State of West Virginia
DEPARTMENT OF HEALTH AND HUMAN RESOURCES
Office of Inspector General
Board of Review
2699 Park Avenue, Suite 100
Huntington, WV 25704

Joe Manchin III
Governor

Martha Yeager Walker
Secretary

December 4, 2006

_____
_____
_____

Dear Ms. _____:

Attached is a copy of the findings of fact and conclusions of law on your hearing held December 1, 2006. Your hearing request was based on the Department of Health and Human Resources' action to deny Medicaid coverage for orthodontic services.

In arriving at a decision, the State Hearings Officer is governed by the Public Welfare Laws of West Virginia and the rules and regulations established by the Department of Health and Human Resources. These same laws and regulations are used in all cases to assure that all persons are treated alike.

Eligibility for the Medicaid Program is based on current policy and regulations. Some of these regulations state as follows: Medicaid coverage for orthodontic services is provided on medical necessity (Medicaid Regulations Chapter 500-Section 524).

The information which was submitted at your hearing revealed that the medical necessity criteria was not met for Medicaid coverage.

It is the decision of the State Hearings Officer to uphold the action of the Department to deny Medicaid coverage for orthodontic services.

Sincerely,

Thomas M. Smith
State Hearing Officer
Member, State Board of Review

cc: Erika H. Young, Chairman, Board of Review
Barbara White, Bureau for Medical Services
Dr. Chris Taylor, Bureau for Medical Services

WEST VIRGINIA DEPARTMENT OF HEALTH & HUMAN RESOURCES
BOARD OF REVIEW

_____,

Claimant,

v. **Action Number: 06-BOR-3130**

West Virginia Department of Health and Human Resources,

Respondent.

DECISION OF STATE HEARING OFFICER

I. INTRODUCTION:

This is a report of the State Hearing Officer resulting from a fair hearing concluded on December 1, 2006 for _____. This hearing was held in accordance with the provisions found in the Common Chapters Manual, Chapter 700 of the West Virginia Department of Health and Human Resources. This fair hearing was convened on December 1, 2006 on a timely appeal filed October 4, 2006.

It should be noted here that the claimant's benefits have been denied pending a hearing decision.

II. PROGRAM PURPOSE:

The Program entitled Medicaid is set up cooperatively between the Federal and State governments and administered by the West Virginia Department of Health & Human Resources. The 1965 Amendments to the Social Security Act established, under Title XIX, a Federal-State medical assistance program commonly known as Medicaid. The Department of Health and Human Resources administers the Medicaid Program in West Virginia in accordance with Federal Regulations. The Bureau for Medical Services is responsible for development of regulations to implement Federal and State requirements for the program. The Department of Health and Human Resources processes claims for reimbursements to providers participating in the program.

III. PARTICIPANTS:

1. [redacted]_____, Claimant's mother.
2. Barbara White, Program Manager, Bureau for Medical Services (by speaker phone).
3. Dr. Chris Taylor, Dental Consultant, Bureau for Medical Services (by speaker phone).
4. Evelyn Whidby, Appeals Coordinator, Bureau for Medical Services (observing only).
5. Cheryl McKinney, State Hearing Officer (observing only).

Presiding at the Hearing was Thomas M. Smith, State Hearing Officer and a member of the State Board of Review.

IV. QUESTIONS TO BE DECIDED:

The question to be decided is whether the Department took the correct action to deny Medicaid coverage for orthodontic services.

V. APPLICABLE POLICY:

Medicaid Regulations Chapter 500, Section 523 and 524.

VI. LISTING OF DOCUMENTARY EVIDENCE ADMITTED:

Department's Exhibits:

A Copy of request for prior authorization for Comprehensive Orthodontic Treatment 7-18-06 (2 pages).
B Copy of notice of initial denial-dental review 7-31-06 and reconsideration (11 pages).
C Copy of Medicaid Chapter 500, Section 523 & 524 (2 pages).

Claimant's Exhibits:
None.

VII. FINDINGS OF FACT:

1) A request for authorization for Medicaid coverage for orthodontic services for [redacted]_____ dated 7-18-06 was received by the Bureau for Medical Services on 7-26-06 (Exhibit #A).

2) The request for Medicaid coverage for orthodontic services was denied on 7-26-06 based on not meeting the criteria for medical necessity with notification sent to Dr. [redacted] and the claimant on 7-31-06 (Exhibit #B).

3) A request for reconsideration was received and was again denied with notification issued on 9-7-06 (Exhibit #B).

4) A hearing request was received by Client Services on 10-4-06, by the Bureau for Medical Services on 10-23-06, by the Board of Review on 10-5-06, and by the State Hearing Officer on 10-10-06.

5) Ms. White testified about the regulations in Medicaid Chapter 500, Section 524. (Exhibit #C)

6) Testimony from Dr. Taylor purported that he reviewed the x-rays, photographs and model of teeth along with the request for prior authorization, that there was no crossbite or openbite, that the class I molar relationship was ideal, that the crowding was 1-2 milimeters, that he agreed with the diagnosis but that the malocclusion was not severe enough to meet medical necessity criteria.

7) Testimony from the claimant purported that the claimant's twin sister was approved for braces under Medicaid and she did not understand why the claimant was denied, but that the twin sister [redacted] had an overbite that was worse than the claimant's.

8) Medicaid Regulations from Medicaid Chapter 500, Section 524 state, in part:

"PRIOR AUTHORIZATION – ORTHODONTIC SERVICES

Orthodontic services are covered on a limited basis for Medicaid members less than 21 years of age, whose malocclusion creates a disability and impairs their physical development. Medicaid coverage for orthodontic services is provided based on medical necessity. However, because a member meets criteria submitted for consideration, does not mean that coverage is automatic. All requests for treatment are subject to prior approval review by the Bureau's contracting agency. Treatment is routinely accomplished through fixed appliance therapy and maintenance visits.

NOTE: Orthognathic surgical procedures associated with orthodontic treatment will be covered even if the member exceeds 21 years of age if the needed surgery is documented in the original request and is requested before the member comes 21 years of age.

Medically necessary orthodontic coverage is limited to services for dento-facial anomalies. This excludes impacted teeth, crowding, and cross bites. The following situations, with supporting documentation, will be considered for coverage:

- Member with syndromes or craniofacial anomalies such as cleft palate, Alperst Syndrome or craniofacial dysplasia.

- Severe malocclusion associated with dento-facial deformity. (e.g., a patient with a full cusp Class II malocclusion with a demonstrable impinging overbite into the palate).

Attachment 2 contains the form to request prior authorization for orthodontic services. This form is different from the authorization form for general dentistry. Supporting documentation must be submitted with the treatment request. Failure to submit any of the following information will result in a denial of the request for prior approval of orthodontic services:

- Panoramic Film

- Cephalometric Tracing

- Cephalometric X-ray
- Photographs – Intra and Extra Oral
- Treatment Plan, including findings, diagnosis, prognosis, length of treatment, and phases of treatment.
- Upper and lower study casts trimmed to the correct occlusion. Failure to trim study casts to correct occlusion will delay decision.

The completed form and any supporting documentation must be sent to the BMS contracted agency.

Comprehensive orthodontic treatment is reimbursable only once in the members lifetime. If treatment is discontinued or the patient transfers before completion of orthodontics, payment for the uncompleted portion must be returned to BMS. A provider who accepts a transfer patient must complete a prior authorization request for continuing the previously initiated orthodontic treatment, and submit it to the BMS contracted agency.

If an eligible member under 21 years of age moves to WV from another State while undergoing active orthodontic treatment, a WV provider may request prior authorization to provide the balance of the treatment.

WV Medicaid does not cover orthodontic services for cosmetic purposes."

VIII. CONCLUSIONS OF LAW:

(1) Regulations from Medicaid Chapter 500 Section 524 clearly state that Medicaid coverage is provided based on medical necessity and that medical necessity involving malocclusion is defined as severe malocclusion associated with dento-facial deformity.

(2) The documentation shows that the claimant's malocclusion is not severe and does not meet the criteria for medical necessity.

(3) The only other conditions which merit medical necessity consideration are syndromes or craniofacial anomalies such as cleft palate, Alperst Synrdome or craniofacial dysplasia and the documentation does not show that the claimant has any of those conditions.

IX. DECISION:

It is the decision of the State Hearing Officer that the Department took the correct action to deny Medicaid coverage for orthodontic services.

X. RIGHT OF APPEAL:

See Attachment

XI. ATTACHMENTS:

The Claimant's Recourse to Hearing Decision

Form IG-BR-29

ENTERED this 4th Day of December, 2006.

_____

Thomas M. Smith
State Hearing Officer