

STATE OF VERMONT
HUMAN SERVICES BOARD

In re) Fair Hearing No. 10,620
)
Appeal of)

INTRODUCTION

The petitioner appeals the decision of the Department of Social Welfare to deny her orthodontic coverage under Medicaid for treatment of a malocclusion. A recommendation was originally made on October 23, 1991 in this matter which upheld the Department. The petitioner asked that the Board defer consideration of this matter until she had a chance to review the tape recordings. Due to a mechanical failure, the portion of the tape containing the petitioner's and her mother's testimony were never recorded. The hearing officer asked the parties if they could stipulate to the testimony of the petitioner. After some time passed and they could not agree, the hearing officer decided to recreate the record by recording the testimony of those two persons again which was accomplished on April 16, 1992. At that time the petitioner in addition attempted to submit additional medical evidence not on the prior record over the strenuous objection of the Department. Following retaking the testimony, the former recommendation is withdrawn and this one substituted in its place.

FINDINGS OF FACT

1. The petitioner is a twenty-one year old employed woman who seeks Medicaid funding for correction of a malocclusion. Although she does not appear to be currently eligible for Medicaid due to her age, income and status as a single adult, she argues that she should have been found eligible for Medicaid assistance when she was younger and that she was prejudiced by Departmental delay in obtaining benefits for which she was eligible. The petitioner currently has no insurance and has not pursued this treatment on her own.

2. The petitioner claims that as a high school student she suffered severe headaches on a regular and constant basis and jaw pain when chewing gum which kept her out of school some three to four days per month and which also prevented her from attending extracurricular activities. Her mother testified to the same and said that she frequently saw her daughter rubbing her jaw and that chewing some foods caused her special difficulty. The Petitioner took aspirin for the pain. Although she was covered by both private health insurance (obtained by her father with whom she did not live) and Medicaid (through her mother who received A.N.F.C.) and appears to have had a regular family physician throughout her high school years, the petitioner never sought assessment or treatment of any kind for her pain and headaches. No medical evidence from her physician corroborating her claim of severe headaches

and pain was presented by the petitioner. As her failure to seek medical assessment and treatment or referral is inconsistent with her claim of debilitating pain and headaches, the petitioner's statement as to the extent and severity of her pain cannot be credited. It can be found, however, based on the petitioner and her mother's testimony that she experienced some occasional jaw pain and headaches during this time of unknown etiology.

3. In the fall of 1988, when she was seventeen and a half, the petitioner visited her pediatric dentist for a routine check-up. At that time, her dentist told the petitioner that she appeared to have a malocclusion and referred her to an orthodontist for assessment.

4. In September of 1988, she visited an orthodontist who examined the petitioner and concluded that she had an anterior crossbite. The petitioner reported to him that she had experienced some jaw pain and headaches. There is no evidence that the orthodontist evaluated and assessed the extent and severity of the petitioner's jaw pain or headaches or related them in any way to the malocclusion or that he asked any physician to make that assessment.

5. After x-rays and molds were taken, the petitioner's orthodontist determined that orthodontic treatment was appropriate to correct the crossbite and that it would take about two years to complete.

6. Both the petitioner and her orthodontist believed that this service would be paid for by her father's health

insurance. However, the petitioner's father balked at paying the deductible and the orthodontist refused to begin the procedure. Over the next year, the petitioner had no treatment for either pain or the malocclusion while she tried to persuade her father to pay the deductible. He finally agreed and she was to return to begin treatment in December of 1989.

7. However, on the day of the appointment, the petitioner's father contacted the orthodontist and said he would be unable to pay the portion of the bill not covered by insurance which coverage was to run out as to his daughter in February of 1990. At that point, the orthodontist and the petitioner decided to wait two months until her 19th birthday, when the petitioner's private health insurance under her father's policy would terminate and she would be covered solely by Medicaid. The orthodontist agreed to go through the Medicaid approval process with her.

8. The Division of Dental Services of the Department of Health is the agency which authorizes orthodontic procedures through a two-step process. First, it is necessary for the orthodontist to request authorization to make "records", x-rays, and molds, through a "Champus form" which measures and details irregularities in the patient's teeth accompanied by a dental claim form. After authorization is obtained for the "records", they are made and returned to the Department with another claim form

outlining the treatment plan.

9. On April 2, 1990, after her private health insurance had lapsed, the petitioner's orthodontist again examined her teeth, but did not make new x-rays and molds. On April 11, 1990 he sent a "Champus form" containing measurements and an evaluation and treatment statement to the State Department of Health requesting prior authorization for Medicaid coverage. That form did not claim that treatment was needed to alleviate pain. The orthodontist's nurse sent the "records" made in September of 1988 along with the requests. Although the "Champus form" was used, the dentist was not asking for authorization to make models and take x-rays as he had already done so.

10. After having received no reply to the April 1990 request form, the orthodontist's assistant, at the request of the petitioner, called the Department of Health on September 6, 1990 and was told that the "records" were never received. She learned for the first time from the Department that new records had been authorized June 13, 1990 and was advised to begin again and make the new "records" and submit a new claim form.

11. On November 13, 1990, the petitioner's orthodontist took new x-rays and made a new model which was sent for completion to a lab. He also submitted one of the required claims forms at that time. There is no evidence that these forms contained any claim that the procedures were needed to alleviate pain. On December 15, 1990, after the model was

received from the labs, her orthodontist filled out a new complete treatment plan form for the petitioner. However, the form and the new "records" were not submitted immediately based on advice from the Division of Dental Health that all new applications should be held until January 15, 1991, at which time new criteria for authorizing procedures were expected to be completed and published. In early January, a response to the November 13 form was received stating that orthodontic "records" submitted prior to January 1, 1991 no longer require prior authorization.

12. Two letters dated January 3, 1991 and January 4, 1991 were mailed to all Vermont dentists by the Director of Dental Health Services detailing the procedures and criteria under the new orthodontic program. The petitioner's orthodontist did not receive these initial mailings until March and April of 1991. Other mailings were also sent subsequently.

13. After receiving the mailings and reviewing the new criteria, the petitioner's orthodontist felt that the petitioner's condition did not meet the new criteria. He, therefore, did not submit the treatment plan or "records" he had completed on December 15, 1990.

14. The petitioner's orthodontist did not state in his affidavit why he thinks she would have been eligible for treatment under the old criteria or why he thinks she is not eligible under the new criteria. The only statement he made was that "she was referred to me by [Dr. (a pediatric

dentist)] because she had an anterior and posterior crossbite and was suffering from jaw pain and headaches" and that he had treated 30-40 "similar" cases each year since 1982 under the Medicaid criteria. He did not assess the severity of her jaw pain, the need for orthodontic treatment as a means to relieving her jaw pain nor the chances that jaw pain would be alleviated by the procedure. His examination and reports to the Department of Health do not indicate headaches or jaw pain. Neither do they indicate impaired chewing ability, possible risk to the health of support tissues, nor that the malocclusion was grossly disfiguring. They simply diagnose the petitioner as having a malocclusion consisting of an anterior crossbite.

15. In early June, 1991, the Department of Health received a request from the petitioner for a written decision on what she believed to be her denial for orthodontic services. In that letter, the petitioner stated that "due to severe headaches it has been requested by [her orthodontist] that I need this dental care."

16. Upon receipt of this letter, the Acting Director of the Division of Dental Health called the petitioner's orthodontist to ask that the forms and "records" be sent so that a formal evaluation could be made. The petitioner was notified of that fact.

17. A day or two later, the form and "records" were received by the Department and the petitioner was notified at once that she was not eligible because her case did not

meet the criteria based on a lack of "severity". It was the dental assessor's opinion that her condition was primarily an aesthetic problem.

18. After the appeal was filed, the Acting Director of Dental Health who is himself an expert in dentistry and who had personally assessed the petitioner's claim in June, assessed the claim under the old criteria as well to see if it would have made a difference in her eligibility. It was his opinion that it would not have because her situation was not "crippling", i.e., there was no indication that she had impaired chewing ability, did not affect the health of support tissues, and did not indicate that her malocclusion was grossly disfiguring.

19. The Dental Director, who testified via telephone, characterized the new criteria adopted by the Department as not eliminating the old but rather as making them more specific and clear. He did not believe that headaches alone were a criterion for security because they are difficult to relate to the malocclusion. It was his opinion as well that the existence and severity of a headache related to a malocclusion was an assessment to be made by a physician and not an orthodontist and that no such assessment had been made in this case. As there is no controverting evidence on the medical issue, it is found that the director's opinion as to the lack of expertise of the orthodontist to diagnose headaches and their etiology and assess their severity represents fact.

20. Subsequent to the closure of the record and the first recommendation in this matter, the petitioner attempted to submit some further medical documents regarding the petitioner's condition. The petitioner could offer no reason why these documents were not submitted at the hearing other than her inability to perceive that the petitioner's medical condition was at issue. The documents proffered by the petitioner consist of a statement from her treating physician that he might have discussed headaches and jaw pain with the petitioner but that he had no recollection or record of such a discussion and a "clarifying" affidavit from her orthodontist stating in addition to his prior remarks that jaw pain and headaches associated with chewing in the absence of other causes could be related to a malocclusion and that orthodontic treatment is a medically appropriate intervention which is likely to relieve pain to a significant degree. His affidavit did not discuss any assessment of the extent or degree of any jaw pain or headaches¹ allegedly suffered by the petitioner. Neither did it explain why he felt the petitioner qualified for treatment under either the old or new Medicaid regulations.

ORDER

The decision of the Department is affirmed.

REASONS

The Medicaid regulations provide for the coverage of dental and orthodontic services under the following relevant circumstances:

For recipients who have not reached their 21st birthday dental services are covered when provided by a licensed dentist (DMD or DDS) enrolled in Medicaid.

Covered services include: complete examination and diagnosis including radiographs when indicated; elimination of pain and infection; treatment of injuries; elimination of diseases of bone and soft tissue; treatment of anomalies; restoration of decayed teeth; periodic recall for prophylaxis and treatment services; replacement of missing teeth; treatment of malocclusion with priority for interceptive treatment, treatment of disfiguring and handicapping malocclusion; dentures.

. . .

Some services, such as prosthodontia or orthodontia require prior approval from the Medicaid Dental Consultant. A complete list of procedures which require prior authorization is available from the Medicaid fiscal agent upon request.

. . .

Coverage of orthodontic services is limited to Medicaid recipients under the age of 21. Payment will be made when services are provided in accordance with an approved plan of treatment. Approvals are granted for treatment periods of six months. Bills must be submitted and payments will be made consonant with approved six month periods.

Payments will be made for all services rendered under an approved plan of orthodontic treatment including services rendered to a recipient who has been terminated from Medicaid during the approved treatment period. However, when recipients reach their 21st birthday during a period covered by an approved orthodontic treatment plan, payment will be made only for the portion of the period in which the recipients were under 21.

A partial, proportional payment will be made on behalf of a recipient who becomes newly eligible for Medicaid coverage while undergoing a course of orthodontic treatment which began before Medicaid eligibility. The orthodontic treatment plan must be approved by Medicaid.

M 9 620

Prior to January of 1991, the Department adopted a

policy which provided Medicaid coverage for malocclusions in the following circumstances:

SEVERELY HANDICAPPING MALOCCLUSION - means those conditions of tooth arrangement and/or jaw relationship which present a hazard to the health of tooth supporting structure, a mechanically inefficient masticatory function or a grossly unaesthetic arrangement.

As of January 1991, that criteria was changed to the following:

Orthodontic Need Documentation of a severe malocclusion consisting of at least one major malocclusion criterion or two minor malocclusion criteria. Criteria must be evident on diagnostic records presented for review.

Prospective patients must satisfy all criteria in order to qualify for comprehensive orthodontic treatment. The criteria are applied sequentially during case review. Consequently, a patient failing the review due to oral health status is not reviewed for severity of malocclusion.

Patient age is evaluated as part of eligibility determination. For cases to be eligible for comprehensive orthodontic care, treatment must be able to be completed before loss of coverage due to patient age.

For comprehensive cases, orthodontic need is defined as cases presenting with either one major or two minor criteria for severity of malocclusion.

Criteria for Determining Severity of Malocclusion

<u>Type</u>	<u>Eligible Conditions</u>
Major	Cleft palate 3 congenitally missing teeth, same arch Other severe congenital craniofacial anomalies. Deep bite impinging on the palate Impacted cuspid
Minor	Open bite _ 4 mm Functional shift of mandible _ 2 mm Open bite involving 3 or more adjacent teeth

Anterior crossbite
2 blocked out cuspids, same arch
1 blocked out cuspid
Overjet _ 10 mm
Overbite _ 8 mm

The petitioner does not take issue with the validity of either set of criteria adopted by the Department and appears to concede that she does not meet the new criteria. Rather, the petitioner argues that but for the Department's delay in processing her application for prior approval, she would have been considered under the old criteria. The old criteria, the petitioner argues, were met by the petitioner's condition.

Even if it were found that the Department caused the delay in this matter and that a decision should have been made before January 1, 1991,² the petitioner has put forth no evidence that she met the specific criteria for treatment of malocclusions under the old regulations. Her orthodontist has provided no information that she meets any of these specific criteria, either old or new. The forms he sent to the Department show that the petitioner only has one of the minor criteria--anterior crossbite--which he agrees does not meet the new criteria.

If the petitioner is to be eligible for Medicaid coverage for her orthodontic services, it must be that the service is needed to eliminate pain. See M ə 620 above.

The petitioner has alleged that she has constant severe headaches and jaw pain when chewing certain items which she believes are caused by her malocclusion. If the petitioner

can show that the pain exists, is significant, and is related to and will only be alleviated by the orthodontic procedures requested, it appears that the regulations would provide coverage. In this case, although it can be concluded from the evidence that the petitioner does suffer from headaches from time to time, there is no medical evidence that these headaches are severe or are necessarily related to her malocclusion. The petitioner has presented no diagnosis or treatment statement or records from any physician who may have been helping her with her headaches although she had medical coverage and a regular treating physician. If her headaches were as severe and frequent as she claims, it is inconceivable that a person with the means to do so should not have sought diagnosis or treatment through a physician.

Although the jaw pain was reported to her orthodontist, there is no evidence that he assessed its severity and relation to her malocclusion. He never reported to the Department that she had mechanical difficulty chewing and never indicated such in his affidavit. Neither did he assess whether there were other ways of dealing with any jaw pain she experiences other than this procedure or the possible efficacy of the procedure in this regard. In short, he gave no opinion as to whether she needed this procedure to eliminate pain.

The total lack of corroborating evidence presented at the hearing regarding the severity and etiology of her

headaches and the conflicting circumstantial evidence makes the petitioner unable to sustain her burden of demonstrating her eligibility for this service under the pain criteria. It is not necessary, therefore, to analyze the delay issue.

The final issue here is whether the hearing officer should have allowed the petitioner to submit additional evidence after the record closed and the recommendation was issued. The hearing officer has the discretion to open the record for new evidence under her implied authority to take needed procedural steps to conduct hearings. See In re DeCato Bros. Inc. 149 Vt. 493 (1988). Although not bound by rules used by the judiciary in similar instances, those rules can sometimes provide guidance to exercising discretion. Rule 60 of the Vermont Rules of Civil Procedure give various reasons why a court may give relief, the most relevant which are: (1) mistake, inadvertence, surprise, or excusable neglect; (2) newly discovered evidence which by due diligence could not have been discovered in time to move for a new trial; (3) fraud (whether heretofore denominated intrinsic or extrinsic), misrepresentation, or other misconduct of an adverse party; and (4) any other reason justifying relief from the operation of the judgment.

Certainly an over-riding concern in an administrative benefits case is assuring that all evidence concerning a petitioner is in the record before facts are found affecting eligibility. To that end, the hearing officers usually grant liberal leave to hold the record open for additional

evidence if the petitioner so requests. However, after a petitioner, particularly one who is represented by trained legal personnel, indicates that the record is closed and a recommendation is issued, it is unfair to the opposing party and the process itself to take additional evidence unless some criteria like those above are met. In this case, the petitioner does not claim newly discovered evidence or fraud. Clearly, all the evidence she wished to submit could have been easily available at the hearing. Rather she claims something akin to excusable neglect or surprise in that she could not have known that the petitioner's medical condition was really at issue. Although the petitioner clearly stated her appeal as involving a delay problem, the Department's decision clearly shows that the petitioner's medical condition was very much at issue and, indeed, the very reason for her denial, not her age or the timing of her request. It is difficult, therefore, to conclude that the petitioner has shown that she was understandably surprised or had other good cause for the extraordinary action she requests. If this request were granted on such a flimsy basis, it would open the door for anyone who disagreed with a recommendation to insist on putting in new information to bolster her case just because she was unhappy with the outcome. The havoc such action would wreak with the process is too obvious to belabor here.

It should be noted that even if the "new" evidence were accepted as part of the record, it does almost nothing to

improve the petitioner's case but rather highlights the fact that even with great diligence and digging the petitioner could produce no medical evidence supporting her claim of significant pain caused by her malocclusion. The "new" medical evidence still does not show any medical consultation for headache pain and contains no assessment by anyone, including her orthodontist, as to the severity of the petitioner's jaw pain or the necessity of this procedure in eliminating it. At best, the evidence establishes the petitioner's orthodontist's opinion of a general possible link between jaw pain/headaches and malocclusions and a general possibility of relief from treatment. The evidence which already exists suggests that an orthodontist is not competent to trace the etiology of headache pain; and even if he is able to trace the cause of jaw pain, his failure to answer the above questions with regard to the petitioner's individual care renders his opinion to be of less than decisive weight. The proffered evidence does not provide any information as to how the petitioner may meet any of the other (non-pain related) criteria, old or new. As such, it must be concluded that, even if admitted, the evidence does not support the petitioner's complaint of significant pain related to her malocclusion which can only be and will probably be alleviated by the proposed treatment. As such, it must be concluded that the Department properly denied coverage for the orthodontic treatment.

FOOTNOTES

¹Given the credible testimony of the Department's expert, it is doubtful that the orthodontist is competent to assess the origin of headaches.

²Although the major part of the delay appears to have occurred because of the change over in regulations, there is considerable evidence that the petitioner's dentist sent in the wrong form at one point and totally failed to send in the second set of forms and records based on his belief that it was futile until requested to do so by the Department.

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