

STATE OF VERMONT

HUMAN SERVICES BOARD

In re) Fair Hearing No. 13,332

) & 13,672

Appeal of)

)

INTRODUCTION

The petitioner appeals two decisions of the Department of Social Welfare denying her request for payment of dentures under the Medicaid program and under the General Assistance program.

FINDINGS OF FACT

1. The petitioner is a fifty-four-year-old woman who has diabetes with complications, including amputations, which have resulted in paraplegia. She has had a kidney transplant and now takes drugs to suppress her immune system which also makes her subject to infections. She has recently been treated for infections from bedsores. The petitioner has also developed several small sores in her mouth from dentures which do not fit her properly. She has not developed any infections in those sores.
2. On December 7, 1994, the petitioner applied for Medicaid coverage for a new set of dentures. In support of her request she provided a letter from her physician who confirmed that she has the sores and that they could become infected and present a problem for control of her diabetes. It was his recommendation that new properly fitting dentures be approved as a medical necessity for avoiding "the complications that can occur from ill fitting dentures." The petitioner's dentist also provided a letter stating⁽¹⁾ that her current dentures are broken and ill fitting and affect both her ability to chew and cause her "oral harm in the form of sore spots".
3. The petitioner's request under Medicaid was denied on December 13, 1994, because dentures "are a non-covered adult service". The petitioner appealed that decision but asked that the hearing be put on hold until she could pursue dentures through the General Assistance program.
4. On April 20, 1995, her request for payment of the dentures through the General Assistance program was denied. The notice gave several reasons: (1) the petitioner's income during the last thirty days was in excess of regulatory standards; (2) her resources are greater than her emergency need; (3) she has failed to seek out income from other sources; (4) dentures are not covered by the GA program; and (5) her situation was not considered catastrophic under the GA program. After review by the Commissioner,

the Department conceded that dentures are sometimes paid for under GA but stood by its decision that the petitioner could not meet regular GA requirements because of her income and because of the lack of emergency involved. The Department particularly relied on its belief that the petitioner had about \$1500 available which she could borrow through her life insurance policy. The petitioner's situation was also deemed non-catastrophic because of the lack of an emergency.

5. The petitioner appealed and consolidated both hearings. The evidence presented at hearing shows that the petitioner's only source of monthly income is social security disability benefits of \$819. From that total, the petitioner must pay for all of her household expenses including a \$96 per month mortgage, \$50 in unreimbursed medical expenses and the usual expenses for taxes, insurance, utilities, credit cards, groceries and home maintenance. The petitioner uses almost her entire check on these expenses and has no additional income from which to purchase dentures which will cost about \$800. Recently, she also had the additional expense of paying room and board of \$275 per month to her daughter after her doctor advised her not to live alone following an accident which resulted in a broken arm. After living at her daughter's for a short while, the petitioner entered a Medicaid covered nursing home on a temporary basis where she lived at the time of the hearing.

6. The petitioner has \$1,511.64 available as a loan amount against her life insurance policy. She has borrowed from this policy before, approximately fifteen years ago. She does not know how she would pay back a loan she borrows as she cannot make monthly payments from income. Her prior loan, which was approximately \$600, was repaid through dividends owed to her. Other than the life insurance policy which the petitioner bought to pay for her burial expenses, she has no other resources.

7. After the decisions were made, the petitioner presented a further letter from her dentist which states as follows:

This letter serves to support our belief that [petitioner] would be best aided by placement of upper and lower dentures. [Petitioner] suffers from diabetes. Her oral health is of great importance. Properly fitted dentures would allow her to maintain a better level of overall health and avoid possible infections which can occur from sores created by ill-fitting dentures.

8. The petitioner has presented no evidence that she must have dentures in order to treat a nutritional deficiency, gastrointestinal disorder or temporomandibular joint syndrome. The petitioner has offered no evidence that dentures in general are a medical necessity for her other than in relation to contributing to her overall health. She has not shown that dentures are a necessary part of her treatment for diabetes nor has she shown that without dentures she is likely to suffer immediate harm. The petitioner does suffer some discomfort and sores in her mouth from wearing her current ill fitting dentures. She has not shown that she would suffer the same discomfort and injury if she wore no dentures.

ORDER

The decisions of the Department denying eligibility for dentures under both the Medicaid and General Assistance programs are affirmed.

REASONS

There is no question that the petitioner's overall health and well-being would be improved by the provision of dentures which fit her and that well-fitted dentures are medically necessary and desirable in

terms of her ability to chew her food properly. The Commissioner recognized as much in a letter to the petitioner's attorney. However, the Department has adopted regulations which prohibit the payment for this medical service as follows:

Effective January 1, 1989, coverage of dental services is extended to recipients age 21 and older. The scope of the program includes emergency dental care for relief of pain, bleeding and infection, selected preventive and restorative procedures rendered to limit disease progression, and necessary diagnostic and consultative services.

Covered services include:

- o Oral examinations - including oral cancer screenings
- o Diagnostic care services - radiography and related testing
- o Preventive/Restorative care - limited to oral prophylaxis, root planing and scaling, amalgam and composite restorations, and placement of prefabricated crowns.
- o Endodontia - not to exceed three teeth treated per person
- o Oral surgery - all necessary surgery for tooth removal, and palliative treatment, such as abscess drainage. Third molar surgery will initially require authorization prior to treatment.

Rehabilitative, cosmetic, or elective procedures are not covered. Services not covered include:

- o Cosmetic dentistry
- o Bonding
- o Sealants
- o Periodontal surgery
- o Non-surgical, comprehensive/periodontal care
- o Orthodontia
- o Crown and bridge
- o Dentures (full or partial)
- o Elective care

Other program limits include:

- o Annual benefits maximum \$400 per person

o Services:

limits same as in M620

o Prior Authorization:

a complete list of procedures which require prior authorization is available from the Medicaid fiscal agent upon request.

o Procedure Review:

all services reviewed during post-audit for appropriateness.

M621

In the event that the provision of dentures were needed to relieve pain or to stop bleeding and infection or the like, the above regulation appears to require their provision. Otherwise dentures are not to be covered, even to rehabilitate a person's dentition needed for eating. The Board has interpreted this regulation and other provisions in the Medicaid regulations as requiring the provision of dentures in some very narrow circumstances, such as alleviating the pain of temporomandibular joint syndrome, Fair Hearing #10,379 and #11,207; and providing a prosthetic form of dentition when it was medically necessary and the only way to treat another covered disease such as serious gastro-intestinal or nutritional disorders, Fair Hearings No. 12,180 and 12,210.

The petitioner is a very sick person but has not shown that she needs to have dentures to alleviate pain or as a necessary treatment for her diabetes. The petitioner's discomfort and mouth sores are caused by wearing dentures that don't fit her. There is every reason to suppose that the chewing pain and sores would go away if she stopped wearing the dentures. The petitioner has not shown that a lack of dentures presents some specific problem for her in terms of the treatment of her disease. Naturally, it would be better for her and everyone to have some sort of dentition for chewing food but Medicaid will not pay for dentures for that purpose alone. Neither can dentures be provided as a measure to prevent some potential harm which does not now exist and which may never occur (such as potential TMJ, potential infections or bleeding). Fair Hearing No. 11,625. It cannot be concluded that the petitioner's situation as currently portrayed by the evidence makes her eligible for the provision of new dentures under the Medicaid program.

Turning to her eligibility for General Assistance, an assessment must be made as to whether she meets the eligibility criteria for that program. There are two ways to become eligible for GA, one is by meeting the criteria for regular "emergency" help and the other is by meeting the criteria for help in a "catastrophic situation". W.A.M. 2600 and 2602.

The pertinent regulations for regular eligibility to meet "emergency needs which cannot be met by other programs" are as follows:

B. Except as specifically provided in 2602 (catastrophic situations), General Assistance shall be granted to applicants who have no minor dependents included in their application only if they:

1. are not able-bodied . . . and meet the conditions of C (1-6) below,

...

C. . . .

1. Have received during the 30-day period immediately prior to application net income computed pursuant to General Assistance regulations which is below the applicable ANFC payment level for that size household in similar living arrangements.
2. Have not been disqualified for ANFC or Medicaid benefits because of their refusal to comply with a program eligibility requirement; . . .
3. Actively pursue all potential sources of income, such as ANFC, SSI/ABATE, Medicaid, Social Security benefits, Veterans benefits, wages, unemployment or workmen's compensation, support, insurance, etc. Pursuit of income means initiating an application and cooperating with requirements for a timely decision; and:
4. Have emergency need; and:
5. Have exhausted all available income and resources except that:
 - a. Applicants who have available resources less than their need shall have the amount of the resources deducted from the G.A. grant.
 - b. Single individuals age 62 or over, or in receipt of SSI/ABATE or social security based on blindness or disability, may have up to \$1,500 of available resources disregarded. . . . Only resources in excess of these amounts will be counted as "available" in determining eligibility or benefits for such persons, excluding eligibility and benefits payable relating to burial expenses (Section 2640-2648).
 - c. Resources which have been set aside in an escrow account for the purpose of paying property taxes or insurance shall be disregarded except as to their availability for payment of such intended expenses.
6. Have complied with the employment requirements in 2607.1, if applicable.

W.A.M. § 2600

Under these regulations, the petitioner must meet all of the above requirements to be eligible for "regular" general assistance. However, the facts show that the petitioner cannot even meet the first requirement. Her income from Social Security for the preceding thirty days was \$819, an amount which is entirely countable under GA regulations. W.A.M. 2608. She is entitled to no deductions under the regulations. See W.A.M. 2608.1-6. The maximum payment level for a one-person ANFC household is \$411.64 per month. W.A.M. 2245. She has almost double the income level set as a maximum.

Because she fails the first requirement, it is not necessary to examine the rest in any detail, although it should be noted that the petitioner's failure to show an "emergency need", as discussed further below, is also a disqualifying obstacle. Also, the Department's determination that the petitioner had available

resources which disqualified her is certainly inconsistent with the regulations themselves which specifically exempt \$1500 for persons who have a disability. W.A.M. 2600(5)(b).

The second category for GA eligibility disregards the above requirements in certain "catastrophic situations" and provides as follows:

Any applicant who has exhausted all available income and resources and who has an emergency need caused by one of the following catastrophic situations may have that need which is indeed caused by the catastrophe met within General Assistance standards disregarding other eligibility criteria. Subsequent applications must be evaluated in relation to the individual's potential for having resolved the need within the time which has elapsed since the catastrophe to determine whether the need is now caused by the catastrophe or is a result of failure on the part of the applicant to explore potential resolution of the problem:

...

d. An emergency medical need. Actions which may be evaluated as emergency in nature include, but are not limited to, the following:

1. Repair of accidental injury;
2. Diagnosis and relief of acute pain;
3. Institution of treatment of acute infection;
4. Protection of public health; or
5. Amelioration of illness, which if not immediately diagnosed and treated could lead to disability or death.

W.A.M. 2602

The Department has refused to grant assistance to the petitioner under these provisions for two reasons, the first is her lack of an emergency as defined in W.A.M. 2602 and in W.A.M. 2623 regarding covered dental care; the second is her possession of a resource which could be used to cover her dentures.

The regulations, which are not exhaustive, would include the petitioner's request for dentures if needed to relieve acute pain, infection or to ameliorate a serious illness likely to lead to disability or death. The regulations covering dental care at W.A.M. 2623 further provide that:

[t]o be considered an emergency, care must be rendered to relieve pain, bleeding and/or infection. Payment shall not be made for preventive or routine examinations or treatment, for replacement of missing teeth or for dentures.

The Department does not rely on the language above which appears to prohibit payment for dentures, stating that it does make exceptions to this rule. However, the Department does maintain that the petitioner's request for new dentures does not meet the criteria for relief from pain, bleeding and/or

infection found in both sections which would identify the request as an "emergency".

The facts as presented by the petitioner in this matter do not indicate that she does have acute pain, bleeding or infection at present. Even if she did, it appears that she could obtain relief by not wearing the ill-fitting dentures. This analysis is much the same as the one under Medicaid in terms of distinguishing rehabilitation from emergent need. The petitioner has put forth no evidence from which it can be concluded that her need for a new set of dentures is emergent under some other definition of that term. Helpful, beneficial or even "medically necessary" are not descriptions which can meet the kind of criteria described as "catastrophic" above.

As the petitioner has shown no emergency need for any kind of dentures, it is not necessary to examine whether she should be given a resource exemption, as she argues, under the catastrophic situation category. In essence, she has failed to show the kind of emergency need contemplated under either version of General Assistance and as such cannot be assisted under that program. As the Department's decision is in accord with its regulations, affirmation by the Board is compelled. 3 V.S.A. § 3091(d).

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1. The original letter asked only for reimbursement for upper dentures. She has since provided documentation of her need for upper and lower dentures.