**STATE OF MICHIGAN**
**MICHIGAN ADMINISTRATIVE HEARING SYSTEM**
**FOR THE DEPARTMENT OF COMMUNITY HEALTH**
P.O. Box 30763, Lansing, MI 48909
(877) 833-0870; Fax: (517) 334-9505

IN THE MATTER OF:

[redacted],

Docket No. 2011-36418 QHP
Case No. [redacted]

Appellant
_____/

## DECISION AND ORDER

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

After due notice, a hearing was held [redacted], the Appellant, appeared on her own behalf. [redacted], Appeals Coordinator, represented [redacted] the Medicaid Health Plan. [redacted], Chief Medical Officer, appeared as a witness for [redacted].

## ISSUE

Did the Medicaid Health Plan properly deny Appellant's request for an oral prosthesis?

## FINDINGS OF FACT

Based upon the competent, material, and substantial evidence presented, I find, as material fact:

1. The Appellant is a [redacted]-year-old female Medicaid beneficiary who is enrolled in [redacted], a Medicaid Health Plan (MHP). (Exhibit A, page 12)

2. On [redacted], the MHP received a request for a custom fabrication oral appliance from the Appellant's dental provider, [redacted]. The attached assessment indicated that the Appellant has cervicalgia, interstitial myosisitis of the masticatory and cervical muscles, TMJ degenerative joint disease bilaterally, and TMJ disc displacement of the right side. (Exhibit A, pages 11-15)

3. On [redacted], the MHP sent the Appellant a denial notice stating that the request for fabrication of an oral prosthesis was not authorized because it is not a covered benefit under the [redacted] Evidence of Coverage Guidelines, specifically noting that the requested code 21085, is not covered per the Michigan Department of Community Health Medicaid Medical Suppliers/Orthotics/Prosthetics/DME Database. (Exhibit A, pages 2-5)

4. On [redacted], the Appellant requested a formal, administrative hearing contesting the denial. (Exhibit 1)

## 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.

On May 30, 1997, the Department received approval from the Health Care Financing Administration, U.S. Department of Health and Human Services, allowing Michigan to restrict Medicaid beneficiaries' choice to obtain medical services only from specified Medicaid Health Plans.

The Respondent is one of those Medicaid Health Plans.

> The covered services that the Contractor has available for enrollees must include, at a minimum, the covered services listed below (List omitted by Administrative Law Judge). The Contractor may limit services to those which are medically necessary and appropriate, and which conform to professionally accepted standards of care. Contractors must operate consistent with all applicable Medicaid provider manuals and publications for coverage(s) and limitations. If new services are added to the Michigan Medicaid Program, or if services are expanded, eliminated, or otherwise changed, the Contractor must implement the changes consistent with State direction in accordance with the provisions of Contract Section 1-Z.
>
> *Article II-G, Scope of Comprehensive Benefit Package. MDCH contract (Contract) with the Medicaid Health Plans, September 30, 2004.*

> The major components of the Contractor's utilization management plan must encompass, at a minimum, the following:
>
> - Written policies with review decision criteria and procedures that conform to managed health care industry standards and processes.
> - A formal utilization review committee directed by the Contractor's medical director to oversee the utilization review process.
> - Sufficient resources to regularly review the effectiveness of the utilization review process and to make changes to the process as needed.
> - An annual review and reporting of utilization review activities and outcomes/interventions from the review.
>
> The Contractor must establish and use a written prior approval policy and procedure for utilization management purposes. The Contractor may not use such policies and procedures to avoid providing medically necessary services within the coverage(s) established under the Contract. The policy must ensure that the review criteria for authorization decisions are applied consistently and require that the reviewer consult with the requesting provider when appropriate. The policy must also require that utilization management decisions be made by a health care professional who has appropriate clinical expertise regarding the service under review.
>
> *Article II-P, Utilization Management, Contract, September 30, 2004.*

As stated in the Department-MHP contract language above, a MHP, "must operate consistent with all applicable Medicaid Provider Manuals and publications for coverages and limitations." The MHP asserted that they properly denied the Appellant's prior authorization request for an oral prosthesis because the code, 21085, is not a covered benefit per the Michigan Department of Community Health Medicaid Medical Suppliers /Orthotics/Prosthetics/DME Database. (Exhibit A, page 2)

However, the Medicaid Provider Manual policy also states:

> **1.2.A. HEALTHCARE COMMON PROCEDURE CODING SYSTEM (HCPCS) CODES**

> The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requirement, as defined by the Code of Federal Regulations (CFR) under 45 CFR 162.10002 for standardized coding systems, established HCPCS level II codes as the standardized coding system for describing and identifying health care equipment and supplies in health care transactions that are not identified by HCPCS level I or Current Procedural Terminology (CPT) codes.
>
> **HCPCS is a system for identifying items and services. It is not a system for making coverage or payment determinations, and the existence of a code does not determine coverage or non-coverage of an item or service**. Decisions regarding the addition deletion, or revision of HCPCS codes are made independent of the process for determination of coverage and payment. (Emphasis added by ALJ)
>
> *Department of Community Health,*
> *Medicaid Provider Manual, Medical Supplier*
> *Version Date: April 1, 2011, Pages 2-3.*

The bottom of each page of the Michigan Department of Community Health Medicaid Medical Suppliers/Orthotics/Prosthetics/DME Database also notes, "This database is not a source for Medicaid coverage policy. For current policy, consult the Medicaid Policy Manual." *Michigan Department of Community Health Medicaid Medical Suppliers/Orthotics/Prosthetics/DME Database* Michigan Department of Community Health Medicaid Medical Suppliers/Orthotics/Prosthetics/DME Database, Version Date January 1, 2011. The MHP should not have based their coverage determination on coding in the database.

During the hearing proceedings, the Chief Medical Officer gave another reason for the denial of the Appellant's prior authorization request for oral prosthetic for the diagnosis of TMJ. He referred to the Molina Member Handbook, which states:

> **25. Oral Splints and Appliances.** Oral Splints and appliances associated with TMJ, orthographic, and oral and maxillofacial surgeries are excluded.
>
> (Exhibit A, page 8)

There is some support for this policy as the Medicaid Provider Manual specifically excludes coverage of TMJ services from dental providers. (Department of Community Health, Medicaid Provider Manual, Dental, Version Date: April 1, 2011, Page 21)

Further, the Medicaid Provider Manual also states:

> **SECTION 1 – GENERAL INFORMATION**
>
> **This chapter applies to Dentists/Dental Clinics.** *(Emphasis added by ALJ)*
>
> ***
>
> **1.1.C. ADULT DENTAL PROGRAM**
>
> Beneficiaries age 21 and older receive dental benefits that are more limited in coverage. Dental benefits are provided through the Medicaid fee-for-service (FFS) Program. **Medicaid Health Plans (MHPs) are not responsible for the coverage of dental benefits for their enrolled beneficiaries.** The Program of All-Inclusive Care for the Elderly (PACE) is responsible for the coverage of dental benefits for PACE enrollees. *(Emphasis added by ALJ)*
>
> *Department of Community Health,*
> *Medicaid Provider Manual, Dental*
> *Version Date: April 1, 2011, Pages 1-2.*

In this case, the prior authorization request and the additional documentation provided with the appeal were submitted by a dentist, [redacted] (Exhibit 1, page 3; Exhibit A, pages 10 and 12-15) Accordingly, the MHP is not responsible for coverage as dental benefits are provided through the Medicaid fee-for-service program for beneficiaries age 21 and older.

While the MHP should not have utilized the coding in the Michigan Department of Community Health Medicaid Medical Suppliers/Orthotics/Prosthetics/DME Database to make their determination, ultimately, the denial must be upheld. The prior authorization request was submitted by the Appellant's dentist, requesting coverage for an oral prosthesis for a diagnosis of TMJ.

## DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the MHP properly denied the Appellant's request for an oral prosthesis.

[redacted]
Docket No. 2011-36418 QHP
Decision and Order

**IT IS THEREFORE ORDERED** that:

The Medicaid Health Plan's decision is AFFIRMED.

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

cc: [redacted]

Date Mailed: 9/20/2011

***** 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.