Rhode Island Executive Office of Health and Human Services
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Hearing Date 07/31/19
Docket # 19-1827

[redacted]

ADMINISTRATIVE HEARING DECISION

The Administrative Hearing that you requested has been decided against you. During the course of the proceeding, the following issue(s) and Agency policy reference(s) were the matters before the hearing:

EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES (EOHHS)
R.I. MEDICAID CODE OF ADMINISTRATIVE RULES (MCAR)
210-RICR-30-05-02

The facts in your case, the Agency Rules and Regulations, and the complete administrative decision in this matter follow. Your rights to judicial review of this decision are found on the last page of this decision.

Copies of this decision have been sent to the following: You (the Appellant) and Agency representatives: Jack Demus, Deborah Meiklejohn and Lissa DiMauro.

Present at the hearing were your mother and Agency representative: Jack Demus (Senior Medical Care Specialist), and Dr. Samuel Zwetchkenbaum. (Dental Director)

ISSUE: Is the appellant eligible for Medicaid Orthodontia?

EOHHS Rules and Regulations:
Please see the attached APPENDIX for pertinent excerpts from the Rhode Island Executive Office of Health and Human Services (EOHHS) Medicaid Code of Administrative Rules (MCAR).

APPEAL RIGHTS: Please see attached NOTICE OF APPELLATE RIGHTS at the end of this decision.

DISCUSSION OF THE EVIDENCE:

The Agency representatives testified:

- The Office of Health and Human Services contracts with United Rite Smiles, the dental program for children, under Medicaid.
- The Appellant's child was enrolled in Rite Smiles.
- The orthodontist, for Rite Smiles reviewed a prior authorization request, submitted by [redacted], in April 2019.
- The orthodontist reviewed the X-rays, photos and each element of the HLD score.
- United Rite Smiles, who does the Medicaid program in the state uses what is called the HLD scoring mechanism, to evaluate prior authorization requests for treatment. Basically, orthodontics requires a prior authorization approval.
- The prior authorization is based on the clinical information that is submitted by the child's orthodontist.
- The child's orthodontist, [redacted], submitted the HLD scoring sheet, which was reviewed by the dentist in United Rite Smiles.
- A score of twenty-six is needed for treatment. The scoring sheet has two parts, A and B.
  In part A, one through six, if any of those conditions are indicated no further scoring is required, the child would automatically qualify for treatment. The conditions in part A are severe situations, where there is tissue damage, deep impinging overbite or any condition in part A. If none of these conditions are indicated in part A, part B is used. Part A is comprised of severe conditions that are medical necessities.
- In part B, the dentist takes measurements from X-rays and so forth, when they use part B measurements it has to be a score of twenty-six or more, to qualify. They measure over-jet, over-bite, crowding and crossbite. The Appellant's child did have scores in these categories but a total score of 21 was indicated, which unfortunately is below the score needed for treatment.

- the Department's Dental Director, Dr. Samuel Zwetchkenbaum, testified that
  The child still has baby teeth which should be coming out soon. The child did receive a score of 8 for over-jet. She also scored a 3 for over-bite, and 10 for crowding for a total score of 21.

- Dr. Samuel Zwetchkenbaum feels that the scoring was done accurately. Nine years old is on the young side for orthodontia. Most Dental insurers will only pay for a course of orthodontic treatment once, and a lot of the child's primary teeth are not even out. If she had to have treatment again when that happened, it would not be paid for.

- The child could reapply when she is older. About twelve or thirteen.

- Mr. Demus has to follow the criteria set up by the Department and the bar is quite high.

The Appellant's mother testified:

- Looking at her daughter's case, she sees a child whose teeth protrude severely.

- She thinks about accidents, if she falls face forward, severe damage to her teeth causing her to potentially need root canal or crowns in the future. Something as severe as implants if see where to have an accident. The position of her teeth will not be fixed without orthodontia. Her teeth are not going to align on their own.

- Her son who had a similar problem, perhaps worse, but he hurt his teeth twice.

- Because of the over -crowding, her daughter is prone to decay and cavities.

- She knows her child's teeth are not going to properly align on their own.

- Her daughter does still have baby teeth.

Findings of fact:

- The Appellant received a Denial of appeal Notice from United Health Rite Smiles on April 26, 2019.
- The Appellant filed for a hearing with the Department on May 17, 2019.
- The hearing was held July 31, 2019.

CONCLUSION:

The issue to be decided is whether the appellant was eligible for Medicaid Orthodontia treatment.

A review of Agency Rules and Regulations reveals that the Medicaid Program provides payment/allowance for covered services only when the services are determined to be medically necessary.
The term "medical necessity" or "medically necessary service" means medical, surgical, or other services required for the prevention, diagnosis, cure or treatment of a health-related condition including such services necessary to prevent a detrimental change in either medical or mental health status.
Medically necessary services must be provided in the most cost effective and appropriate setting and shall not be provided solely for the convenience of the member or service provider.

For orthodontic treatment to be determined as medically necessary it must be in order to correct a handicapping malocclusion. Determinations that a service or procedure is medically necessary are made by the staff, consultants and designees of the Health Care Quality, Financing and Purchasing Division, and by individuals and organizations under contract to the OHHS. Policies relative to medical necessity are set forth in the OHHS Manual, the Medicaid Program Provider Reference Manuals, and the Rhode Island State Plan under Title XIX of the federal Social Security Act.
The HLD Index is to measure the presence or absence and the degree of the handicap caused by the components of the Index, and not to diagnose "malocclusion". All measurements are made with a Boley Gauge scaled in millimeters. Absence of any conditions must be recorded by entering "0". The Agency representatives testified that if any of the conditions in Part A of the scoring index are present then the applicant is eligible. This was not the case with the Appellant.
In order to be found eligible an applicant must score at least 26 points in Part B of the scoring index. The Appellant scored a 21, which the Agency representative testified was below the score of 26 thereby determining that the Appellant did not meet the medically necessary criteria base on her dentist's evidence.
The Appellant testified that she is worried about her daughter hurting her teeth because of the overjet and cavities due to crowding.

Dr. Zwetchkenbaum testified that the scoring was done accurately, and the child still has baby teeth that should be coming out soon that would give a orthodontist a better idea of what work will be needed.

After careful review of the Agency's Rules and Regulations as well as the evidence and testimony given, this Appeals Officer finds that the Agency followed the Rules and Regulations for Medicaid orthodontic treatment eligibility; therefore, the Appellant's request for relief is denied.

Geralyn B. Stanford
Appeals Officer

APPENDIX

MEDICAID CODE OF ADMINISTRATIVE RULES (MCAR)
(Pertinent excerpts)

210-RICR-30-05-02
TITLE 210 - EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES

CHAPTER 30 - MEDICAID FOR CHILDREN, FAMILIES AND AFFORDABLE CARE ACT (ACA) ADULTS

SUBCHAPTER 05 – SERVICE DELIVERY OPTIONS
Part 2 – Managed Care Delivery Options

2.1 RIte Care Overview

A. RIte Care was initially established as a statewide managed care demonstration project in 1994 under a Medicaid Title XIX Section 1115 waiver. The project's goal was to use a managed care delivery system to increase access to primary and preventative care for certain individuals and families who otherwise might not be able to afford or obtain affordable coverage. Medicaid members participating in RIte Care are enrolled in a managed care organization (MCO). EOHHS contracts with MCOs to provide these health services to members at a capitated rate (fixed cost per enrollee per month). RIte Care managed care plans serve the following MACC coverage groups: families, children, parent caretakers, foster children (DCYF custody), and pregnant women.
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2.8 Overview of RIte Care Services

A. Individual and families enrolled in RIte Care receive the full scope of services covered under the Medicaid State Plan and the State's Section 1115 waiver, unless otherwise indicated. Covered services may be provided through the MCO or through the fee-for-service delivery system if the service is "out-of-plan" – that is, not included in the MCO but covered under Medicaid. Fee-for-service benefits may be furnished by any participating provider. Rules of prior authorization apply to any service required by EOHHS. Each RIte Care member selects a primary care provider (PCP) who performs the necessary medical care and coordinates referrals to specialty care. The primary care provider orders treatment determined to be medically necessary in accordance with MCO policies. Beneficiaries in the Extended Family Planning (EFP) coverage group do not require a PCP. The extended family planning group is entitled only to family planning services.

2. Delivery of Benefits – The coverage provided through RIte Care is categorized as follows:
    a. In-Plan Benefits
    b. Out-of-Plan Benefits.

3. **Medical necessity** – The standard of "medical necessity" is used as the basis for determining whether access to Medicaid-covered services is required and appropriate. A "medically necessary service" means medical, surgical or other services required for the prevention, diagnosis, cure, or treatment of a health-related condition including any such services that are necessary to prevent a detrimental change in either medical or mental health status or substance use disorder or services needed to achieve age-appropriate growth and development or to attain, maintain, or regain functional capacity. Medically necessary services must be provided in the most cost-efficient and appropriate setting and must not be provided solely for the convenience of the member or service provider.

2.10 Out-of-Plan Benefits

A. Out-of-plan benefits are not included in the capitated rate paid to the MCOs and are not the responsibility of the MCO to provide. These services are provided by existing Medicaid-approved providers who are reimbursed directly by EOHHS on a fee-for-service basis. Out-of-plan benefits are provided to all RIte Care enrollees with the following exceptions: Individuals eligible for Extended Family Planning only; Pregnant women who are otherwise ineligible for Medicaid and post-partum women with income above 253% of FPL; and anyone enrolled in the guaranteed enrollment period but otherwise ineligible for Medicaid. The covered benefits are as follows:

ELIGIBLE GROUP	BENEFIT(S) PROVIDED OUT-OF-PLAN
All Rhody Health Partners, RIte Care and Expansion members	Dental services >>>>>

2.64 RITE SMILES DENTAL PLAN OVERVIEW

A. The RIte Smiles Program is a statewide dental benefit managed care delivery system established under a federal waiver. The program's goal is to improve access to oral health services for Rhode Island children who receive Medicaid. Emphasis is placed on preventive and primary care dental services and education.
B. Children born on or after May 1, 2000 who are receiving dental benefits through Medicaid are enrolled in a RIte Smiles dental plan. EOHHS contracts with one or more dental plans to provide oral health services to these Medicaid-eligible children.

2.65 Legal Authority

Title XIX of the Social Security Act provides the legal authority for the Medicaid Program. The RIte Smiles Program operates under a waiver under the authority of Section 1115 of the Social Security Act.

2.66 Coverage Groups

A. Participation in the RIte Smiles Program is mandatory for all children in the following populations who were born on or after May 1, 2000 and who are receiving Medicaid:
1. Section 1931 children and related populations (including poverty level groups and RI Works cash recipients);
2. Blind and/or disabled children;
3. Foster care children who are receiving foster care or adoption subsidy assistance (Title IV-E), are in foster care, or are otherwise in an out-of-home placement;
4. Section 1115 Waiver Children.

Medical Necessity

The Medicaid Program provides payment/allowance for covered services only when the services are determined to be medically necessary.

The term “medical necessity” or “medically necessary service” means medical, surgical, or other services required for the prevention, diagnosis, cure or treatment of a health related condition including such services necessary to prevent a detrimental change in either medical or mental health status.

Medically necessary services must be provided in the most cost effective and appropriate setting and shall not be provided solely for the convenience of the member or service provider.

Appeal of Denial of Medical Necessity

Determinations made by the Medicaid Program are subject to appeal by the recipient only. Providers may not appeal

Prior Authorization

For some procedures, prior authorization is required before services are performed, unless the service is an emergency. Prior authorization is required for all inpatient or outpatient hospitalization except for life-threatening emergencies or traumatic injuries. Prior authorization requests must include clinical information justifying the need for hospitalization and the name of the facility.

Prior authorization does not guarantee eligibility or reimbursement. It is the responsibility of the provider to check the client's eligibility on the date of service. If there is a verifiable emergency service which requires prior authorization, and needs to be done immediately, the procedure should be performed and the PA requested retroactively. The consultants will review these claims and consider them for payment. The Medicaid Program Dental policy designates those codes, which require prior authorization.

Payment for any prior authorization services can only be made if the services are provided while the person remains eligible for the Rhode Island Medicaid Program. If the case is closed after prior authorization has been granted, but before treatment has been completed, only those services provided while the person was eligible can be considered for payment by the Rhode Island Medicaid Program.

Services Reviewed by Medicaid

The Medicaid Program reserves the right to refuse payment for treatment performed when the prognosis was unfavorable, the treatment impractical, or a lesser cost procedure would have achieved the same ultimate results.

Consultants

The Office of EOHHS, in consultation with the Rhode Island Dental Association, contracts with General Practice consultants, Oral Surgery consultants, and Orthodontic consultants for professional review of specific services or billings before payment will be authorized by the Medicaid Program.

If, in the opinion of the consultant, the clinical information furnished does not support the treatment or services provided, payment will be denied.

The Rhode Island Dental Association will be requested to provide peer review on specific issues through the regularly established peer review system of the Association. The prevention of fraud and abuse may be pursued at the discretion of the Rhode Island Medicaid Program and is not limited to Rhode Island Dental Association peer review.

Individual Consideration

Requests for payment for dental services listed as "IC", must be submitted with a full description

ORTHODONTIC SERVICES

Orthodontics is medically necessary services needed to correct handicapping malocclusion in recipients under age

21. The HLD (RI Mod) Index (Handicapping Labio-lingual Deviation Index) is applied to each individual case by Board qualified orthodontic consultants to identify those cases that clearly demonstrate medical necessity by determining the degree of the handicapping malocclusion. The HDL Index is a tool that has proven to be successful in identifying a large range of very disfiguring malocclusions and two known destructive forms of malocclusion (deep destructive impinging bites and destructive individual anterior crossbite). *Please see example HDL scoring sheet at the end of this section.*

Handicapping Malocclusion

An occlusion that has an adverse effect on the quality of a person's life that could include speech, function or esthetics that could have sociocultural consequences. Examples would be significant discrepancies in the relationships of the jaws and teeth in anteroposterior, vertical or transverse directions.

Medically Necessary

When a situation exists, that could have a detrimental effect on the structures that support the teeth, and if damaged sufficiently, could lead to the loss of function.

Allowance may continue for orthodontic services on recipients losing EPSDT eligibility (reaching their 21st birthday) under the following circumstances:

1. Eligibility for Medicaid is maintained;

2. The request for prior authorization is approved and the work is initiated prior to the recipient's 21st birthday.

Prior Authorization Requests

All requests for prior authorization of payment must include the diagnosis, length, and type of treatment. Records, which include diagnostic casts (study models), cephalometric film, panoramic film or a complete series of intraoral radiographs, and diagnostic photographs, must be submitted for full orthodontic treatment review.

Orthodontic treatment will be approved only where there is evidence of a favorable prognosis and a high probability of patient compliance in completing the treatment program.

Payment for Orthodontic Records

If an orthodontic case is not approved for payment, Medicaid will pay the orthodontist a fee for examination and records when a claim is submitted using procedure code **D8660**. ***This is limited to once every two (2) years.*** This code is tied to each distinct Prior Authorization (PA) request for full orthodontic treatment. If a subsequent request is received in less than two years, and denied at that time, an allowance would not be made. If a subsequent request is received in less than two years and approved because of changes in the child's mouth, an allowance would be made.

If an orthodontist sees a patient for an examination only, and the patient does not proceed with diagnostic records, Medicaid will pay for a Comprehensive Oral Evaluation.

Post-treatment maintenance retainers will not be replaced if lost or damaged.

Orthodontic Services Claims Coding and Reimbursement

DENTITION

Primary Dentition: Teeth developed and erupted first in order of time.

Transitional Dentition: The final phase of the transition from primary to adult teeth, in which the deciduous molars and canines are in the process of shedding and the permanent successors are.

Adolescent Dentition: The dentition that is present after the normal loss of primary teeth AND PRIOR to cessation of growth; that would affect orthodontic treatment.

Adult Dentition: The dentition that is present after the cessation of growth that would affect orthodontic treatment.

NOTICE OF APPELLATE RIGHTS

This Final Order constitutes a final order of the Department of Human Services pursuant to RI General Laws §42-35-12. Pursuant to RI General Laws §42-35-15, a final order may be appealed to the Superior Court sitting in and for the County of Providence within thirty (30) days of the mailing date of this decision. Such appeal, if taken, must be completed by filing a petition for review in Superior Court. The filing of the complaint does not itself stay enforcement of this order. The agency may grant, or the reviewing court may order, a stay upon the appropriate terms.

CERTIFICATION

I hereby certify that I mailed, via regular mail, postage prepaid, a true copy of the foregoing to [redacted]; copies were sent via email to OHHS representatives Jack Demus, Samuel Zwetchkenbaum, and Lissa DiMauro on this_____ day of _____ 2019.