STATE OF MICHIGAN
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
FOR THE DEPARTMENT OF COMMUNITY HEALTH
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(877) 833-0870; Fax: (517) 334-9505

IN THE MATTER OF:

Docket No. 2011-32550 PA
Case No. [redacted]

[redacted],

Appellant
_____/

DECISION AND ORDER

This matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9 and 42 CFR 431.200 *et seq.,* upon the Appellant's request for a hearing.

After due notice, a hearing was held on [redacted], the Appellant, appeared on her own behalf. [redacted], represented the Department. [redacted], appeared as a witness for the Department.

ISSUE

Did the Department properly deny the Appellant's request for prior authorization for a complete lower denture?

FINDINGS OF FACT

The Administrative Law Judge, based upon the competent, material and substantial evidence on the whole record, finds as material fact:

1. The Appellant is a Medicaid beneficiary.

2. On [redacted], the Department received a prior authorization request for a complete lower denture from the Appellant's dentist. (Exhibit 1, page 6)

3. On [redacted], the Department determined that the Appellant did not qualify under the 5 year rule. The payment history indicated that partial upper and lower dentures were placed [redacted]. (Exhibit 1, pages 6-7)

4. On [redacted], the Department sent the Appellant a Notification of Denial. (Exhibit 1, pages 4-5)

5. On [redacted], the Appellant's Request for a hearing was received. (Exhibit 1, pages 2-3)

CONCLUSIONS OF LAW

The Medical Assistance Program is established pursuant to Title XIX of the Social Security Act and is implemented by Title 42 of the Code of Federal Regulations (CFR). It is administered in accordance with state statute, the Social Welfare Act, the Administrative Code, and the State Plan under Title XIX of the Social Security Act Medical Assistance Program.

1.10 PRIOR AUTHORIZATION

> Medicaid requires prior authorization (PA) to cover certain services before those services are rendered to the beneficiary. The purpose of PA is to review the medical need for certain services.
>
> *MDCH Medicaid Provider Manual, Practitioner Section, January1, 2011, page 4.*

The issue in this case is whether the Department properly applied the five year rule for denture coverage. *MDCH Medicaid Provider Manual, Dental Section, January 1, 2011, pages 17-18,* outlines coverage for dentures:

6.6 PROSTHODONTICS (REMOVABLE)

6.6.A. GENERAL INSTRUCTIONS

> Complete and partial dentures are benefits for all beneficiaries. All dentures require PA. Providers must assess the beneficiary's general oral health and provide a five-year prognosis for the prosthesis requested. An upper partial denture PA request must also include the prognosis of six sound teeth.
>
> Complete or partial dentures are authorized:
>
> - If there is one or more anterior teeth missing;
> - If there are less than eight posterior teeth in occlusion (fixed bridges and dentures are to be considered occluding teeth); or
> - Where an existing complete or partial denture cannot be made serviceable through repair, relining, adjustment, or duplicating (rebasing) procedures. If a partial denture can be made serviceable, the dentist should provide the needed restorations to maintain use of the existing partial, extract teeth, add teeth to an existing partial, and remove hyperplastic tissue.

> Before final impressions are taken and any construction begun on a complete or partial denture, healing adequate to support a prosthesis must take place following the completion of extractions or surgical procedures. This includes the posterior ridges of any immediate denture. An exception is made for the six anterior teeth (cuspid to cuspid) only when an immediate denture is authorized.
>
> Reimbursement for a complete or partial denture includes all necessary adjustments, relines, repairs, and duplications within six months of insertion. This includes such services for an immediate upper denture when authorized.
>
> If a complete or partial denture requires an adjustment, reline, repair, or duplication within six months of insertion, but the services were not provided until after six months of insertion, no additional reimbursement is allowed for these services.
>
> Complete or partial dentures are not authorized when:
>
> - **A previous prosthesis has been provided within five years, whether or not the existing denture was obtained through Medicaid.**
> - An adjustment, reline, repair, or duplication will make them serviceable.
> - Replacement of a complete or partial denture that has been lost or broken beyond repair is not a benefit within five years, whether or not the existing denture was obtained through Medicaid.
>
> Medicaid Provider Manual, Dental Section,
> Version date January 1, 2010
> Pages 17-18.
> (emphasis added by ALJ)

The Department introduced the Appellant's Medicaid beneficiary payment history into evidence showing that partial upper and lower dentures were placed [redacted]. (Exhibit 1, page 7) The Medicaid Utilization Analyst explained that the Appellant's [redacted], prior authorization request for a complete lower denture was denied because the Appellant had a lower dental prosthesis provided within the past five years. The Medicaid Utilization Analyst testified that the denial was in accordance with the policy outlined in the Dental Section of the Department's Medicaid Provider Manual.

The Appellant disagrees with the denial and testified she has lots of physical problems that could get worse. She stated that a medication she takes causes dry mouth and her

doctor is concerned about her low blood count. The doctor indicated that the Appellant's anemia may be due to not being able to eat the right foods and he is considering a blood transfusion. The Appellant stated that even eating toast makes her gums bleed. The Appellant also explained that the original lower partial was only for her back teeth. The wire and metal from the partial damaged her eye teeth, and the backs of her front teeth. Five of her front teeth have fallen out. (Appellant Testimony)

However, the Appellant's dentist did not note any pertinent medical history on the prior authorization form. (Exhibit 1, page 6) The Appellant submitted a brief letter from her doctor dated [redacted]. (Exhibit 2) The Appellant testified that the doctor is willing to provide more information. However, this letter or any additional information he can provide was not available at the time the Department reviewed the [redacted], prior authorization request.

While this ALJ has sympathy for the Appellant's circumstances, the program parameters do not allow for coverage for dentures more than 1 time in a 5 year period. No indication of a pertinent medical history was provided with the [redacted], prior authorization request for the Department to consider a medical exception to the 5 year rule. The Department provided sufficient evidence that its denial was in accordance with policy based on the information available at the time the [redacted] prior authorization request was reviewed.

If she has not already done so, the Appellant may wish to have her dentist submit a new prior authorization request noting the pertinent medical history. Detailed information from her doctor should be included so that the Department can consider a medical exception to the 5 year rule.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the Department properly denied the Appellant's request for prior authorization for an upper complete denture.

IT IS THEREFORE ORDERED that:

The Department's decision is AFFIRMED.

Colleen Lack
Administrative Law Judge
for Olga Dazzo, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 7/27/2011

***** NOTICE *****

The Michigan Administrative Hearing System may order a rehearing on either its own motion or at the request of a party within 30 days of the mailing date of this Decision and Order. The Michigan Administrative Hearing System will not order a rehearing on the Department's motion where the final decision or rehearing cannot be implemented within 90 days of the filing of the original request. The Appellant may appeal the Decision and Order to Circuit Court within 30 days of the receipt of the Decision and Order or, if a timely request for rehearing was made, within 30 days of the receipt of the rehearing decision.