Office of Medicaid
BOARD OF HEARINGS

Appellant Name and Address:

[redacted]

Appeal Decision:	Approved in Part, Denied in Part	**Appeal Number:**	2300958
Decision Date:	6/22/2023	**Hearing Date:**	05/11/2023
Hearing Officer:	Mariah Burns		

Appearance for Appellant:
Pro se

Appearance for MassHealth:
Dr. Cheryl Ellis, M.D., Long-Term Care Medical Director
Dr. Trevor Smith, D.M.D., Associate Director, Clinical Consulting

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:	Approved in Part, Denied in Part	**Issue:**	SCO Prior Authorization - Dental
Decision Date:	6/22/2023	**Hearing Date:**	05/11/2023
MassHealth's Rep.:	Dr. Cheryl Ellis, M.D.; Dr. Trevor Smith, D.M.D	**Appellant's Rep.:**	Pro se
Hearing Location:	Remote	**Aid Pending:**	No

Authority

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

Jurisdiction

On December 15, 2022, United Healthcare Senior Care Options issued an Appeal Decision Letter denying the appellant's request for prior authorization for certain dental procedures (see 130 CMR 508 and Exhibit 1). The appellant filed this appeal in a timely manner on January 31, 2023 (see 130 CMR 610.015(B) and Exhibit 2). Denial of assistance is valid grounds for appeal (see 130 CMR 610.032).

An initial hearing date was held on April 13, 2023. The hearing officer ordered a second day of testimony, which reconvened on May 11, 2023.

Action Taken by United Healthcare

United Healthcare denied the appellant's prior authorization request for three dental codes.

Issue

The appeal issue is whether United Healthcare was correct denying the appellant's prior authorization request.

Summary of Evidence

The appellant is over the age of 65 and has enrolled in the United Healthcare Senior Care Organization (SCO) through MassHealth. He represented himself at hearing telephonically. United Healthcare (UHC) was represented telephonically at hearing by their Long-Term Care Medical Director, a medical doctor, and their Associate Director for Clinical Consulting, a dentist. The following is a summary of the testimony over multiple hearing days and the submitted documentary evidence.

UHC requires members to undergo prior authorization for certain dental procedures. They have subcontracted with a company called Skygen, who processes UHC dental prior authorization requests. The UHC representatives were unfamiliar with how a request is submitted and evaluated. Once Skygen makes its initial determination, a notice is sent to the member that informs them of the decision and any appeal rights to which they are entitled.

According to the UHC Member Handbook, a member who is not satisfied with a coverage decision may make a "Level 1 Appeal" within 60 days wherein the decision is reviewed to ensure that "we were following all of the rules directly." Exhibit 6 at 214. It is unclear whether the Level 1 Appeal is conducted by Skygen or UHC, although Dr. Smith reported that he does not review any decision unless and until a member submits a Fair Hearing request. A Fair Hearing request can be made when a Level 1 appeal is denied, and the appeal is heard before the Board of Hearings. In those situations, Dr. Smith reviews the submission to determine whether he believes UHC should continue to challenge the member's appeal.

In this case, the appellant's provider apparently submitted a prior authorization request on the appellant's behalf some time before November 3, 2022. On that date, UHC issued two notices: one explaining the approval of certain dental codes, and one detailing the denial of certain codes. *See* Exhibit 6 at 312-317. The approval notice reflects the approval of extraction of 12 of the appellant's teeth (dental code D7210) and four implants (dental code D6010). *Id.* The denial notice describes two denied implants, six requests for bone grafts (dental code 7953), and six requests for skin grafts (dental code 4266). *Id.* at 314-315. The codes were denied for the following reasons:

1. D6010– "This service exceeds the maximum count allowed per period."
2. D7953 – "This service is not covered under the member's benefit package."
3. D4266 – "This request is not medically necessary. The service is denied. Bone surgery to treat gum disease can be covered if x-rays sent show a bone defect. Records sent do not

show bone defects. Skygen USA criteria used for review."

Id. at 315. The appellant filed a Level 1 appeal, which was denied on December 15, 2022. Exhibit 1 at 1. The appellant timely submitted a fair hearing request on January 31, 2023. Exhibit 2.

Dr. Smith testified that he would expect to see the requested codes when the final goal is to introduce a removable denture, which he distinguished from a partial denture. Partial dentures could be a less expensive treatment option, but can cause issues with remaining teeth, and there are circumstances where implants are preferable. In explaining why the requested codes were denied, Dr. Smith referred to Appendix B of the UHC Massachusetts Dental Provider Manual, stating that code D7953 is not listed within the benefit grid, meaning it is not a covered service. *See* Exhibit 6 at 30-37 of pdf. Neither Dr. Smith nor Dr. Ellis were able to state whether code D7953 is covered by MassHealth; Dr. Smith explained that the dental codes are uniform by American Dental Association standards, and that UHC and MassHealth use the same codes for each respective procedure.

For code 6010, Dr. Smith again referred to Appendix B, which does list the code but states as a limitation "4 PER ACCUM YEAR." *Id.* at 32. As four implants were previously approved, Dr. Smith submitted this as proof that the appellant exceeded his maximum benefit allowance for that code.[1]

With respect to code D4266, Dr. Smith reported that when he accessed the appellant's Skygen portal, he did not see any clinical documentation submitted by the appellant's provider, such as x-rays or a narrative. He took this to mean that the provider did not submit any such documentation, which is the actual reason why the code was denied. When questioned about the significant difference between his believed reason for the denial and what was stated in the notice, Dr. Smith indicated that it was his belief that Skygen uses boilerplate language for their notices and that they simply picked the reason that they felt best described why the appellant's request was denied.

The hearing officer asked Dr. Smith if he would be able to accept a direct submission of records from the appellant's provider to make a determination as to whether the appellant was eligible for code D4266. Dr. Smith expressed a hesitancy to agree to the request without consulting the UHC legal department. Among the reasons he gave for his hesitation was that he is not licensed to practice in the Commonwealth of Massachusetts. The record was kept open, and the hearing was ordered to be reconvened in several weeks' time.

During the record open period, the appellant submitted x-rays and other documentation to the Board of Hearings, which were forwarded to Dr. Smith the morning of the hearing. *See* Exhibit 7,

[1] In a post-hearing communication, Dr. Smith reported that the appellant is eligible for additional implants on January 1, 2024. See Exhibit 7 at 7.

Exhibit 8. On the second day of testimony, Dr. Smith was asked about whether he learned anything additional about the UHC prior authorization process. He reported that he was instructed to refer the hearing officer to an email address for any questions. He also indicated that the submitted records would not be enough for him to make a determination about the appellant's eligibility and stated that he is "encouraged" to see a patient "in the chair" before doing so. Dr. Smith provided some testimony, described *supra*, and he also indicated that in these circumstances, a dentist would not be able to perform a guided tissue regeneration without bone grafts.

The appellant testified that his teeth have been an ongoing issue for years. He worked with a UHC ombudsman to submit his request in the proper manner and to navigate the Level 1 appeal process. He currently has 10 remaining teeth, four on the bottom and six on top, all of which are cracked and hurt. He reported that, as far as he is aware, he has no issues with his gums. His dentist attempted to treat his issues with traditional partial dentures, with limited success. The appellant testified that the denture grip would not hold his teeth in and they kept cracking every time he bit in to them.

MassHealth has made its contracts with SCOs available through its website. As such, the contract with UHC, which was most recently amended on February 28, 2019, and consists of 561 pages, shall be incorporated into the hearing record.[2] The agreement requires UHC to "comply with all applicable statutes, orders, and regulations promulgated by any federal, state, municipal, or other governmental authority relating to the performance of this Contract." Section 2.1(B). It also obligates UHC and its subcontractors to "have in place, and follow, written policies and procedures for processing requests for initial and continuing authorization of services." Section 2.4(A)(15).

Findings of Fact

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

1. The appellant is over 65 years of age and a MassHealth Standard member enrolled in United Healthcare's Senior Care Options SCO. Exhibit 5, Exhibit 1.

2. Some time before November 3, 2022, the appellant's provider submitted a prior authorization request on the appellant's behalf for dental codes D7210 (tooth extractions), D7953 (bone grafting), D6010 (implants), and D4200 (tissue grafting). Exhibit 6 at 312.

3. The request was reviewed by a subcontractor, Skygen, who used an unknown criterion to evaluate the submission. Testimony. On November 3, 2022, Skygen approved code 7210 in full

[2] https://www.mass.gov/doc/2nd-amended-and-restated-sco-contract-unitedhealthcare-insurance-company-unitedhealthcare/download

along with four counts of code D6010, and denied codes D7953, 4266, and two counts of D6010.

4. The notice indicated that the codes were denied for the following reasons:
   1. D6010– "This service exceeds the maximum count allowed per period."
   2. D7953 – "This service is not covered under the member's benefit package."
   3. D4266 – "This request is not medically necessary. The service is denied. Bone surgery to treat gum disease can be covered if x-rays sent show a bone defect. Records sent do not show bone defects. Skygen USA criteria used for review." Exhibit 6 at 305.

5. The appellant filed a Level 1 internal appeal, which was denied on December 15, 2022 for the same reasons. Exhibit 6 at 312.

6. The appellant timely filed a request for fair hearing with the Board of Hearings on January 31, 2023. Exhibit 2.

7. The UHC representatives are unfamiliar with the criteria Skygen uses to review prior authorization requests and the process by which they do so. Testimony. There is no evidence within the record that establishes these facts.

8. Neither MassHealth nor UHC cover code D7953. *See* Appendix D of the MassHealth *Dental Manual* and Exhibit 6 at 28-36.

9. UHC only covers four procedures for code D6010 per benefit year. Exhibit 6 at 32. MassHealth does not cover code D6010. *See* Appendix D of the MassHealth *Dental Manual.*

10. Dr. Smith's belief is that code D4266 was denied because the appellant's provider did not submit the necessary clinical documentation to support the request, which he acknowledges is different from what is stated on the notice. Testimony, Exhibit 1.

11. The appellant submitted documentation prior to the May 11, 2023 hearing date, which appears to include x-rays and a narrative. Exhibit 8. Dr. Smith was unable to review the documents to help determine the appellant's eligibility, saying he is encouraged to see patients "in the chair." Testimony.

Analysis and Conclusions of Law

I. Legal Framework and Obligations of Senior Care Organizations

MassHealth has contracted with individual private insurance companies, referred to as managed care organizations (MCOs), to deliver care to relevant members under the regulations. *See* 130 C.M.R. One such type of MCO is a senior care organization (SCO), designed to manage the care of

certain MassHealth members over the age of 65. Massachusetts law defines an SCO as "a comprehensive network of medical, health care, and social service providers that integrates all components of care, either directly or through subcontracts." M.G.L. ch. 118E § 9D(a). Further, "SCOs will be responsible for providing enrollees with the full continuum of Medicare and MassHealth covered services." The MassHealth regulations establish the member selection process for SCOs at 130 C.M.R. 508.008.

An SCO has specific statutory and regulatory requirements by which it must abide regarding the scope of its coverage and its internal appeal process. "[T]he amount, duration, and scope of Medicaid-covered services shall be at a minimum no more restrictive than the scope of services provided under MassHealth standard coverage." M.G.L. ch. 118E § 9D(d). In essence, the SCO must provide everything under the MassHealth regulations and may have services or coverage that range beyond the scope of those provided by MassHealth.

Additionally, SCOs are obligated to abide by federal statutes requiring such organizations to create a grievance mechanism that includes an "explanation of determination." 42 U.S.C. § 1395(f) and (g). "Such a determination that denies coverage, in whole or in part, shall be in writing and shall include a statement in understandable language or the reasons for the denial and a description of the reconsideration and appeals process." *Id.* This must include a "clear statement of the specific reasons supporting the intended action." 42 C.F.R. §431.210. Clear and specific have been defined in this context as "free from ambiguity," while specific means "the opposite of general, generalized, and generic." *Maas v. Sudders*, 35 Mass. L. Rptr. 150, 3 (2018).

Further, while "[d]ue process does not require that notices of the administrative proceedings 'be drafted with the certainty of a criminal pleading,'" the notice must be "sufficient for persons whose rights may be affected to understand the substance and nature of the grounds upon which they are called to answer." *Langlitz v. Board of Registration of Chiropractors*, 396 Mass. 374, 377 (1985) *quoting Higgins v. License Commissioners of Quincy*, 308 Mass. 142, 145 (1941). These requirements provide parties to administrative proceedings "reasonable opportunity to prepare and present evidence and argument." M.G.L. ch. 30A §11.

MassHealth regulations apply to SCOs and provide that "[m]embers are entitled to a fair hearing under 130 C.M.R. 610.00: MassHealth Fair Hearing Rules to appeal…a determination by…one of the…SCOs…if the member has exhausted all remedies available through the contractor's internal appeals process." 130 C.M.R. 508.010(B). This obligates an SCO to follow the fair hearing rules when defending a decision before the Board of Hearings.

Typically, '[a]ll medical services to members enrolled in an MCO…are subject to the prior authorization and referral requirements of the MCO." 130 C.M.R. 508.004(2). In this case, the UHC representatives did not provide testimony about their prior authorization procedures. Meanwhile, Appendix C of the Dental Provider Manual provides little guidance, stating only that prior authorization is sometimes needed to show "necessity". *See* Exhibit 6 at 38. As UHC must

abide by MassHealth rules, the regulations shall be used as criteria.

MassHealth pays only for medically necessary services to eligible MassHealth members and may require that medical necessity be established through the prior authorization process. 130 C.M.R. 420.410(A)(1). 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, that is more conservative or less costly to MassHealth.

130 C.M.R. 450.204(A). Medical necessity for dental and orthodontic treatment must be shown in accordance with the regulations governing dental treatment codified at 130 CMR 420.000 and within the MassHealth *Dental Manual*.

II. Fair Hearing Obligations of Appellant and an SCO

As 130 C.M.R. 508.010 entitles SCO members to a fair hearing when they exhaust their internal appellate remedies, this obligates the SCO and members to comply with the Fair Hearing Rules when appearing before the Board of Hearings. An SCO appellant is afforded all rights provided in 130 C.M.R. 610, but also bears "the burden 'to demonstrate the invalidity of the administrative determination.'" *Coppinger v. Executive Office of Health and Human Services*, 101 Mass. App. Ct. 1123, 2 (2022), *citing Andrews v. Division of Medical Assistance*, 68 Mass. App. Ct. 228, 231 (2007)).

As the Acting Entity, the SCO is bound not only by the constitutional, statutory, and regulatory notice requirements described *supra*, but also has certain rights and responsibilities found at 130 C.M.R. 610.062. The relevant provisions include the following:

1. The acting entity is required to "submit to the hearing officer at or before the hearing *all evidence* on which any action is based." 130 C.M.R. 610.062(A) (Emphasis added);
2. The acting entity will "introduce into evidence material from pertinent documents that pertain to the issue or issues raised during the hearing and that are not otherwise confidential." *Id.* at §§ 062(G);
3. The acting entity will "present and establish all relevant facts and circumstances by oral testimony and documentary evidence." *Id.* at §§ 062(H);

4. "[W]here the acting entity is a managed care contractor, ensure that the relevant paperwork is present at the hearing and that the appellant has adequate opportunity to examine it before and during the hearing." *Id.* at §§ 062(L).

III. The Legal Framework as Applied to This Case

A. Procedural Concerns Regarding UHC's Notice and Evidentiary Submission

For purposes of this decision, I will reference the specific codes requested rather than the item or tooth numbers. Both UHC's initial November 3, 2022 notice ("the notice") and the December 15, 2022 Appeal Decision Letter ('the Decision Letter") indicate that three codes were denied, each for different reasons. *See* Exhibit 1, Exhibit 6 at 305 and 312. Code D6010 was denied because the services "exceeds the maximum count allowed per period," which matches the explanation Dr. Smith gave for the denial at hearing. *Id.* Further, Code D7953 was denied due to it not being covered within the appellant's benefit package, which is also consistent with Dr. Smith's testimony. *Id.* As the notice and the Decision Letter both stated the actual reasons why those codes were denied and provided the appellant the opportunity to refute those reasons, there are no notice issues with respect to those two dental codes.

However, the testimony at hearing raised significant issues with respect to proper notice for code D4266. Both the notice and the Decision Letter state "this request is not necessary. This service is denied. Bone surgery to treat gum disease can be covered if x-rays sent show a bone defect. Records sent to not show bone defects. Skygen USA criteria used for review." Exhibit 1, Exhibit 6 at 305 and 312. A plain reading of that notice would seem to indicate that UHC (or Skygen as its subcontractor) was able to review the appellant's submission and determined that, based on the records sent, the requested treatment was not medically necessary.

At hearing, Dr. Smith testified that, because he was unable to see any supporting documentation in the appellant's "Skygen portal," it was his belief that, in fact, no records were ever submitted by the appellant's provider. He reported that his presumption was that the appellant's request for code D4266 was unable to be sufficiently evaluated because the necessary documentation was not provided. When pressed, Dr. Smith agreed that this was a different reason than what was written in both the notice and the Decision Letter. His given explanation was that he believes that Skygen has form responses and that they picked the reason that they thought best fits the situation.

Dr. Smith's testimony raises due process concerns regarding the adequacy of the notice for code D4266. The reason given for the denial was neither clear nor specific, and was factually inaccurate, Dr. Smith acknowledged the distinction between when a service is needed and

when the insurance company is unable to determine its necessity. Further, the stated reason implies that the records were received, which Dr. Smith testified does not appear to be the case. The appellant stated that the had no idea that his clinical records were not received by UHC and expressed confusion about how this was possible given his reliance on a UHC ombudsman. Although, as discussed *supra*, I do not fully credit Dr. Smith's contention that the appellant's records were received, UHC is prohibited from raising new issues at hearing and is bound by the notice it provided. *See generally*, M.G.L ch. 30A §11.

A hearing officer's decision must be "rendered in accordance with the law…includ[ing] the state and federal constitutions, statutes, and duly promulgated regulations, as well as decisions of the state and federal courts." 130 C.M.R. 610.082. I therefore find that UHC's November 3, 2022 and December 15, 2022 notices to the appellant were insufficient based on federal and state regulations. Indeed, this notice may even be constitutionally deficient, though I decline to find as such today. UHC should exercise caution going forward, as it is their responsibility to ensure that any subcontractors are abiding by MassHealth rules and regulations. The regulations are silent as to a remedy for a notice violation. Thus, while I approve the appeal for dental code D4266 on procedural grounds, I will also address the substantive issues, *infra*.

B. Procedural Concerns Regarding the Sufficiency of UHC's Evidence

As stated, *supra*, the acting entity is obligated to provide all evidence upon which a decision is based before or at the hearing. 130 C.M.R. 610.032(A). Typically, one would expect this to include, at minimum:

1. The appellant's prior authorization request;
2. Any submitted supporting clinical, financial, and/or narrative documentation;
3. The criteria upon which a decision was made, if it deviates from MassHealth regulations;
4. The initial denial notice;
5. The Level 1 appeal request;
6. The Level 1 appeal packet with all evidence upon which the appeal decision was based;
7. The Level 1 appeal decision.

UHC submitted only the initial denial notice (Exhibit 6 at 318) and the Level 1 appeal decision (Exhibit 6 at 305). Not only did UHC fail to provide any of the remaining evidence upon which the decisions were based, and not only did they instruct the hearing officer to submit any procedure-related inquiries to some unknown email address, but both Dr. Ellis and Dr. Smith were apparently patently unfamiliar with the process by which UHC evaluates prior authorization requests with respect to dental cases. UHC seems to rely entirely on the discretion of a third party, Skygen, and the third party's unknown and unaccounted for criteria, and Dr. Ellis and Dr. Smith either do not have access to members' prior authorization

submissions or refused to provide the appellant's at hearing. Their explanations were not sufficient to meet their obligations under 130 C.M.R. 610 and are, frankly, unacceptable for a private company that has contracted with MassHealth to provide services to the Commonwealth's most vulnerable population.

While, as explored, *infra*, I find that UHC established a sufficient factual basis for the denial of codes D6010 and D7953,[3] I find that they failed to meet their burden of production with respect to code D4266. I approve the appeal with respect to that code on those grounds. Because the regulations are silent as to a remedy for procedural violations by the acting entity, I also address the substantive issues of the requested codes, *supra*.

C. Substantive Considerations Regarding UHC's Denial of Appellant's Prior Authorization Request.

As previously stated, the appellant's provider requested and UHC denied coverage of three dental codes: D6010 – surgical placement of implant body (implants); D7953 – bone replacement graft (bone graft); D4266 – guided tissue regeneration (tissue graft). For the reasons described herein, I find that UHC was within its discretion to deny the appellant's request for prior authorization for codes D6010 and D7953, but the record is insufficient with respect to code D4266. The appeal is therefore denied in part and allowed and remanded in part.

1. The Appellant Has Met His Current Maximum Benefit Allowance for Code 6010.

The appellant's request for code D6010 was denied because "the service exceeds the maximum count allowed per period." Exhibit 1, Exhibit 6 at 305, 312. As MassHealth does not cover code D6010, UHC's policies must be relied upon. *See Dental Manual* at Subchapter 6 – Dental Service Codes (D6010 not included as a covered service). The UHC Provider Manual indicates that implants can be covered for clinically eligible members but are limited to four implants per "accum" year. *See* Exhibit 6 at 32. According to submitted UHC documentation, the appellant was previously approved for four implants on August 12, 2022, and the two remaining requested implants were denied for the same reason. Exhibit 6 at 302. Based on this, the appellant must wait until his next benefit year to have the remaining two requested implants covered by UHC. According to post-hearing correspondence from Dr. Smith, the appellant will be eligible for such coverage on January 1, 2024. *See* Exhibit 7 at 7. Thus, UHC was within its discretion to deny the appellant's prior authorization request for D6010.

2. United Healthcare Does Not Cover Payment for Code D7953.

[3] Though the absence of the appellant's prior authorization request and any submitted documentation is troubling.

The appellant's request for D7953 was denied because "this service is not covered under the member's benefit package." Exhibit 1, Exhibit 6 at 305, 312. As with code D6010, MassHealth does not cover code D7953, and UHC's policies are controlling. *See Dental Manual* at Subchapter 6 – Dental Service Codes (D7953 not included as a covered service). The UHC Provider Manual does not list code D7953 as a covered service. According to Dr. Smith's testimony, this means that the code is not covered by UHC under any circumstances. Therefore, UHC was within its discretion to deny the appellant's prior authorization request for code D7953.

3. The Record Lacks Sufficient Evidence as to the Clinical Criteria for Code 4266 and Whether the Appellant Meets It.

Were the appellant a traditional MassHealth member who does not belong to an SCO, he would be obligated to demonstrate that certain are medically necessary through the prior authorization process to be approved for coverage. *See* 130 CMR 450.204 and 420.410. In such circumstances, the MassHealth regulations and the *Dental Manual* provide all necessary guidance as to the clinical standards for any dental procedures that are subject to prior authorization, and it is incumbent upon appellants to show that any submitted evidence meets that criterion. As MassHealth does not cover code D4266 under any circumstances, this hearing officer must rely on UHC's clinical standards for the particular code. *See* 130 CMR 508.004(2) ("All medical services to members enrolled in an MCO…are subject to the authorization and referral requirements of the MCO"). UHC has neglected to provide such criteria.

At hearing, the UHC representative vaguely referenced "clinical documentation" that was allegedly not submitted by the provider. In reviewing the evidence, Appendix B of the Member Guide seems to require a prior authorization request for D4266 to contain "Pre-op x-rays of the tooth/area, Completed 6 point perio chart, narrative." UHC contends that none of this was submitted with the prior authorization request. However, given that they are unfamiliar with their process, do not appear to have access to anything beyond a member's "Skygen Portal," and did not provide any evidence, even a screenshot, indicating what is contained within the appellant's "Skygen Portal," I do not credit this.[4]

The appellant did provide x-rays as well as a narrative supporting the provider's requested course of treatment. However, as UHC did not provide the criteria upon which a clinical decision is made for any of the requested dental codes, I am unable to discern whether the evidence contained within this hearing record is sufficient. Further, the UHC representative was either unable or unwilling to review the evidence submitted by the appellant during the record open period, stating that he would be unable to make any kind of determination without seeing the appellant "in the

[4] Further, there have been other recent fair hearing requests made to the Board of Hearings regarding UHC Dental cases where UHC claims that the appellant's provider did not submit clinical documentation. *See* Appeal No. 2201575 and 2303356. It strains credulity to suggest that this is a coincidence.

chair."[5]

As I am unable to make a determination regarding the appellant's eligibility for dental code D4266, I hereby make the following order: The appeal with respect to code D4266 is ALLOWED and the case is remanded back to United Healthcare. UHC, not Skygen, will be ordered to communicate with the appellant's provider to ensure that all of the necessary clinical documentation is properly submitted. In addition, UHC will provide the clinical requirements that the documentation must demonstrate to establish eligiblity for coverage so that the appellant and his provider may have full knowledge of the criteria. UHC, not Skygen, will then be able to make a full and fair determination of the appellant's eligibility for code D4266.[6] UHC will then issue a notice containing a full and accurate description of its decision, whether it is allowed or denied. The appellant will possess new appeal rights stemming from such a notice.

To summarize: the appeal is **denied** with respect to codes D6010 and D7953 and **allowed and remanded** with respect to code D4266.

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.

Implementation of this Decision

If this decision is not implemented within 30 days after the date of this decision, you should contact your MassHealth Enrollment Center. If you experience problems with the implementation

[5] How any UHC members are able to successfully submit prior authorization requests under such circumstances is puzzling, to say the least.

[6] At hearing, UHC asserted that, under the circumstances of the appellant's treatment plan, he would not be able to receive code D4266 without code D7953, which UHC does not cover, and therefore D4266 should not be covered on that basis. However, as the appellant has the option of paying for D7953 out of pocket, this fact should not preclude him from having code D4266 covered if he meets the clinical requirements.

of this decision, you should report this in writing to the Director of the Board of Hearings, at the address on the first page of this decision.

Mariah Burns
Hearing Officer
Board of Hearings

cc:
MassHealth Representative: United Healthcare SCO, Attn: Susan Coutinho McAllister, MD, LTC Medical Director, 950 Winter St., Ste. 3800, Waltham, MA 02451, 856-287-2743