State of West Virginia
DEPARTMENT OF HEALTH AND HUMAN RESOURCES
Office of Inspector General
Board of Review
P.O. Box 1736
Romney, WV 26757

Earl Ray Tomblin
Governor

Rocco S. Fucillo
Cabinet Secretary

July 31, 2012

Dear ------:

Attached is a copy of the Findings of Fact and Conclusions of Law on your daughter's hearing held July 27, 2012. Your hearing request was based on the Department of Health and Human Resources' action to deny your daughter's prior authorization for Medicaid payment of orthodontic services.

In arriving at a decision, the State Hearing 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 orthodontic services under the Medicaid program is based on current policy and regulations. Some of these regulations state that medical necessity review criteria may be based on adaptations of dental standards developed by the Periodicity and Anticipatory Guidance Recommendations by the American Academy of Pediatric Dentistry (AAPD), the American Academy of Pediatrics (AAP), the American Dental Association (ADA), and research-based nationally accredited medical appropriateness criteria, such as InterQual, or other appropriate criteria approved by Bureau of Medical Services (BMS). A request for prior authorization is reviewed by the Utilization Management Contractor (UMC). It is the responsibility of the treating/prescribing practitioner to submit the appropriate Prior Authorization Request Form with medical documentation to the UMC. When a request for service is denied based on medical necessity, the denial is communicated with the reason(s) of denial to the provider of service and the member or their legal guardian by the UMC. (Bureau for Medical Services Provider Manual, Chapter 505, §505.8)

The information which was submitted at your daughter's hearing failed to demonstrate that orthodontic services are medically necessary.

It is the decision of the State Hearing Officer to uphold the action of the Department in denying your daughter's request for prior authorization of Medicaid payment for orthodontic services.

Sincerely,

Eric L. Phillips
State Hearing Officer
Member, State Board of Review

cc: Erika Young-Chairman, Board of Review
Stacy Broce-Bureau of Medical Services

WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES
BOARD OF REVIEW

IN RE: ------,

Claimant,

v. **ACTION NO.: 12-BOR-1296**

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 for ------. This hearing was held in accordance with the provisions found in Chapter 700 of the West Virginia Department of Health and Human Resources' Common Chapters Manual. This fair hearing was convened on July 27, 2012 on a timely appeal, filed April 13, 2012.

II. PROGRAM PURPOSE:

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:

------, Claimant's father
Virginia Evans, DHHR Specialist-Bureau of Medical Services (BMS)
Christopher Taylor, D.D.S-Orthodontic Consultant-BMS

Presiding at the hearing was Eric L. Phillips, State Hearing Officer and a member of the Board of Review.

IV. QUESTION TO BE DECIDED:

The question to be decided is whether or not the Department was correct in its decision to deny the Claimant's prior authorization request for Medicaid payment of orthodontic services.

V. APPLICABLE POLICY:

WV Medicaid Provider Manual, Chapter 505 (Covered Services, Limitations and Exclusions for Dental, Orthodontic and Oral Health Services), Section 505.8 (Prior Authorization)

VI. LISTING OF DOCUMENTARY EVIDENCE ADMITTED:

Department's Exhibits:

D-1 Request for Prior Authorization for Comprehensive Orthodontic Treatment from ------, D.M.D dated March 20, 2012
D-2 Notice of Denial for Dental Services dated March 23, 2012
D-3 WV Medicaid Provider Manual, Chapter 505 (Covered Services, Limitations and Exclusions for Dental, Orthodontic and Oral Health Services), Section 505.8 (Prior Authorization)

VII. FINDINGS OF FACT:

1) On March 20, 2012, ------, D.M.D. (Provider), submitted a Request for Prior Authorization for Comprehensive Orthodontic Treatment (Exhibit D-1) on behalf of the Claimant to the West Virginia Medical Institute (WVMI). The purpose of this request was to determine medical necessity for prior authorization of Medicaid payment of orthodontic services for the Claimant.

2) On March 23, 2012, WVMI issued the Claimant and the Provider a Notice of Denial for Dental Services (Exhibit D-2) which indicated that the request for prior authorization for Medicaid payment of orthodontic services was denied because the documentation provided (Exhibit D-1) did not indicate medical necessity. Specifically, this exhibit documents that "Patient's malocclusions does not meet any of the criteria for treatment to be covered by BMS." It shall be noted that the Provider's Notice of Denial for Dental Services documents that a written reconsideration of the denial could be submitted within 60 days of receipt of the corresponding notice.

3) Christopher Taylor, D.D.S., Orthodontic Consultant for BMS, reviewed the prior authorization request (Exhibit D-1) and explained how the medical findings relate to established policy. Provider documented the Claimant's complete diagnosis in the request as Convex profile, Skeletal Class I malocclusion, Dental Class II Malocclusion [Rt.], overjet of 3-4mm, 3rd molars forming, 75% deep bite (tissue impingement), history of Bruxism, good hygiene, maxillary 4-6mm crowding, mandibular spacing, and impacted maxillary canine. According to Dr. Taylor,

in order for prior authorization for Medicaid payment to be approved, the individual must meet one of the ten established criteria which include:

1) Overjet in excess of 7mm
2) Severe malocclusion associated with dento-facial deformity
3) True anterior open bite
4) Full cusp classification from normal (Class II or Class III)
5) Palatal impingement of lower incisors into the palatal tissue causing tissue trauma
6) Cleft palate, congenital or developmental disorder
7) Anterior crossbite (2 or more teeth and in cases where gingival stripping from the cross bite is demonstrated and not correctable by limited orthodontic treatment)
8) Unilateral posterior crossbite with deviation or bilateral posterior crossbite involving multiple teeth including at least one molar
9) True posterior open bite (Not involving partially erupted teeth or one or two teeth slightly out of occlusion and not correctable by habit therapy
10) Impacted teeth (excluding 3rd molars) cuspids and laterals only

Dr. Taylor testified that the information supplied by the Provider failed to meet the established criteria set forth by BMS. Specifically, the Claimant's diagnosis of a Dental Class II Malocclusion [Rt.] is not a full cusp classification from normal, the overjet of 3-4mm does not exceed 7mm and the diagnoses of crowding and spacing are not considered when determining prior authorization. Dr. Taylor reviewed the Claimant's diagnosis of a 75% deep bite tissue impingement against dental models supplied by the Provider and opined that the upper and lower jaws overlap, but there was no evidence of tissue impingement to the roof of the mouth. Additionally, Dr. Taylor reviewed models and x-rays concerning the diagnosis of an impacted right maxillary canine tooth. At the time of the prior authorization request, the Claimant was eleven years-of-age. Dr. Taylor stated that by medical definition, the canine tooth should erupt between ages eleven and thirteen, but could be delayed until age 15. Dr. Taylor testified that upon review of the Claimant's x-rays, it was determined that the canine tooth is still developing and has the potential to erupt and move into position; therefore, the Claimant could avoid an unnecessary oral surgery. Dr. Taylor indicated that the Claimant did not meet the criteria for an impacted tooth due to her age, but opined that if the tooth has not erupted at twelve years-of-age, further assessment can be completed under the impacted tooth criteria.

4) The Claimant's father indicated that the canine tooth in question has yet to erupt. Testimony indicated that his daughter is afraid to smile and that his daughter is in need of the requested procedure for cosmetic purposes.

5) WV Medicaid Provider Manual, Chapter 505 (Covered Services, Limitations and Exclusions for Dental, Orthodontic and Oral Health Services), Section 505.8 (Prior Authorization) documents in pertinent part:

> Medical necessity review criteria may be based on adaptations of dental standards developed by the Periodicity and Anticipatory Guidance Recommendations by the American Academy of Pediatric Dentistry (AAPD), the American Academy of Pediatrics (AAP), the American Dental Association (ADA), and researched-based, nationally accredited medical appropriateness criteria, such as InterQual, OR other appropriate criteria approved by BMS.
>
> The Utilization Management Contractor (UMC) reviews all request for services requiring prior authorization. It is the responsibility of the treating/prescribing practitioner to submit the appropriate Prior Authorization Request Form with medical documentation to the UMC.
>
> When a request for service is denied based on medical necessity, the denial is communicated with the reason(s) of denial to the provider of services and the member or their legal guardian by the UMC.

VIII. CONCLUSIONS OF LAW:

1) Policy stipulates that prior authorization is reviewed by the Utilization Management Contractor (UMC) and it is the responsibility of the treating/prescribing practitioner to submit the appropriate Prior Authorization Request Form with medical documentation to the UMC. When a request for service is denied based on medical necessity, the denial is communicated with the reason(s) of denial to the provider of service and the member or their legal guardian by the UMC.

2) Testimony and evidence presented during the hearing reveals that the Claimant's condition at the time of the request for prior authorization failed to demonstrate medical necessity for orthodontic services. Therefore, the Department was correct in its decision to deny the Claimant's prior authorization request for Medicaid payment of orthodontic services.

IX. DECISION:

It is the decision of the State Hearing Officer to uphold the action of the Department to deny the Claimant's prior authorization request for Medicaid payment of orthodontic services.

X. RIGHT OF APPEAL:

See Attachment

XI. ATTACHMENTS:

The Claimant's Recourse to Hearing Decision

Form IG-BR-29

ENTERED this _____ day of July 2012.

_____

Eric L. Phillips
State Hearing Officer