Office of Medicaid
BOARD OF HEARINGS

Appellant Name and Address:

[redacted]

Appeal Decision:	Denied	**Appeal Number:**	2112449
Decision Date:	9/17/2021	**Hearing Date:**	06/09/2021
Hearing Officer:	Christopher Jones	**Record Open to:**	07/27/2021

Appearance for Appellant:
[redacted]

Appearance for MassHealth:
Dr. Harold Kaplan

The Commonwealth of Massachusetts
Executive Office of Health and Human Services
Office of Medicaid
Board of Hearings
100 Hancock Street, Quincy, Massachusetts 02171

APPEAL DECISION

Appeal Decision:	Denied	**Issue:**	Prior Authorization – Orthodontia
Decision Date:	9/17/2021	**Hearing Date:**	06/09/2021
MassHealth's Rep.:	Dr. Harold Kaplan	**Appellant's Rep.:**	[redacted]
Hearing Location:	Quincy Harbor South Tower		

Authority

This hearing was conducted pursuant to Massachusetts General Laws Chapter 118E, Chapter 30A, and the rules and regulations promulgated thereunder.

Jurisdiction

Through a notice dated February 22, 2021, MassHealth denied the appellant's prior authorization request for comprehensive orthodontia. Exhibit 2. The appellant filed this timely appeal on March 31, 2021. Exhibit 2; 130 CMR 610.015(B). Denial of assistance is valid grounds for appeal. 130 CMR 610.032. Following the hearing, the record was left open until July 27, 2021 for the appellant to supplement the hearing record.

Action Taken by MassHealth

MassHealth denied the appellant's request for comprehensive orthodontia because the appellant has less than 22 points on the Handicapping Labio-lingual Deviations Scale.

Issue

The appeal issue is whether MassHealth was correct, pursuant to 130 CMR 420.431, in determining that that comprehensive orthodontia was not medically necessary for the appellant.

Summary of Evidence

HLD Score

On or around February 18, 2021, the appellant's provider, Dr. Rizkallah, submitted a prior authorization request on the appellant's behalf seeking MassHealth coverage for comprehensive orthodontic treatment. Along with photographs and x-rays, Dr. Rizkallah submitted a Handicapping Labio-Lingual Deviations ("HLD") Form, with a total score of 31 points.[1] Though the HLD Form indicates that no medical necessity narrative is attached, Dr. Rizkallah attached a document of his own devising labeled "Medical Necessity Narrative Form." Dr. Rizkallah's HLD score was comprised of:

- Six points for six mm of overjet;
- Nine points for nine mm of overbite;
- Seven points for seven mm of labio-lingual spread; and
- Nine points for three posterior impactions or congenitally missing posterior teeth.

DentaQuest, MassHealth's dental review contractor, reviewed the submitted images and determined the appellant's HLD score to be 16 points, based upon three mm of overjet, seven mm of overbite, and five mm of labio-lingual spread. No points were allowed for missing or impacted posterior teeth. Dr. Kaplan explained that MassHealth developed the HLD scale system to ensure that the agency can continue to afford to provide orthodontic treatment to those in the Commonwealth who need it the most. He explained that these limitations include only allowing orthodontia for children and requiring an HLD score of 22 or above or the existence of one of seven automatic qualifying characteristics. Dr. Kaplan testified that there are many people who need orthodontia, according to the standards of care for orthodontia, who do not qualify for MassHealth to cover their orthodontia.

Dr. Kaplan made his own measurements based upon the submitted images and arrived at an HLD score of 17 points. He agreed with MassHealth's measurements regarding overbite and overjet. He explained that he measures these dimensions on a photograph is based upon his knowledge of the size of children's teeth and then comparing the relevant measurement to the size of the tooth. He testified that three mm for overjet is generous based upon the photographs submitted, and that if the appellant had a nine mm overbite, you would not be able to see any of the appellant's lower teeth. The bottoms of the lower front teeth are visible in the submitted photographs. Dr. Kaplan agreed with Dr. Rizkallah's score of seven for labio-lingual spread. Dr. Rizkallah did not go into detail as to why Dr. Kaplan's measurements for overjet or overbite were wrong, rather he focused on the three impacted teeth he had identified.

Dr. Rizkallah identified three second molars as being impacted, one on the top right and both bottom ones. Dr. Kaplan saw no impacted teeth. Dr. Kaplan agreed that these teeth typically erupt

[1] The prior authorization request was submitted in February 2021, but the x-rays and photographs are dated June 2020.

at age 12, but he argued that each child is different and by looking at the overall development of the child's teeth you can determine the "dental age" of the child. He noted that one of the appellant's second bicuspids had not come in yet, and the roots had not fully formed on the lower molars. There was also nothing that was causing an apparent blockage. Based on this, he argued that the appellant's "dental age" is still below 12. He agreed that the upper molar is possibly impacted, but he felt that this could be easily confirmed with updated images to see if the tooth has moved. Dr. Kaplan testified that there was no harm in waiting for six months to see if there was any movement.[2] Dr. Kaplan's professional opinion, based upon his experience and the evidence available to him in the record, was that the teeth were not impacted. However, he refused to put a specific percentage to his degree of certainty.

Dr. Rizkallah argued that the appellant was already about a year behind and the top molar was about a centimeter away from erupting, with fully formed roots. He argued that in orthodontia, nothing gets measured in centimeters, therefore this tooth must be considered impacted. Because the regulatory definition of "medical necessity" looks to treatments that are "reasonably calculated" to treat a condition, he argued that a percentage of certainty needs to be in the record in order for a factual finding to be made on the matter. Dr. Rizkallah felt that "reasonably sure" should be a 51% degree of certainty, or more likely than not. However, he testified that he was 80% sure that the appellant's three molars would not erupt in the next three years, and he was reasonably sure the appellant's molars would not erupt by the time he was 18 years old. He could not be reasonably certain, however, that the teeth would never erupt on their own.

Dr. Rizkallah argued that he calculates his degree of certainty based upon his professional experience treating children with unerupted molars. In his experience, children with unerupted molars have "tongue habits" of rubbing the gum line with their tongue, which causes the gum surface to toughen. In the regular course of his practice, he often surgically exposes teeth by cutting through the gum tissue, and he likened that toughened gum tissue to leather. Dr. Rizkallah testified that waiting to expose teeth can damage the adjacent teeth. However, in expounding upon this explanation, the basis for his urgency in treating the appellant was that delaying treatment would foreclose the patient's ability to have orthodontia paid for by MassHealth if the patient aged out of EPSDT eligibility.[3]

Dr. Kaplan argued that Dr. Rizkallah's "calculated" percentage of certainty is merely an assumption based upon anecdotal evidence. Dr. Rizkallah agreed that this is anecdotal experience but argued Dr. Kaplan's refusal to express his opinion in a percentage discredited his testimony. Dr. Kaplan agreed that he would treat the appellant now as a private patient, but MassHealth requires certainty that a tooth is impacted to score it on the HLD Scale. Based on the singular x-ray and photographs,

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[2] This hearing took place over a year after the images of the appellant's teeth were made. Neither party referenced this fact during the hearing.

[3] Dr. Rizkallah initially testified that, because EPSDT services are mandated by federal law, MassHealth cannot get federal money without covering EDSDT services. When asked why he believed the appellant was EPSDT eligible, he testified that all patients for whom he seeks orthodontia through MassHealth are eligible for MassHealth Standard coverage. After a brief discussion, he clarified that he was unaware of what the different MassHealth eligibility categories were, and he could not testify with certainty as to the eligibility coverage of each member.

he felt there was insufficient information for a reviewer to determine that these teeth are impacted. He argued that a new set of x-rays and photographs after six months to a year would allow verification that the teeth had not moved, which would support the argument that the teeth are impacted. In his opinion, the appellant would not be harmed in waiting a year for treatment. After a back and forth, Dr. Kaplan clarified that he meant "reasonably sure," when determining the degree of certainty that the tooth was impacted to qualify for scoring. While he was unwilling to put a specific percentage on his sureness, he testified that there is simply not enough information in a singular set of images to determine whether these teeth are moving or if they are impacted.

He testified that a second set of x-rays after six months to a year would allow him to be reasonably sure one way or the other. Dr. Rizkallah argued that Dr. Kaplan's opinion—that he was reasonably sure these teeth were not impacted—was evidentiarily insufficient to establish the fact that the teeth are not impacted because the opinion was not expressed as a specific percentage. He argued that the percentage is necessary to better understand what "reasonably" means. Dr. Kaplan responded that his opinion is similarly based upon his own clinical experience and the amount of information he was provided by the appellant to form his opinion.

Legal Arguments

Dr. Rizkallah submitted a 190-page exhibit packet. He reviewed certain disagreements he had with previous fair hearing decisions regarding coverage for orthodontia.[4] Citing 130 CMR 420.408, Dr. Rizkallah argued that MassHealth members who are eligible for Early and Periodic Screening, Diagnosis and Treatment ("EPSDT") Services need only show that their requested services are "medically necessary," and their request cannot be prevented by the other service restrictions detailed in 130 CMR 420.000. If the remainder of 130 CMR 420.000 is ignored, the only guidance for determining whether services are covered is the definition of "medical necessity" at 130 CMR 450.204. Dr. Rizkallah also highlighted that the HLD Form itself only requires the provider to certify that the requested services are "medically necessary" as defined by 130 CMR 450.204, and it does not reference any other regulation.

Dr. Rizkallah's argument is that EPSDT services are mandated by federal law for children, and EPSDT services include "dental" services. He acknowledged the federal law makes no mention of orthodontia and that the definition of dentistry that is required to be covered by EPSDT services was very general. However, he argued that this makes it inclusive. He argued further that by accepting federal funding for EPSDT services, Massachusetts opted into an "expanded" Medicaid benefits scheme, which requires Massachusetts to cover orthodontia. No specific legal citation was given for this assertion.

Medical Necessity

Dr. Rizkallah devised his own medical necessity "narrative," which was submitted as part of the appellant's prior authorization request. This narrative is designed as a flow chart that starts with the definition of "medical necessity" at 130 CMR 450.204 and checks off boxes for each criterion of

[4] His arguments are encapsulated in Appendix Q to his exhibit packet. This argument is reviewed more fully below.

the definition of medical necessity. For the appellant, Dr. Rizkallah checked boxes indicating that the requested treatment would "Prevent Worsening of a Condition" that would "Result in Infirmity (Physical or Mental)," and that no other medical service was available, suitable, have a comparable effect, or be less costly or more conservative. The form then finds "Spacing (gingival food-impaction)" and "Deep Impinging Overbite" as the harmful conditions and "Causes Gum & Bone Infirmity," "Causes Tooth Infirmity," "Causes TMJ Infirmity," and "Causes Emotional Infirmity" as the harmful effects.

Specifically, the appellant has upper tooth spacing that will not go away without orthodontia. In his exhibit, as Appendix F, Dr. Rizkallah included the largest longitudinal study ever done regarding orthodontia.[5] Published in 2018, it concluded that maxillary incisor spacing causes significant periodontal disease. The study was started in 1969 by the Department of Veteran's Affairs ("VA"), enrolling "1231 mostly white, medically healthy, community-dwelling male veterans" who received their medical and dental care through the private sector, rather than through the VA. The study reviewed a "retrospective sample of 400 maxillary and 408 mandibular plaster casts" of participants who had at least three triennial periodontal examinations between 1971 and 2009, had all their front teeth at the beginning of the study, and not undergone orthodontic treatment. The conclusion of the study was that there is "evidence that certain malalignment traits (maxillary incisor crowding, maxillary incisor spacing, mandibular incisor mild crowding, mandibular incisor moderate-to-severe crowding, mandibular incisor moderate irregularity, and mandibular incisor severe irregularity) are risk factors in periodontal disease progression." Therefore, Dr. Rizkallah argued that in the absence of this treatment, it is reasonably calculated that the appellant will develop significant periodontal disease.

Regarding the deep bite, he identified the appellant as having chipped upper front teeth because of having a deep bite. He also argued that the lower teeth are constricted in their ability to move forward and back, which will result in jaw disorders. He believed the appellant's bite is impinging because the child reported to him that his lower teeth hit his upper palate when he bites. He acknowledged that the images would not satisfy MassHealth's definition because they do not show damage done by the lower teeth, but he argued that children would stop themselves from biting that deeply because they do not want to be in pain. He testified that he has notes from his examination that document that the patient reported feeling his lower teeth hitting is upper palate, but these notes were not in evidence.

Dr. Kaplan agreed the patient has a deep overbite and that the images did not satisfy MassHealth's criteria.

Findings of Fact

Based on a preponderance of the evidence, I find the following:

[5] Alsulaiman A.A., Kaye E., Jones J., Cabral H., Leone C., Will L., Garcia R. "Incisor malalignment and the risk of periodontal disease progression." Am. J. Orthod. Dentofac. Orthop. 153:512–522 (Apr. 2018).

1. On or around February 18, 2021, Dr. Rizkallah submitted a prior authorization request on the appellant's behalf seeking MassHealth coverage for comprehensive orthodontic treatment. Included with this request were an HLD Form dated June 17, 2020, x-rays and photographs dated June 8, 2020, and a "Medical Necessity Narrative Form" dated November 23, 2020. Exhibit 3.

2. The appellant's HLD form scored 31 points based upon 6 mm of overjet, nine mm of overbite, seven mm of labio-lingual spread, and three posterior impactions. Exhibit 3, p. 9.

3. The initial review done by DentaQuest, based upon the submitted photographs and x-rays, found 16 points based upon three mm of overjet, seven mm of overbite, and six mm of labio-lingual spread. Exhibit 3, p. 15.

4. Dr. Kaplan generally agreed with the original review, based upon the submitted images, but found seven mm of labio-lingual spread, for a total of 17 points. He explained that his measurements are made by comparing the apparent space from the photographs to the size of the teeth in the photograph, combined with his knowledge of the size of teeth generally. Testimony by Dr. Kaplan.

5. The appellant's top second molar has fully formed roots and is about a centimeter away from erupting. The bottom second molars do not have fully formed roots, and the appellant has other permanent teeth that are still coming into his mouth. Testimony by Dr. Kaplan and Dr. Rizkallah.

6. The x-rays indicate that the appellant's teeth are coming in late in comparison to the appellant's chronological age, but they are not obviously blocked, and the lower teeth appear to still be forming. Testimony by Dr. Kaplan.

7. There would be no harm caused to the appellant in waiting six months to a year to determine whether any movement has occurred in the appellant's second molars that have yet to erupt. Testimony by Dr. Kaplan.

8. The second molars may cause damage to the adjacent teeth if left wholly untreated indefinitely. They are unlikely to erupt within a year from when the images were taken but will probably erupt eventually if left untreated. The urgency in treating the appellant arises from the risk that he may lose MassHealth eligibility. Testimony by Dr. Rizkallah.

9. The appellant's MassHealth benefit type is unknown. Testimony by Dr. Rizkallah.

10. Maxillary incisor spacing is a risk factor for periodontal disease progression if left untreated until the mid-50s. Exhibit 4, pp. 54-65.

Analysis and Conclusions of Law

Federal law requires that Medicaid agencies provide "early and periodic screening, diagnostic, and treatment services" to "all persons in the State who are under the age of 21 and who have been

determined to be eligible for medical assistance including services described in section 1396d(a)(4)(B) of this title … .” 42 USC § 1396a(a)(43). “Medical assistance” includes “early and periodic screening, diagnostic, and treatment services (as defined in subsection (r)) for individuals who are eligible under the plan and are under the age of 21 … .” 42 USC § 1396(a)(4)(B).

> The term “early and periodic screening, diagnostic, and treatment services” means the following items and services:
>
> …
>
> (3) Dental services—
>
> (A) which are provided—
>
> (i) at intervals which meet reasonable standards of dental practice, as determined by the State after consultation with recognized dental organizations involved in child health care, and
>
> (ii) at such other intervals, indicated as medically necessary, to determine the existence of a suspected illness or condition; and
>
> (B) which shall at a minimum include relief of pain and infections, restoration of teeth, and maintenance of dental health.

42 USC § 1396d(r), (3).[6]

MassHealth’s regulations limit eligibility for early and periodic screening, diagnostic, and treatment (“EPSDT”) services to “MassHealth Standard and MassHealth CommonHealth members younger than 21 years old … .” 130 CMR 450.140(A)(1). However, MassHealth’s dental benefits, as detailed at 130 CMR 420.000, are available for more coverage types than just CommonHealth and Standard members under the age of 21. See 130 CMR 450.105. In addition to the guidance set forth directly in the regulations, sub-regulatory guidance is provided in the MassHealth Dental Manual and the Office Reference Manual (“ORM”). See 130 CMR 420.410 (requiring prior authorization for services identified in the Dental Manual and in accordance with procedures laid out in the ORM).[7]

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[6] Federal regulation mirrors the statutory language:

> (c) *Diagnosis and treatment.* In addition to any diagnostic and treatment services included in the plan, the agency must provide to eligible EPSDT beneficiaries, the following services, the need for which is indicated by screening, even if the services are not included in the plan –
>
> (2) Dental care, at as early an age as necessary, needed for relief of pain and infections, restoration of teeth and maintenance of dental health; and …

42 CFR § 441.56.

[7] Federal law requires that state Medicaid agencies create such “procedures relating to the utilization of, and the payment for, care and services available under the plan … as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments are consistent with efficiency, economy, and quality of care … .” 42 USC § 1396a(30)(A).

Eligibility for Orthodontia under 130 CMR 420.000

MassHealth requires that members establish their eligibility for dental procedures, including orthodontia, in accordance with the MassHealth dental regulations, the Dental Manual, and the ORM. The regulatory language regarding orthodontia is:

> 420.431: Service Descriptions and Limitations: Orthodontic Services
>
> (A) General Conditions. The MassHealth agency pays for orthodontic treatment, subject to prior authorization, service descriptions and limitations as described in 130 CMR 420.431. The provider must seek prior authorization for orthodontic treatment and begin initial placement and insertion of orthodontic appliances and partial banding or full banding and brackets prior to the member's 21 birthday.
>
> …
>
> (C) Service Limitations and Requirements.
>
> …
>
> (3) Comprehensive Orthodontics. The MassHealth agency pays for comprehensive orthodontic treatment, subject to prior authorization, once per member per lifetime younger than 21 years old **and only when the member has a handicapping malocclusion**. The MassHealth agency determines whether a malocclusion is handicapping **based on clinical standards for medical necessity as described in Appendix D of the Dental Manual.** Upon the completion of orthodontic treatment, the provider must take post treatment photographic prints and maintain them in the member's dental record.

130 CMR 420.431 (emphasis **in bold**).

Appendix D of the Dental Manual sets forth three avenues for establishing that the member has a handicapping malocclusion.[8] First, the member could have one of seven "autoqualifiers," conditions so severe that they automatically qualify as handicapping. Second, objective measurements of various bite conditions are scored using the HLD Scale; if the member's score is 22 points or higher, they are found to have a handicap. Finally, the HLD Form provides instructions for submitting a "Medical Necessity Narrative and Supporting Documentation":

> Providers may establish that comprehensive orthodontic treatment is medically necessary by submitting a medical necessity narrative and supporting

[8] The Dental Manual and Appendix D are available on MassHealth's website, in the MassHealth Provider Library. (Available at https://www.mass.gov/lists/dental-manual-for-masshealth-providers, last visited August 16, 2021). Additional guidance is at the MassHealth Dental Program Office Reference Manual ("ORM"), available at: https://www masshealth-dental net/MassHealth/media/Docs/MassHealth-ORM.pdf (last visited August 16, 2021). The relevant HLD Form is also published through Transmittal Letter DEN-108, available at: https://www mass.gov/doc/den-108-revised-appendix-d-0/download (last visited August 16, 2021).

documentation, where applicable. The narrative must establish that comprehensive orthodontic treatment is medically necessary to treat a handicapping malocclusion, including to correct or significantly ameliorate

i. a severe deviation affecting the patient's mouth and/or underlying dentofacial structures;

ii. a diagnosed mental, emotional, or behavioral condition caused by the patient's malocclusion;

iii. a diagnosed nutritional deficiency and/or a substantiated inability to eat or chew caused by the patient's malocclusion;

iv. a diagnosed speech or language pathology caused by the patient's malocclusion; or

v. a condition in which the overall severity or impact of the patient's malocclusion is not otherwise apparent.

Providers may submit a medical necessity narrative (along with the required completed HLD) in any case where, in the professional judgment of the requesting provider and any other involved clinician(s), comprehensive orthodontic treatment is medically necessary to treat a handicapping malocclusion. Providers must submit this narrative in cases where the patient does not have an autoqualifying condition or meet the threshold score on the HLD, but where, in the professional judgment of the requesting provider and any other involved clinician(s), comprehensive orthodontic treatment is medically necessary to treat a handicapping malocclusion.

The medical necessity narrative must clearly demonstrate why comprehensive orthodontic treatment is medically necessary for the patient. If any part of the requesting provider's justification of medical necessity involves a mental, emotional, or behavioral condition; a nutritional deficiency; a speech or language pathology; or the presence of any other condition that would typically require the diagnosis, opinion, or expertise of a licensed clinician other than the requesting provider, then the narrative and any attached documentation must

i. clearly identify the appropriately qualified and licensed clinician(s) who furnished the diagnosis or opinion substantiating the condition or pathology (e.g., general dentist, oral surgeon, physician, clinical psychologist, clinical dietitian, speech therapist);

ii. describe the nature and extent of the identified clinician(s) involvement and interaction with the patient, including dates of treatment;

iii. state the specific diagnosis or other opinion of the patient's condition furnished by the identified clinician(s);

iv. document the recommendation by the clinician(s) to seek orthodontic

evaluation or treatment (if such a recommendation was made);

v. discuss any treatments for the patient's condition (other than comprehensive orthodontic treatment) considered or attempted by the clinician(s); and

vi. provide any other relevant information from the clinician(s) that supports the requesting provider's justification of the medical necessity of comprehensive orthodontic treatment. The medical necessity narrative must be signed and dated by the requesting provider and submitted on the office letterhead of the provider. If applicable, any supporting documentation from the other involved clinician(s) must also be signed and dated by such clinician(s), and appear on office letterhead of such clinician(s). The requesting provider is responsible for coordinating with the other involved clinician(s) and is responsible for compiling and submitting any supporting documentation furnished by other involved clinician(s) along with the medical necessity narrative.

The appellant does not have an autoqualifier. Dr. Rizkallah had testified that he had a deep impinging overbite, but he acknowledged that this was not apparent from the images submitted and would not qualify under the HLD Scale. He did not identify the appellant as having a deep impinging overbite on his HLD Form. Nor is the flowchart created by Dr. Rizkallah a "medical necessity narrative" in accordance with the instructions in the HLD form. The flowchart does not identify "a handicapping malocclusion," it identifies a "harmful condition" that could potentially cause a "harmful effect." It does not "discuss any treatments for the patient's condition (other than comprehensive orthodontic treatment) considered or attempted by the clinician(s)." Dr. Rizkallah argues that his flowchart is allowable based upon the arguments he outlines in his Appendix Q.

The instructions for the medical necessity narrative use "including" before listing five conditions that could be identified as needing to be "correct[ed] or significantly ameliorate[d]." By using "including," Dr. Rizkallah argues the HLD Form's instructions allow him to identify any potentially harmful condition that would be corrected or ameliorated. He created his form to reference 130 CMR 450.204(A)'s definition of "medical necessity" since that is a more inclusive definition than the five examples listed on the HLD Form's instructions. To highlight his argument, Appendix Q includes an excerpt from a fair hearing decision (Appeal No. 2112176). Dr. Rizkallah appears to have misread this decision.

That hearing officer explained the "narrative must establish that comprehensive orthodontic treatment is medically necessary to treat **a handicapping malocclusion** … ." The following five example conditions in the instructions are not exclusive, but as that decision highlights, the medical necessity narrative must **identify a handicapping malocclusion**. Because this language is identical to language in 130 CMR 420.431(C)(3), labeled "Service Limitations and Requirements," Dr. Rizkallah argues it should be ignored. MassHealth must cover "all medically necessary dental services for EPSDT-eligible members … without regard to services limitations described in 130 CMR 420.000." 130 CMR 420.408. Therefore, Dr. Rizkallah reasons he may apply the definition of "medical necessity" directly from 130 CMR 450.204(A) without needing to bother with identifying

a handicapping malocclusion. This argument is discussed further below. For now, it is sufficient to note that Dr. Rizkallah's flowchart does not satisfy the instructions set out on the HLD Form as required when applying the full regulatory framework set out in 130 CMR 420.000, and by reference the requirements identified in the Dental Manual and the ORM.

Regarding the HLD score, Dr. Kaplan and the original orthodontist who reviewed the information agreed that the appellant did not qualify on HLD score. Their scores were based upon finding fewer millimeters of overjet and overbite. Dr. Rizkallah's testimony focused solely on the impacted teeth, for which he scored nine points. He did not contest MassHealth's other measurements. In the absence of any rebuttal, I credit the opinions of Dr. Kaplan and the original dental consultant who both measured less overbite and overjet. Therefore, before addressing the impacted teeth, the relevant HLD score is only 17 points.

There is insufficient evidence in the record to establish that three of the appellant's molars are impacted. Dr. Kaplan was willing to agree that the appellant's upper molar might be impacted, but he argued that the appellant's lower molars did not have fully developed roots. Despite the time spent on the topic of impacted teeth, Dr. Rizkallah never addressed whether the appellant's lower molars were sufficiently developed to be ready to enter the mouth. He focused on the upper molar being impacted and the tendency of late developing dentition to be further delayed by a toughening of the gums. He also emphasized his willingness to put his certainty into percentages as to whether the appellant's molars will erupt within the next year or three, though he would not provide an opinion as to whether the teeth would ever erupt.

Dr. Kaplan's explanation is more creditable because he identified the facts upon which he formed his opinion and because he identified readily available evidence that he would accept as disproving his position. While the upper molar is a closer issue, Dr. Kaplan identified the appellant's lower molars as not fully developed. Dr. Kaplan also gave a reasonable explanation that some children's dental age may be different from their chronological age. The appellant had other teeth that were behind schedule from a purely chronological viewpoint, which supports Dr. Kaplan's opinion that the lower molars are not impacted but simply still developing. These factors were uncontested by Dr. Rizkallah. His response was that his experience that children with late developing molars often toughen their gums through a tongue habit. While this may be true, it does not actually address the question of whether the lower molars are ready to come into the appellant's mouth.

Furthermore, Dr. Kaplan's opinion was that there was insufficient information available to establish that these teeth were impacted. A tooth is impacted when it is stuck or blocked from erupting into mouth. For the lower molars, which were still developing, it cannot be ascertained from a single snapshot in time whether the tooth is moving or able to move. Especially, in the absence of some obvious blockage. Dr. Kaplans' testimony is that there is no harm in waiting to see if these teeth move and starting treatment when the child is a little older. As an evidentiary matter, the appellant's case could have been strengthened significantly with readily available evidence. As of the hearing, a year had passed since the photographs and x-rays were created. This fact was not discussed at the hearing, but it remains that a second data point could have easily been provided for the hearing record. MassHealth would have covered a new orthodontic evaluation with new x-rays and photographs, but even a self-taken photograph of the appellant's teeth would have shown whether

any of those molars had erupted.[9] This additional data point could have strongly supported Dr. Rizkallah's "80 percent" certainty, or conclusively refuted it

With regards to Dr. Rizkallah's objection that testimony cannot be credited without a specific percentage of certainty, I credit Dr. Kaplans' testimony as an expression of his professional opinion.[10] I am unaware of any requirement that a professional opinion be expressed as a percentile of certainty. See Views of the Commission Use of the Term "Reasonable Scientific Certainty," Nat. Comm'n on Forensic Science (March 22, 2016) (available at https://www.justice.gov/archives/ncfs/file/839726/download). Nor, in the absence of extensive statistical analysis regarding the scientific matter at hand, is it unclear to me how expressing one's opinion in such a manner is fruitful. Fair hearings are decided based upon a preponderance of the evidence, 130 CMR 610.082(B), and the explanations provided by Dr. Kaplan are compatible with that standard. For these reasons, the appellant's request for orthodontia under the HLD Form and the requirements of 130 CMR 420.000 is DENIED.

EPSDT-Eligible Medical Necessity

Dr. Rizkallah's alternative argument is that the rules set out through 130 CMR 420.000 are irrelevant to an EPSDT-eligible member. As noted above, this argument is premised upon the requirement that the "MassHealth agency pays for all medically necessary dental services for EPSDT-eligible members in accordance with 130 CMR 450.140: *Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services: Introduction*, **without regard to service limitations described in 130 CMR 420.000**, and with prior authorization." 130 CMR 420.408 (emphasis **in bold**). Therefore, Dr. Rizkallah created his own medical necessity flow chart to establish eligibility for EPSDT-eligible members "without regard to … 130 CMR 420.000."

This argument fails both factually and legally. Factually, there is no evidence in the record that the appellant is EPSDT-eligible. Nothing in the record reflects the appellant's MassHealth coverage type, therefore it is unclear whether they have Standard or CommonHealth, or if they are covered by Family Assistance under 130 CMR 505.005. See also 130 CMR 450.105(G)(3). Dr. Rizkallah unequivocally testified that all patients for whom he sought prior authorization from MassHealth were covered by MassHealth Standard. He soon acknowledged he was unaware that there was more than one category of MassHealth benefit that qualified for orthodontia. Because this argument requires that the appellant be EPSDT-eligible, and there is no evidence that he is, this argument is unavailing.[11]

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[9] I am cognizant that parents may not wish for their children to be x-rayed more frequently than is necessary. That said, it is also possible the appellant's regular dentist may have updated bitewing x-rays since June 2020.

[10] Fair hearings are not bound by the formal rules of evidence, and this decision makes not formal determination of either testifying orthodontist as an "expert." See Art. VII, Mass. Guide to Evidence.

[11] The evidence also fails to establish that orthodontia is medically necessary under 130 CMR 450.204(A)'s criteria. The study included in the appellant's Appendix F identifies that a lifetime of incisor malalignment increases the risk for periodontal disease development in late middle age. While it is likely true that having orthodontia now would reduce that risk for the appellant, nothing in this study indicates that having that treatment now would be more beneficial than having it at 16, or 20, or 30. There are a variety of other assumptions in the study that also undercut the urgency of using

Legally, the appellant's analysis requires interpretations of law that would make superfluous the entirety of 130 CMR 420.000. It would be bizarre for MassHealth to promulgate the entirety of 130 CMR 420.000, much of which governs services only provided to children under the age of 21, if it were not intended to apply to EPSDT-eligible members. It is clear, therefore, that MassHealth was cognizant of its requirement to provide EPSDT-eligible members with any "medically necessary" service when it added the "medical necessity narrative" instructions to the HLD Form.

The regulations defining dental care for EPSDT-eligible members and defining "medical necessity" reference 130 CMR 420.000 (or other regulations) as providing additional governing instruction.

> Dental Care — dental services customarily furnished by or through dental providers **as defined in 130 CMR 420.000: Dental Services**, to the extent the furnishing of those services is authorized by the MassHealth agency.
>
> EPSDT Dental Protocol and Periodicity Schedule (the Dental Schedule) — a schedule (see Appendix W: EPSDT Services: Medical and Dental Protocols and Periodicity Schedules of all MassHealth provider manuals) developed and periodically updated by the MassHealth agency in consultation with recognized medical and dental organizations involved in child health care. The Dental Schedule consists of screening and treatment procedures arranged according to the intervals or age levels at which each procedure is to be provided.

130 CMR 450.141 (emphasis **in bold**).

> 450.204: Medical Necessity
>
> The MassHealth agency does not pay a provider for services that are not medically necessary and may impose sanctions on a provider for providing or prescribing a service or for admitting a member to an inpatient facility where such service or admission is not medically necessary.
>
> (A) A service is medically necessary if
>
> (1) it is reasonably calculated to prevent, diagnose, prevent the worsening of, alleviate, correct, or cure conditions in the member that endanger life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or to aggravate a handicap, or result in illness or infirmity; and
>
> (2) there is no other medical service or site of service, comparable in effect, available, and suitable for the member requesting the service,

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orthodontia at adolescence to treat periodontal disease at 50. From a "medical necessity" perspective, it is sufficient that doing nothing now is "comparable in effect" and "less costly to the MassHealth agency" to the member receiving treatment at a later point. The fact that the member may bear more financial responsibility for the treatment at a later time is not part of the calculation of "medical necessity," except to the extent that it is "less costly to the MassHealth agency." This would not be true if the study had concluded that orthodontic treatment at 25 was less effective at reducing the risk for periodontal disease.

> that is more conservative or less costly to the MassHealth agency. Services that are less costly to the MassHealth agency include, but are not limited to, health care reasonably known by the provider, or identified by the MassHealth agency pursuant to a prior-authorization request, to be available to the member through sources described in 130 CMR 450.317(C), 503.007: *Potential Sources of Health Care*, or 517.007: *Utilization of Potential Benefits*.
>
> …
>
> (**D) Additional requirements about the medical necessity of MassHealth services are contained in other MassHealth regulations and medical necessity and coverage guidelines.**
>
> …

130 CMR 450.204 (emphasis **in bold)**.

Therefore, the regulatory structure in place is that "medical necessity" as defined by 130 CMR 450.204, must be established in accordance with the "[a]dditional requirements … contained in other MassHealth regulations and medical necessity and coverage guidelines." For dental services, that guidance is 130 CMR 420.000, and by extension the Dental Manual and the ORM. MassHealth satisfies its obligation to provide "medically necessary" orthodontic services to EPDST-eligible members by allowing them to prove that they have a handicapping malocclusion through narrative explanation. The fact that the appellant disagrees with the MassHealth's methodology—that a member must have a "handicapping malocclusion" rather than any malocclusion—does not obviate the complicated regulatory framework in place for reviewing eligibility for MassHealth to cover orthodontia.

For these reasons, this appeal is DENIED. To the extent that the appellant argues that this regulatory structure is an illegal restriction upon EPSDT services as mandated federal law that issue is outside the scope of a fair hearing and must be addressed to the Superior Court. See 130 CMR 610.082(C)(2).

Order for MassHealth

None.

Notification of Your Right to Appeal to Court

If you disagree with this decision, you have the right to appeal to Court in accordance with Chapter 30A of the Massachusetts General Laws. To appeal, you must file a complaint with the Superior Court for the county where you reside, or Suffolk County Superior Court, within 30 days of your receipt of this decision.

Christopher Jones
Hearing Officer
Board of Hearings

cc: DentaQuest 2, MA
[redacted]