Rhode Island Executive Office of Health and Human Services
Appeals Office, 57 Howard Ave., LP Building, 2nd floor, Cranston, RI 02920
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August 27, 2015

Docket #15-793
Hearing Date: May 26, 2015

[redacted]

ADMINISTRATIVE HEARING DECISION

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

EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES (EOHHS)
MEDICAID PROVIDER MANUAL: Dental

The facts of your case, the Agency rules and regulations, and the complete administrative decision made 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 in c/o your mother), and Agency representatives Jack Demus and Robin Etchingham.

Present at the hearing were: Your mother, a Spanish Interpreter, and Agency representative Jack Demus.

ISSUE: Does the appellant child qualify for Medicaid covered comprehensive orthodontic services?

Rules, Regulations, and Guidelines:
Please see the attached APPENDIX for pertinent excerpts from the Rhode Island Executive Office of Health and Human Services (EOHHS) Medicaid Dental Provider Manual

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

DISCUSSION OF THE EVIDENCE:

The Agency representative testified:

- The February 27, 2015 notice addressed to the appellant child's orthodontist, Daniel M. Eves, DMD, denies service code D8081, which is comprehensive orthodontic treatment, otherwise known as braces.
- On April 21, 2015, the State's orthodontic consultant, Dr. McMillan, reviewed a prior authorization request for orthodontic services submitted by the child's orthodontist, Dr. Eves.
- The State's orthodontist used what is called a HLD scoring index, which is used to measure the severity of the condition of the child's teeth.
- For orthodontic treatment to be approved, the child's condition must be considered severe and handicapping.
- A HLD score of 20 or more is needed to qualify for treatment.
- The State's orthodontist uses a photo submitted by the child's orthodontist to determine the HLD score.
- Part A of the HLD index lists severe conditions. If any of the conditions were found to exist, no further scoring would have been necessary and the child would have qualified for the requested service.
- The appellant child did not meet the criteria for any of the listed conditions in Part A.
- When a child does not qualify in Part A, then the Part B procedure is used. Part B is where scoring is done based on measurements.
- The appellant child scored a 3 for overjet, which is when the teeth flare forward.
- The appellant child scored a 1 for overbite, which is when the top teeth cover the bottom teeth.
- There was no score given for eruption of teeth.
- The child received a score of zero for anterior crowding.

- The child's total score in Part B was 4, which falls below the score of 20 that is needed to qualify for treatment.

The appellant child's mother testified:

- She appealed because her daughter sustained an injury to her mouth after she had been seen by the orthodontist.
- Her daughter fainted and fell on her face and her top front tooth moved.
- Her daughter's overbite is worse now and her bottom tooth keeps pushing on the top front tooth.
- She took her daughter to the hospital emergency room and to the dentist. The dentist took x-rays and the tooth is okay, but the dentist said the bottom tooth is going to bother the top tooth all the time now.
- When her daughter eats something hard it bothers her and she has to take pain medication.
- Her daughter has not been seen or re-examined by the orthodontist since the injury.

FINDINGS OF FACT:

- Daniel M. Eves, DMD, submitted a request for prior authorization for comprehensive orthodontic services for the appellant minor child.
- The Agency sent a notice to Dr. Eves dated February 27, 2015, to inform him that his request for prior authorization had been denied because the child failed to meet the HLD score.
- The Agency provided written notification of the prior authorization denial to the appellant child's mother. The date of the notification is unknown.
- The appellant child's mother filed a request for hearing, received by the Agency on April 7, 2015.
- An Administrative Hearing was convened on May 26, 2015.

- Per the appellant's request at hearing, the record of hearing was held open for four weeks, through the close of business on June 23, 2015, for the submission of additional evidence.

- Per the appellant's post hearing request, the record of hearing was held open an additional four weeks, through the close of business on July 21, 2015. The appellant agreed to allow the Agency three weeks, through the close of business on August 11, 2015, to review any additional evidence submitted to determine if it changed their decision.

- During the held open period, additional evidence was received on behalf of the appellant child from Tollgate Orthodontics and Rhode Island Hospital.

- On July 29, 2015, the Agency informed the Appeals Officer that the additional evidence had been reviewed by the OHHS Orthodontic Consultants and the Agency's decision to deny the appellant child's orthodontic treatment under Medicaid remained.

- On July 30, 2015, the Appeals Officer notified the appellant in writing that the Agency's decision remained unchanged and that an Administrative Hearing Decision would be forthcoming.

- To qualify for Medicaid covered comprehensive orthodontic services, the requested service must be medically necessary and required to correct a handicapping malocclusion.

- A HLD (Handicapping Labiolingual Deviation) score of 20 or more demonstrates medical necessity.

- The appellant has a HLD score less than 20.

CONCLUSION:

The issue to be decided is whether the appellant child qualifies for Medicaid covered comprehensive orthodontic services.

The Agency's Medicaid Provider Manual for Dental Services stipulates that Medicaid payments will be provided only for covered dental services that the Agency's Medicaid Program, as the final arbiter, determines to be medically necessary. The Provider Dental Manual further stipulates that orthodontic services are limited to medically necessary services that are needed to correct a handicapping malocclusion in individuals under the

age of 21. A handicapping malocclusion is defined as an occlusion having an adverse effect on the quality of the individual's life, including such things as speech, function, and/or esthetics that could have sociocultural consequences. A HLD (Handicapping Labiolingual Deviation) index is used to determine the degree of malocclusion to determine if and to what extent it is handicapping and whether orthodontic services are medically necessary.

The record establishes that the Agency received and denied a request for prior authorization from Daniel M. Eves, DMD for comprehensive orthodontic services for the appellant child. The Agency testifies that for orthodontic treatment to be approved, the appellant child's condition must be severe and handicapping as represented by the existence of certain conditions or a HLD (Handicapping Labiolingual Deviation) score of at least 20. The Agency submits a HLD Index–Orthodontic Diagnostic Score Sheet, completed and signed by the Agency's reviewing orthodontist, Dr. McMillan, and testifies that Dr. McMillan measured and scored the child's condition based on photos submitted by the child's orthodontist. According to the HLD Score Sheet, Dr. McMillan concluded that the appellant child had none of the conditions listed in Part A that would have automatically met the medically necessary standard. In Part B the child was given a score of 3 for Overjet, 1 for Overbite, a 0 for anterior crowding, and no score for ectopic eruptions, for a total HLD score of 4.

The appellant child's mother does not dispute the HLD score of 4 that was based on Dr. Eves initial submission of nine photos along with his request for prior authorization. The appellant child's mother testifies that the child sustained an injury soon after being examined by Dr. Eves, but before the Agency's denied Dr. Eves prior authorization request. She argues that the condition of the child's teeth, specifically her overbite, worsened due to the injury and the child should now meet the criteria for approval of braces. The appellant child's mother explains that her daughter fainted and fell forward on her face causing one of her top front teeth to move and now the child's bottom tooth pushes on the top tooth. She further testifies that when her daughter eats something hard, her tooth bothers her and she has to take pain medication. Upon questioning, she testifies that at the time of injury her daughter was examined at a hospital emergency room and then by her dentist, who took x-rays. The appellant's mother testifies that the x-rays showed that the tooth is healthy, but the child's dentist advised that braces were needed or the bottom tooth is going to bother the top tooth all the time now.

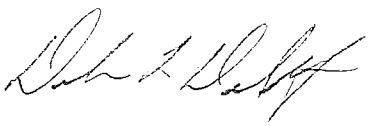
Additional evidence was submitted on behalf of the appellant child post-hearing. The Agency's consulting orthodontists reviewed all of the additional evidence submitted and concluded that the appellant child still did not meet the criteria for Medicaid covered orthodontic treatment. A review of the evidence submitted post hearing finds Rhode Island Hospital (RIH) records pertaining to a February 28, 2015 emergency room (ER) visit subsequent to a fainting episode that caused the appellant child to fall and hit her head and face. The records indicate that there was a question of a minimally loose tooth,

though there is no clear evidence of an examination of the tooth and the record fails to clearly indicate whether it was the child or the examining hospital staff that was questioning the looseness of the tooth. Follow-up with the child's dentist was advised. No records from the child's dentist were submitted into the record. The appellant child's orthodontist, Dr. Eves, submitted a letter along with one photo post-hearing. In his letter, Dr. Eves indicates that his resubmission is at the request of the appellant and is based on the appellant's report to him that she fell and suffered trauma to tooth #8 and her hopes that she will now get approved for orthodontic treatment. While Dr. Eves describes tooth #8 as being high in occlusion, he fails to provide a clear medical opinion and/or explanation as to the extent of change since his initial examination, and a review of the photo submitted shows only a minimal difference from the initial photos he submitted.

In summary, the appellant child had an initial undisputed Part B HLD score of 4. The evidence record fails to establish that a subsequent injury resulted in any of the qualifying conditions listed in Part A of the HLD scoring index or resulted in an increase in the appellant child's overbite score to increase her overall HLD score to 20 or more.

In conclusion, orthodontic services must be medically necessary and required to correct a handicapping malocclusion established by the existence of a specific medical condition or by a HLD score of at least 20. As the evidence record fails to establish that the appellant child has a malocclusion or condition that is so severe as to be considered handicapping, the requested orthodontic services are thereby not medically necessary.

After a careful review of the Agency's rules and regulations, as well as the testimony and evidence submitted, this Appeals Officer finds that the appellant child does not qualify for Medicaid covered comprehensive orthodontic services. The appellant's request for relief is thereby denied.



Debra L. DeStefano
Appeals Officer

APPENDIX

MEDICAID Provider Manual: Dental

DENTAL SERVICES COVERAGE POLICY

Introduction
Dental services are a benefit to eligible recipients under the Rhode Island Medical Assistance Dental Services Program.

General Policy Requirements
The Medical Assistance Program will only reimburse providers for medically necessary services. The Medical Assistance Program conducts both pre-payment and post-payment reviews of services rendered to recipients. Determinations of medical necessity are made by the staff of the Medical Assistance Program, trained medical consultants, and independent State and private agencies under contract with the Medical Assistance Program. Services that are denied by Medicare because they are not medically necessary are not reimbursable by the Medical Assistance Program.
Providers must bill the Medical Assistance Program at the same usual and customary rates as charged to the self-pay general public. Rates discounted to specific groups (such as Senior Citizens) must be billed at the same discounted rate to Medical Assistance. Payments to providers will not exceed the maximum reimbursement rate of the Medical Assistance Program.

Purpose of Coverage Policy
The purpose of this policy is to establish the rules of payment for services provided to individuals determined to be eligible for medical assistance under the Medical Assistance Program. The General Rules for the Medical Assistance Program and the rules in this policy are to be used together to determine eligibility for services.

Recipient Eligibility
The Medical Assistance Program provides coverage for necessary medical services to recipients who are in two basic benefit levels: Categorically Needy and Medically Needy. The scope of services aries according to the benefit level.
Refer to Section 100-40 in the Provider Reference Manual for further information.

Scope of Services
The Medical Assistance Program provides payment only for services that are included in the scope of services described in the DHS Manual at Section 033.20, Section 0348 for the RIte Care Program, or under a waiver program at Section 0398; or for recipients under the age of 21 pursuant to the Early Periodic Screening, Diagnosis and Treatment (EPSDT) program, for additional services that are not included in the above sections, and that are definable under Section 1905(a) of the federal Social Security Act. Specific details of services covered and limitations thereon are contained in the Medical Assistance Program Provider Reference Manuals, the Rhode Island Title XIX State Plan, Section 1115 and Section 1915 Waiver requests, and the RIte Care Program Managed Care Plan and Contracts. Payment is not made for services other than those described herein.

Medical Necessity
The Medical Assistance 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 Medical Assistance Program are subject to appeal by the recipient only. Providers may not appeal denials of Medical Necessity.
Procedures are available for individuals who are aggrieved because of an agency decision or delay in making a decision of medical necessity. The route of appeal for Title XIX recipients is through the Department of Human Services. RIte Care participants may first appeal through the managed care plan, or may appeal directly through the Department of Human Services.
(Appeals rights and procedures are contained in DHS Manual Sections 0110 and 0348.)
Medical Assistance payments are provided only for covered services that are determined to be medically necessary. No Medical Assistance payment will be made for a medical procedure of an investigative or experimental nature.

Determinations of Medical Necessity
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 Department of Human Services. Policies relative to medical necessity are set forth in the DHS Manual, the Medical Assistance Program Provider Reference Manuals, and the Rhode Island State Plan under Title XIX of the federal Social Security Act. Medical necessity can be determined on procedure-by-procedure basis.

Approval of Medical Necessity
The Medical Assistance Program and its designees determine which services are medically necessary on a case-by-case basis, both in pre-payment and post-payment reviews, and via prior authorizations. Such determinations are the judgment of the Medical Assistance Program. The prescription or recommendation of a physician or other service provider of medical services is required for a determination of medical necessity to be made, but such prescription or recommendation does not mean that the Medical Assistance Program will determine the provider's recommendation to be medically necessary. The Medical Assistance Program is the final arbiter of determination of medical necessity.

ORTHODONTIC SERVICES

Orthodontics is medically necessary services needed to correct handicapping malocclusion in recipients under age 21. The HDL (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.

COMPREHENSIVE ORTHODONTIC TREATMENT

The coordinated diagnosis and treatment leading to the improvement of a patient's dentofacial deformity or dentoalveolar skeletal discrepancies including anatomical, functional and esthetic relationships. Treatment usually, but not necessarily, utilizes fixed orthodontic appliances. Adjunctive procedures, such as extractions, maxillofacial surgery, nasopharyngeal surgery, myofunctional or speech therapy and restorative or periodontal care may be coordinated disciplines. Optimal care requires long-term consideration of patients' needs and periodic re-evaluation. Treatment may incorporate several phases with specific objectives at various stages of dentofacial development. Orthodontic treatment involves the placement of bands or bonded brackets for at least a two-year period during which time appropriate adjustments are made to achieve a proper occlusion for the patient. Comprehensive treatment ends when the entire adult dentition (except third molars) has been placed in proper occlusion.

Certain appliances, such as a lingual arch, tooth positioner, head gear therapy or Hawley appliance, may be required in conjunction with a full course of orthodontic treatment. In other instances, these appliances may be utilized alone and preclude the necessity for a full course of orthodontic treatment.

When billing for comprehensive orthodontic treatment services, the following codes will be used, as appropriate:

Units	Transitional	Adolescent	Adult	Age Restriction	P Requi
Procedure code: 1	D8070	D8080	D8090	<21	
	Procedure codes - 1st 6 months				
1-6	D8071	D8081	D8091	<23*	
	Procedure codes - 2nd 6 months				
1-6	D8072	D8082	D8092	<23*	
	Procedure codes - 3rd 6 months				
1-6	D8073	D8083	D8093	<23*	
	Procedure codes - 4th 6 months				
1-6	D8074	D8084	D8094	<23*	

**applies only if recipients >20 meet all of the following conditions:*

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.

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.