearing Record, Dr. Johnson's testimony)

9. The [redacted] prior authorization request reported that the Appellant had teeth #1, #2, #5, #7, #8, #12, #13, #15, #16, #17, #18, #19, and #30 missing;

tooth #13 was marked by having the number circled, rather than by having an "X" through it, as all the other teeth marked as missing did. (Ex. 1)

10. On [redacted], BeneCare denied the dental provider's request for prior authorization to construct an upper partial denture for the reasons that there was evidence that the Appellant's Medicaid Program paid for full or partial denture(s) within the last seven (7) years, and there was no evidence provided from the Appellant's primary care or attending physician that the requested service met the medically necessary/medical necessity care conditions set by the Department. (Ex. 2: Notice of Action for Denied Services)

11. On [redacted], the Department received the Appellant's request for an administrative hearing; the Appellant stated in part on her hearing request that, "I am unable to eat or chew food due to lack of dentures, and dentist removed more of my teeth". (Ex. 3: Appeal and Administrative Hearing Request Form)

12. On [redacted], a BeneCare appeals representative called the dental provider's office and spoke with an office employee who reported that the Appellant's tooth #13 was extracted on [redacted], and faxed clinical notes verifying that the tooth had been extracted; tooth #13 was the tooth that was identified as missing on the prior authorization request by being marked with a circle rather than with an "X". (Summary, Ex. 5: Clinical Notes, Fact #8)

13. There is no evidence that the Appellant has had any additional teeth removed except for tooth #13, which was circled on the [redacted] prior authorization request, apparently denoting that the tooth was marked for extraction because it was later extracted on [redacted]. (Facts #8, #11)

14. On [redacted] BeneCare notified the Appellant that an appeal review of her case upheld the original decision to deny her provider's request for replacement of existing partial denture, because records showed that [redacted] was the initial placement date for the dentures, and no evidence of medical necessity for replacing the denture was provided by the attending physician. (Ex. 7: Appeal Review Decision Letter)

15. Based on the Appellant's dental records, she has two remaining back teeth which make contact in direct opposition, tooth #4, a 2nd bicuspid on the upper right side, with tooth #29, a 2nd bicuspid on the lower right side. The Appellant also has two back teeth which may make glancing contact, although they are not in direct opposition – tooth #14, a 1st molar on the upper left side, with tooth #20, a 2nd bicuspid on the lower left side. (Ex. 1, Dr. Johnson's testimony)

16. The Appellant cannot chew properly on her left side, and chews with difficulty on her right side. (Appellant's testimony)

17. The Appellant lost her denture about two years ago. (Appellant's testimony)

18. The Appellant did not regularly use her denture to eat before it was lost; she would normally remove it to eat and drink. (Appellant's testimony)

19. The Appellant sees only one doctor, for high blood pressure and kidney issues. (Appellant's testimony)

20. The Appellant does not receive assistance from any person or agency in dealing with personal or medical matters; the only assistance she receives is from her conservator of estate. (Appellant's testimony)

21. The Appellant has not been advised by her primary doctor, or by any medical provider, that replacement of her partial denture is medically necessary. (Appellant's testimony)

22. The issuance of this decision is timely under Connecticut General Statutes § 17b-61(a), which requires that a decision be issued within 90 days of the request for an administrative hearing. The Appellant requested an administrative hearing on [redacted], and the hearing was held on [redacted]. However, the hearing had to be scheduled to reconvene, and the record was reopened to accept evidence from the Appellant, adding a 29-day delay. Therefore, the decision is due not later than [redacted], and is timely.

CONCLUSIONS OF LAW

1. Connecticut General Statutes §17b-262 provides that the Department may make such regulations as are necessary to administer the medical assistance program.

2. Connecticut Agencies Regulations §17-262-864 provides in relevant part that "(b) Coverage of non-emergency dental services provided to all adults twenty-one years of age and older shall be limited as follows:…(2) 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….(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 as a result of misuse, abuse or negligence".

3. Connecticut Agencies Regulations §17-262-863 discusses definitions and provides that, “As used in section 17b-262-862 to 17b-262-866, inclusive, of the Regulations of Connecticut State Agencies:…(28) “Teeth” means “teeth” as described using the Universal/National Numbering System:...(D) Posterior teeth are denoted as 1 through 5, 12-21, 28 through 32;”

4. Connecticut General Statutes §17b-259b provides that, “(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”.

   The Appellant’s medical plan paid a claim to construct a denture prosthesis for her on [redacted]; the Appellant qualified for the prosthesis at the time for functional purposes due to having fewer than 8 posterior teeth in occlusion.

   Only one denture prosthesis is covered per seven-year period, and the dental provider’s [redacted] prior authorization request to replace the Appellant’s denture was within seven years of when the initial claim for the denture was paid. Therefore, approval had to be based on the Department’s replacement policy described in the regulation.

   Replacement of dentures within the seven-year period is limited to replacement for reasons of medical necessity, and there is no evidence that replacement of the Appellant’s denture is medically necessary.

   BeneCare was correct when it denied prior authorization to replace the Appellant’s denture as not medically necessary, in accordance with state statute and regulations.

DISCUSSION

The Appellant still has a functional need for dentures and can have her lost denture replaced after the seven-year period has passed. She may also reapply for a replacement during the remainder of the period if, in consultation with her medical provider(s), it is determined that replacement is medically necessary.

DECISION

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

James Hinckley
Hearing Officer

cc: Diane D'Ambrosio, Connecticut Dental Health Partnership
Rita LaRosa, Connecticut Dental Health Partnership

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.