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

DATE : [redacted] 2019
Signature Confirmation

Client ID # [redacted]
Request # [redacted]

NOTICE OF DECISION

PARTY

[redacted]

PROCEDURAL BACKGROUND

On [redacted] 2018, Connecticut Dental Health Partnership ("CTDHP") / Benecare Dental Health Plan sent [redacted] (the "Appellant") a Notice of Action ("NOA) denying his request for prior authorization for replacement of an existing upper partial dentures and a new lower partial denture indicating that the replacement nor the new partial dentures were medically necessary under state law.

On [redacted] 2018, the Appellant requested an administrative hearing to contest CTDHP/ Benecare's denial of the prior authorization.

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, 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
Rosario Monteza, CTDHP/ Benecare's Representative
Dr. Joseph D'Ambrosio, CTDHP/ Benecare's Dental Consultant
Almelinda McLeod, Hearing Officer

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

STATEMENT OF THE ISSUE

The issue to be decided is whether the CTDHP/ Benecare's decision to deny the prior authorization for the replacement of the Appellant's existing partial upper dentures and the new lower partial dentures for lack of medical necessity was correct 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, DOB-[redacted]). (Exhibit 1- prior authorization form)

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

4. On [redacted] 2018, CTDHP received a prior authorization request from Charter Oak Dental Center for the replacement of an existing upper partial denture and a new lower partial denture for the Appellant. (Exhibit 1)

5. On [redacted] 2018, CTDHP issued a Notice of Action ("NOA") to the Appellant denying his request because the program will only pay for new full or partial dentures once every seven (7) years from the date of the initial dentures. Exceptions will be considered if the Appellant can't complete activities of daily living ("ADL") if it worsens an existing medical condition. (Exhibit 2A)

6. On [redacted], 2018, CTDHP researched the Appellant's history dental record and found evidence that the State of Connecticut paid for an upper partial denture on [redacted], 2014. (Exhibit 4)

7. On [redacted] 2018, [redacted] of [redacted] faxed a letter to CTDHP from [redacted], APRN which states the Appellant was having difficulty eating with his current dentures and would benefit from a replacement. (Exhibit 6B)

8. On [redacted] 2018, CTDHP replied to the CHC letter and stated the letter for medical necessity was insufficient. CTDHP requested the Appellant's clinical diagnosis, treatment onset of illness, related history, any prescribed medication and/ or special diet that would warrant replacement of his dentures. (Exhibit 7)

9. On [redacted], 2018, CTDHP/ BeneCare conducted an administrative review of the Appellant's prior authorization request for an upper partial denture. Through an evaluation of the history of plan payment for partial upper dentures and the letter submitted by [redacted], CTDHP determined the request for partial upper dentures was not medically necessary. (Exhibit 9 : Dental Consultant Grievance Review Record)

10. On [redacted], 2018, CTDHP/ Benecare conducted an administrative review of the Appellant's prior authorization for lower partial dentures and found that the Appellant did not have less than 8 natural teeth in occlusion with no missing front teeth; thus determined to deny the prior authorization for such services. (Exhibit 10)

11. On [redacted], 2018 CTDHP sent the Appellant two determination notices upholding the previous denied request for replacement of upper partial dentures and also the new request for new lower dentures. (Exhibit 11, Determination Letters)

12. The Appellant has become borderline diabetic and lactose intolerant since his last request for dentures. Hard foods like meats, fried plantains and potato chips are difficult for him to swallow. He has chosen to eat softer foods, drink lots of liquids at meal time and cut his food in order to swallow his meal. The Appellant states he lost his dentures approximately two years ago and thinks they could have been thrown away by a family member. (Appellant testimony)

CONCLUSIONS OF LAW

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

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

4. CGS §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 dentists, 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 184 D of the Medical Services Policy provides that payment for dental services is available for all persons eligible for Medicaid, subject to the conditions and limitation that apply to these services.

7. Section 184 E 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.

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10. CTDHP correctly determined that Medicaid paid for complete upper partial dentures for the Appellant within the last seven (7) years.

11. CTDHP / Benecare correctly denied the prior authorization for replacement of his complete upper partial dentures because the Appellant does not meet the medical necessity criteria in accordance with state statutes and regulations.

12. CTDHP/ Benecare correctly denied the new lower partial dentures because at the time of review, the Appellant had more than 8 teeth in occlusion and no missing front teeth.

13. CTDHP/ Benecare correctly issued a copy of the specific guideline or criteria considered in making the determination of medical necessity and issued a notice of denial.

DECISION

The Appellant's appeal is DENIED

Almelinda McLeod
Almelinda McLeod
Hearing Officer

CC: Diane D'Ambrosio. CTDHP
Rita LaRosa, 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.