

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
DEPARTMENTAL APPEALS BOARD

**DECISION OF MEDICARE APPEALS COUNCIL**  
**Docket Number: M-11-2065**

**In the case of**

**Claim for**

G.S.

Medicare Advantage  
(MA) (Part C)

\_\_\_\_\_  
(Appellant)

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\_\_\_\_\_  
(Beneficiary/Enrollee)

\_\_\_\_\_  
(HIC Number)

Health Net of California

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(Medicare Advantage  
Organization (MAO)/MA Plan)

\_\_\_\_\_  
(ALJ Appeal Number)

**INTRODUCTION**

The Administrative Law Judge (ALJ) issued a partially favorable decision, dated May 10, 2011. In pertinent part, the ALJ determined that the Medicare Advantage Organization (Health Net Seniority Plus Amber II Plan - HMO) was not required to authorize certain outpatient dental services requested by the appellant enrollee. The appellant has asked the Medicare Appeals Council (Council) to review this action.

The Medicare Advantage (MA) regulation codified at 42 C.F.R. § 422.608 states that "[t]he regulations under part 405 of this chapter regarding MAC review apply to matters addressed by this subpart to the extent that they are appropriate." The regulations "under part 405" include the appeal procedures found at 42 C.F.R. part 405, subpart I. With respect to original Medicare "fee-for-service" appeals, the subpart I procedures pertain primarily to claims subject to the Medicare, Medicaid and SCHIP Benefits Act of 2000 (BIPA) and the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), 70 Fed. Reg. 11420, 11421-11426 (March 8, 2005). The Council has determined, until there is amendment of 42 C.F.R. part 422 or clarification by the Centers for Medicare & Medicaid Services (CMS), that it is "appropriate" to apply, with certain

exceptions, the legal provisions and principles codified in 42 C.F.R. part 405, subpart I to this case.

The Council reviews the ALJ's decision *de novo*. 42 C.F.R. § 405.1108(a). The Council will limit its review of the ALJ's action to the exceptions raised by the party in the request for review, unless the appellant is an unrepresented beneficiary. 42 C.F.R. § 405.1112(c). The appellant's request for review and subsequent interim correspondence are admitted into the record as Exhibits (Exhs.) MAC-1 and MAC-2, respectively. The MA plan has not filed a response. For the reasons set forth below, the Council adopts the ALJ's decision.

### BACKGROUND

This case involves the enrollee's request for the MAO to pay for dental services reflected in a proposed treatment plan with HCPCS codes D1110 (adult prophylaxis), D7210 (Root Tip Extractions (surgical)), D2330 (one surface anterior composite), D2392 (two surface posterior composite), D2391 (one surface posterior composite), D2332 (three surface anterior composite), D2750 (PFM crown), D5281 (unilateral partial dentures), and D5212 (mandibular stayplate). Dec. at 4, 5 n2.<sup>1</sup> The enrollee's supporting diagnosis was "diverticulosis of the colon" (ICD-9-CM code 562.10). *Id.* at 4. The enrollee's dentist provided a letter, dated January 12, 2010, "ask[ing] the plan to approve the dental care and assert[ing] that the beneficiary required a normal set of molars and dentures in order to thoroughly masticate his food." *Id.*<sup>2</sup>

The MAO denied the enrollee's request on grounds that "the dental services requested were not a covered benefit under Medicare or the health plan." Dec. at 4. MAXIMUS Federal Services, the Independent Review Entity (IRE), affirmed the denial on reconsideration. *Id.* at 5. The enrollee requested an ALJ hearing, and the ALJ conducted a videoteleconference hearing on March 2, 2011. *Id.* The ALJ issued the instant partially favorable decision after proffering post-hearing evidence to the parties and entering that evidence into the record. *Id.*

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<sup>1</sup> CMS has developed the Healthcare Common Procedure Coding System (HCPCS) to establish "uniform national definitions of services, codes to represent services, and payment modifiers to the codes." 42 C.F.R. § 414.40(a).

<sup>2</sup> The MAO's initial denial of coverage indicates that the requesting provider was an "out of network provider." Exh. 3, at 11.

The ALJ stated that the enrollee had "significant medical impairments" and that at least one physician had recommended the proposed dental care as appropriate for the enrollee's condition. Dec. at 9. The ALJ framed the issue for decision as "whether the Medicare Advantage Organization is obligated to cover the requested dental services." *Id.* After extensively examining applicable Medicare law and the MAO's supplemental benefits and Evidence of Coverage (EOC), the ALJ concluded that the MAO was obligated to cover certain diagnostic, prophylactic, and restorative treatments (HCPCS codes D1110, D2391, and D2392), but was not obligated to authorize or cover the outpatient dental services (HCPCS codes D7210, D2330, D2332, D2750, D5281, and D5212). *Id.* at 12.

The beneficiary enrollee filed a request for Council review on July 11, 2011. Exh. MAC-1. The enrollee contends that MAO representatives had verbally advised him by telephone of a disclaimer to the printed EOC, which the enrollee had written down. *Id.* The enrollee argues that the ALJ "totally ignored its existence & did not tell Health Net to provide a written copy, even though it was the basis of my appeal." *Id.* An attachment to the Form DAB-101 request for review, prepared and signed by the enrollee, contains the following statement:

Health Net Disclaimer  
Re: Policy Limitations and Exclusions  
Relating to Dental Care

Under your Professional Services, dental services when medically necessary to properly monitor, control, or treat a severe medical condition when excluded services are being performed are covered at a zero dollar co-pay."

*Id.* at 2.<sup>3</sup>

### DISCUSSION

In his decision, the ALJ first noted that the enrollee indeed had significant medical impairments and that a treating physician/dentist had recommended the dental procedures. Dec. at 9. The ALJ also acknowledged that the enrollee maintained

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<sup>3</sup> The appellant also includes a letter from physician J.A., dated February 24, 2011, which does not differ in any material respect from a letter from the same physician, dated January 27, 2011, which was in the record before the ALJ. Compare Exh. MAC-1, at 3 with Exh. 11, at 6.

that the "dental care is medically necessary to address serious health problems" and that, according to a letter from the enrollee, his primary physician had indicated that the enrollee's digestive problems "were the result of his inability to properly masticate food due to recently extracted molars." *Id.* The ALJ also quoted the disclaimer that the enrollee enclosed with the request for review. *Id.*; see Exh. MAC-1, at 2. The ALJ again acknowledged this disclaimer later, but, after reviewing the enrollee's testimony and an MAO telephone call log, stated as follows:

While the undersigned is not unsympathetic to the beneficiary, the undersigned can neither infer nor conclude that conversations between the beneficiary and the customer service representative(s) for the plan, if reflected in a call log or some other vehicle, such as a recording, would override the plain language of the evidence of coverage and the supplemental dental coverage, as discussed herein.

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The prior conversations between the beneficiary and members of the Medicare Managed Care Organization are not probative on the matter of coverage in the absence of corresponding provisions within the EOC with supplemental benefit coverage.

*Id.* at 10. As noted, the ALJ subsequently examined the MAO plan documents and concluded that the MAO would cover certain diagnostic, prophylactic, and restorative services, but would not cover the outpatient dental services. *Id.* at 12.

The Council has considered the record and the enrollee's exceptions, but sees no basis for disturbing the ALJ's comprehensive and well-reasoned decision. As the ALJ noted, original Medicare excludes coverage of "dental services in connection with the care, treatment, filling, removal, or replacement of teeth, or structures directly supporting the teeth . . . , except for inpatient hospital services in connection with such dental procedures when hospitalization is required because of the individual's underlying medical condition and clinical status or the severity of dental procedures. (See 42 C.F.R. § 411.15(i))." Dec. at 9; see section 1862(a)(12) of the Social Security Act (Act).

As the ALJ stated, the only exception to the dental exclusion that Congress enacted is for hospital-related costs when a beneficiary undergoing dental surgery must be admitted to the hospital as an inpatient. In such circumstances, only the hospital-related costs are covered, under Medicare Part A, and not the dental services themselves. As the ALJ noted, the dental services at issue in this case would be provided on an outpatient basis.

The Medicare Benefit Policy Manual (MBPM) also allows two additional exceptions to the dental exclusion. First, Medicare will cover the extraction of teeth to prepare the jaw for radiation treatment of neoplastic disease. MBPM (Pub. 100-02), Ch. 16, § 140. In addition, if an otherwise non-covered procedure or service is performed by a dentist as incident to and as an integral part of a covered procedure or service *performed by the same dentist*, the total service performed by the dentist on such occasion is covered. MBPM, Ch. 15, § 150. Medicare has also issued a National Coverage Determination (NCD) which provides for coverage of an oral or dental examination performed on an inpatient basis as part of a comprehensive workup prior to renal transplant surgery. Medicare National Coverage Determinations Manual (MNCDM)(Pub. 100-03), § 260.6. As is clear from the record, the enrollee requests services that do not fall within the exceptions for radiation treatment of cancer of the jaw or preoperative services for renal transplants.

The EOC states that “[s]ervices by a dentist or oral surgeon are limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments for neoplastic disease, or services that would be covered when performed by a doctor.” Exh. 1, EOC at 76. This is consistent with the coverage criteria under original Medicare. Even accepting at face value the terms of the Disclaimer the enrollee cites, the Disclaimer is also consistent with the EOC. “[D]ental services when medically necessary to properly monitor, control, or treat a severe medical condition when excluded services are being performed,” are the same types of “services that would be covered when performed by a doctor.” These services are necessary to incidentally “monitor, control, or treat” a coexisting medical condition during dental treatment, but this does not extend coverage to otherwise excluded dental services that, if successful, may also have a positive effect on an underlying medical condition.

Thus, unless the dental or dental-related services at issue fall within one of these narrow exceptions, the services are not covered by Medicare. It is the *nature of the service* being performed that determines Medicare coverage, not the purpose for which it is furnished. In other words, the service is excluded from Medicare coverage if it is "in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting teeth." Absent one of the limited exceptions, Medicare's dental services exclusion applies irrespective of the beneficiary's underlying medical condition.

#### **CONCLUSION**

For the foregoing reasons, the Council adopts the ALJ's decision that the Medicare Advantage Organization is not required to authorize or provide the enrollee with outpatient dental services under HCPCS codes D7210, D2330, D2332, D2750, D5281, and D5212. The MAO is required to provide the diagnostic, prophylactic, and restorative services requested by the enrollee under HCPCS codes D1110, D2391, and D2392.

MEDICARE APPEALS COUNCIL

/s/ Clausen J. Krzywicki  
Administrative Appeals Judge

Date: September 12, 2011