Office of Medicaid
BOARD OF HEARINGS

Appellant Name and Address:

[redacted]

Appeal Decision:	Denied	**Appeal Number:**	2203723
Decision Date:	7/25/2022	**Hearing Date:**	07/14/2022
Hearing Officer:	Sara E. McGrath		

Appearances for Appellant:
[redacted], Appellant

Appearances for UnitedHealthcare:
Dr. Cheryl Ellis, Medical Director
Dr. Brittany Vo, Associate Dental Director

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

APPEAL DECISION

Appeal Decision:	Denied	**Issue:**	Prior Authorization
Decision Date:	7/25/2022	**Hearing Date:**	07/14/2022
UHC's Reps.:	Dr. Cheryl Ellis Dr. Brittany Vo	**Appellant's Reps.:**	Appellant
Hearing Location:	Board of Hearings (Remote)	**Aid Pending:**	No

Authority

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

Jurisdiction

Through a notice dated April 6, 2022, UnitedHealthcare, a Senior Care Options (SCO) managed care program that contracts with MassHealth, notified the appellant that it had denied her internal appeal regarding a request for dental services (Exhibit 1). The appellant filed a timely appeal with the Board of Hearings (130 CMR 610.015(B)). Denial of a request for services is a valid basis for appeal (130 CMR 610.032).

Action Taken by UnitedHealthcare SCO

UnitedHealthcare SCO denied the appellant's request for dental services, and then denied her internal appeal of that initial decision.

Issue

The appeal issue is whether the evidence supports UnitedHealthcare SCO's denial of the appellant's request for dental services.

Summary of Evidence

The UnitedHealthcare (UHC) medical director and associate dental director appeared at the hearing by phone and offered the following factual background through testimony and documentary evidence: The appellant is a female who is a UHC SCO participant. In March 2022, the appellant's provider requested various dental services on the behalf of the appellant. On March 25, 2022, UHC notified the appellant that it had approved most of the requested services, including extractions, dental implants, and false tooth attachments to teeth nos. 3, 8, 9, and 12 (Exhibit 4, p. 4). On March 28, 2022, UHC notified the appellant that it had denied her request for dental procedure code D6110, referred to as "false teeth over implant" on the basis that the requested service is not covered under the member's benefit package (Exhibit 4, p. 6). On April 4, 2022, the appellant filed an internal appeal of UHC's determination. On April 6, 2022, UHC denied the appellant's internal appeal for the same reason (Exhibit 1). The appellant appealed this determination to the Board of Hearings.

The UHC representatives explained that dental procedure code D6110 is also referred to as a "implant/abutment supported removable denture for maxillary edentulous arch." It is a complete denture that is held in by a "ball and socket" type design. It is not permanently cemented in the mouth (like a fixed bridge would be), but rather can and should be removed regularly for cleaning and allowing the gum tissues to breathe. The representatives explained that this type of complete denture is not covered under the appellant's benefit package. They referenced UHC's Dental Provider Manual, and in particular Appendix B, which describes member benefits, exclusions, and limitations (Exhibit 4, pp. 38-48). The introductory language states that "[a]any service not listed as a covered service in the benefit grids (Appendix B.2) is excluded" (Exhibit 4, p. 38). Because procedure code D6110 is not listed in Appendix B.2, UHC determined that it is not a covered service. The UHC representatives explained that there exist other alternative treatment options that UHC would cover. One option is a complete upper denture (not implant-supported) that the appellant's provider has already requested and UHC has recently approved. Another is to have the four approved implants placed, and then request four crowns and a partial upper denture that would be clasped to the crowns.

The appellant appeared at the hearing by telephone and explained that she has been without teeth since August 2021. She had several anterior crowns removed, and her dentist put in something temporary. The temporary appliance broke, and her dentist told her there was nothing he could do. She has also had one of the approved implants placed. If she agreed to the full upper denture, she would have to have the implant removed, which she stated feels like a waste. She also does not want a removable partial denture because she wants something more permanent and also doesn't want visible clasps. She also noted that the partial denture would entail getting four crowns, which would cost more money than the implant-supported denture she wants.

The UHC representatives responded and agreed that some of the covered options would in the end be more costly than the requested denture. However, because the requested denture is simply not covered, the cost issue is not the deciding factor.

Findings of Fact

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

1. The appellant is a female who is a UHC SCO member.

2. In March 2022, the appellant's provider requested various dental services on the behalf of the appellant.

3. On March 25, 2022, UHC notified the appellant that it had approved most of the requested services, including extractions, dental implants, and false tooth attachments to teeth nos. 3, 8, 9, and 12.

4. On March 28, 2022, UHC notified the appellant that it had denied the request for dental procedure code D6110, referred to as "false teeth over implant" on the basis that the requested service is not covered under the member's benefit package.

5. On April 4, 2022, the appellant filed an internal appeal of UHC's determination.

6. On April 6, 2022, UHC denied the appellant's internal appeal for the same reason.

7. The appellant appealed this determination to the Board of Hearings.

Analysis and Conclusions of Law

Under 130 CMR 508.006, MassHealth members who are enrolled in senior care organizations are entitled to a fair hearing under 130 CMR 610.000*: MassHealth: Fair Hearing Rules* to appeal:

> (A) the MassHealth agency's determination that the MassHealth member is required to enroll with a MassHealth managed care provider under 130 CMR 508.001(A);
>
> (B) a determination by the MassHealth behavioral-health contractor, by one of the MassHealth managed care organization (MCO) contractors, or by a senior care organization (SCO), as further described in 130 CMR 610.032(B), if the member has exhausted all remedies available through the contractor's internal appeals process;
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> (C) the MassHealth agency's denial of a request for an out-of-area MassHealth managed care provider under 130 CMR 508.002(F); or

(D) the MassHealth agency's disenrollment of a member from a MassHealth managed care provider under 130 CMR 508.002(G).

The Fair Hearing regulations at 130 CMR 610.032(B) describe in greater detail the bases for appeal:

(B) Members enrolled in a managed care contractor have a right to request a fair hearing for any of the following actions or inactions by the managed care contractor, provided the member has exhausted all remedies available through the managed care contractor's internal appeals process (except where a member is notified by the managed care contractor that exhaustion is unnecessary):

(1) failure to provide services in a timely manner, as defined in the information on access standards provided to members enrolled with the managed care contractor;

(2) a decision to deny or provide limited authorization of a requested service, including the type or level of service;

(3) a decision to reduce, suspend, or terminate a previous authorization for a service;

(4) a denial, in whole or in part, of payment for a service where coverage of the requested service is at issue, provided that procedural denials for services do not constitute appealable actions. Notwithstanding the foregoing, members have the right to request a fair hearing where there is a factual dispute over whether a procedural error occurred. Procedural denials include, but are not limited to, denials based on the following: (a) failure to follow prior-authorization procedures; (b) failure to follow referral rules; and (c) failure to file a timely claim;

(5) failure to act within the time frames for resolution of an internal appeal as described in 130 CMR 508.010;

(6) a decision by an MCO to deny a request by a member who resides in a rural service area served by only one MCO to exercise his or her right to obtain services outside the MCO's network under the following circumstances, pursuant to 42 CFR 438.52(b)(2)(ii):

(a) the member is unable to obtain the same service or to access a provider with the same type of training, experience, and specialization within the MCO's network;

(b) the provider from whom the member seeks service is the main source of service to the member, except that member will have no right to obtain

> services from a provider outside the MCO's network if the MCO gave the provider the opportunity to participate in the MCO's network under the same requirements for participation applicable to other providers and the provider chose not to join the network or did not meet the necessary requirements to join the network;
>
> (c) the only provider available to the member in the MCO's network does not, because of moral or religious objections, provide the service the member seeks; and
>
> (d) the member's primary care provider or other provider determines that the member needs related services and that the member would be subjected to unnecessary risk if he or she received those services separately and not all of the related services are available within the MCO's network; or
>
> (7) failure to act within the time frames for making service authorization decisions, as described in the information on service authorization decisions provided to members enrolled with the managed care contractor.

In this case, the appellant has appealed UHC's decision to deny her request for dental services, and she has appropriately exhausted all remedies available through UHC's internal appeals process (130 CMR 610.032(B)(2); 508.006(B)).

UHC denied the appellant's request for an implant-supported denture on the basis that it is not a covered service under the appellant's benefit package. The appellant argues that she has been without front teeth for almost a year, and does not want a regular full upper denture, or a partial denture that would be clasped to crowns. The UHC Dental Provider Manual uses standard ADA coding guidelines and clearly sets forth that any service not listed as a covered service in Appendix B.2 is excluded (Exhibit 4, p. 38). Dental procedure code D6110 is not listed as a covered service in the manual (Exhibit 4, pp. 38-48). The appellant did not submit any evidence to suggest that procedure code D6110 is in fact a covered service, and therefore she has not met her burden here.[1]

The appeal is denied.

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[1] UHC's determination is consistent with the MassHealth dental regulations and the sub-regulatory MassHealth Dental Program Office Reference Manual, neither of which includes a reference to implant-supported dentures or dental procedure code D6110 (130 CMR 420.401 *et seq*; http://www.masshealth-dental.net/MassHealth/media/Docs/MassHealth-ORM.pdf).

Order for SCO

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.

Sara E. McGrath
Hearing Officer
Board of Hearings

cc: UnitedHealthcare SCO
Attn: Cheryl A. Ellis, MD
LTC Medical Director
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