

STATE OF VERMONT

HUMAN SERVICES BOARD

In re) Fair Hearing No. 18,803
)
Appeal of)
)

INTRODUCTION

The petitioner appeals a determination by the Department of Prevention, Assistance, Transition, and Health Access (PATH) denying payment for gingivectomy surgery under the Medicaid program.

FINDINGS OF FACT

1. The petitioner is a Medicaid recipient who was advised by her dentist last spring that she needed periodontal surgery to treat gingivitis. The petitioner says that she discussed this need with her PATH worker who told her that dental services are covered by Medicaid.

2. The petitioner made an appointment for the surgery and informed the oral surgeon that she was a Medicaid recipient and that her PATH worker said that dental services would be covered.

3. PATH's contract with dental providers includes a list of procedures that are covered and not covered. The contract informs providers that gingivectomy procedures are

not covered. However, PATH also informs providers that they may request an exception by requesting and receiving authorization prior to rendering the service. The contract also tells providers that if Medicaid will not be covering a procedure, the provider is required to tell the beneficiary in advance of the service that the beneficiary will be expected to pay the bill directly and obtain a written verification of this notification. If the provider bills Medicaid for a procedure and is denied, he is not allowed to then send the bill to the beneficiary.

4. The petitioner's dental provider did not contact Medicaid to determine the extent of the petitioner's dental coverage nor did he request a prior authorization exception. He did not inform the petitioner before the surgery that she would have to pay for the surgery herself.

5. The surgery was provided to the petitioner on May 19, 2003 and was billed to Medicaid.

6. Medicaid notified the provider in June of 2003 that it was denying coverage for the periodontal surgery but did not give a reason. No notice was sent to the petitioner of this denial.

7. On July 2, 2003, after Medicaid denied the claim, the provider billed the petitioner directly for the service,

saying that she was now the responsible party. The petitioner contacted her PATH worker to attempt to determine why the claim was not paid by Medicaid. The PATH worker forwarded the inquiry to the claims determination unit. She also advised the petitioner to call the health access office. The petitioner did so but was told that it was not a covered service and that she had no recourse.

8. The petitioner received a second bill from the provider in October of 2003. Since she had not received a satisfactory response from PATH about the reason for the denial, she contacted her worker again to find out what had happened. At that point PATH's dental consultant called the provider to tell him that a gingivectomy is not a covered service and that prior authorization was never requested. He also informed the provider that having already billed Medicaid, he could not now bill the petitioner for the service. At the provider's request, a written denial dated November 3, 2003 containing these reasons was issued to both the petitioner and the provider.

9. The petitioner received another bill for the service on November 25, 2003. She requested a fair hearing on the denial saying that her PATH worker had misled her and her physician about her eligibility for services and that the

failure of PATH to pay this claim under Medicaid would strain relations between herself and the provider.

10. PATH intends to contact the petitioner's provider to warn him that his continued attempt to bill her is in violation of his program contract and that he faces sanctions for that violation. PATH maintains that this dispute is between the provider and its medical office and has no consequence for the petitioner.

ORDER

The decision of PATH is affirmed.

REASONS

PATH's Medicaid coverage regulations for adult dental services exclude certain procedures from coverage:

M621.6 Non-Covered Services

Unless authorized for coverage via M108¹, services that are not covered include: cosmetic procedures; and certain elective procedures, including but not limited to: bonding, sealants, periodontal surgery, comprehensive periodontal care, orthodontic treatment, processed or cast crowns and bridges.

(emphasis supplied)

The contract between PATH and its Medicaid providers clearly defines a gingivectomy as non-covered periodontal

¹ This is the prior authorization exception provision.

surgery. The contract, consistent with PATH's regulation, tells providers that an exception to this non-coverage status must be requested prior to the provision of the service. The petitioner's provider either knew or should have known that this is not a Medicaid covered procedure and that he had to make a prior authorization request before providing this service to the Medicaid recipient. The provider cannot rely on assurances from the recipient as to coverage but must follow the schedule provided to him by PATH. PATH was correct under its own regulations in denying his claim both because the service is not covered and because the provider did not make a prior authorization request before rendering the service.

The petitioner has been put in a frustrating situation by her provider's failure to follow procedures and by PATH's failure to provide her with a timely and definitive answer about the reasons for the claim's denial. However, PATH is correct that these failures have no economic consequences for her as she is not legally required to pay the bill. The physician did not make a prior arrangement with her to bill her privately and cannot now bill her after Medicaid has denied the claim. While this may be cold comfort for her since she desires to maintain a good relationship with her

provider, that desire cannot be turned into an obligation on the part of PATH to pay this claim contrary to Medicaid regulations. As PATH's denial of this claim is consistent with its regulations, it must be upheld by the Board. 3 V.S.A. § 3091(d), Fair Hearing Rule 17.

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