

**STATE OF MICHIGAN
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
FOR THE DEPARTMENT OF COMMUNITY HEALTH**

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IN THE MATTER OF:

Docket No. 2013-48676 PA

██████████

██████████

██████████

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 ██████████ ██████████ the Appellant, appeared on her own behalf. ██████████ Appeals Review Officer, represented the Department. ██████████, Medicaid Utilization Analyst, appeared as a witness for the Department.

ISSUE

Did the Department properly deny the Appellant's request for prior authorization for upper and lower complete dentures?

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 ██████████, the Department received a prior authorization request for upper and lower complete dentures from the Appellant's dentist. (Exhibit 1, page 7)
3. On ██████████, the Department determined the prior authorization request could not be approved because the x-rays were not technically acceptable and because the Appellant had an active prior authorization with another provider, a letter was also needed explaining which provider the Appellant wanted to utilize to get the dental prostheses. The Department returned the prior authorization

request to the dentist requesting additional information. (Exhibit 1, page 7; Medicaid Utilization Analyst Testimony)

4. On [REDACTED], the Department received a re-submission of the [REDACTED] prior authorization request from for upper and lower complete dentures from the Appellant's dentist. The attached note indicated this was a re-submission requesting retroactive approval. The dental clinic, in error, thought previous return requesting additional information was an approval. Accordingly, the dentures were made for the Appellant. (Exhibit 1, pages 7-8)
5. On [REDACTED] the Department determined the prior authorization request could not be approved because all dentures require prior authorization and providers cannot charge the beneficiary for the provider's failure to obtain authorization. (Exhibit 1, page 7)
6. On [REDACTED], the Department sent a Notice of Denial to the Appellant indicting the prior authorization request was denied because all dentures require prior authorization and providers cannot charge the beneficiary for the provider's failure to obtain authorization. (Exhibit 1, page 6)
7. On [REDACTED], the Appellant's Request for Hearing was received by the Michigan Administrative Hearing System. (Exhibit 1, pages 4-5)

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.

1.9 PRIOR AUTHORIZATION [RE-NUMBERED 4/1/13]

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, April 1, 2013, page 4.*

2.2 COMPLETION INSTRUCTIONS

The Dental Prior Approval Authorization Request form (MSA-1680-B) is used to obtain authorization. (Refer to the Forms Appendix for instructions for completing the form.)

When requesting authorization for certain procedures, dentists may be required to send specific additional information and materials. Based on the MSA-1680-B and the documentation attached, staff approves or disapproves the request and returns a copy to the dentist. Approved requests are assigned a PA number. For billing purposes, the PA number must be entered in the appropriate field on the claim form. An electronic copy of the MSA-1680-B is available on the MDCH website. (Refer to the Directory Appendix for website information.)

*MDCH Medicaid Provider Manual,
Dental Section, April 1, 2013, Page 3*

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.

*MDCH Medicaid Provider Manual,
Dental Section, April 1, 2013, Pages 17-18
(emphasis added by ALJ)*

10.2.D. REIMBURSEMENT

Providers cannot charge the beneficiary or beneficiary's representative for the provider's failure to obtain PA. If the provider failed to obtain PA for a service and the service was rendered, he cannot apply his fee for that service in calculating other reimbursement due to him from Medicaid.

*MDCH Medicaid Provider Manual,
General Information For Providers Section, April 1, 2013, Pages 26- 27*

On [REDACTED], the Department received a prior authorization request for upper and lower complete dentures from the Appellant's dentist. (Exhibit 1, page 7) On [REDACTED], the Department determined the prior authorization request could not be

approved without additional information. The x-rays were not technically acceptable¹. Additionally, the Appellant had an active prior authorization with another provider, so a letter was needed explaining which provider the Appellant wanted to utilize to get the dental prostheses. The Department returned the [REDACTED] prior authorization request to the dentist requesting additional information. (Exhibit 1, page 7; Medicaid Utilization Analyst Testimony)

On [REDACTED], the Department received a re-submission of the [REDACTED] prior authorization request from for upper and lower complete dentures from the Appellant's dentist. The attached note indicated this was a re-submission requesting retroactive approval. The dental clinic, in error, thought previous return requesting additional information was an approval. Accordingly, the dentures were made for the Appellant. (Exhibit 1, pages 7-8) On [REDACTED] the Department determined the prior authorization request could not be approved because all dentures require prior authorization. The Department also noted that providers cannot charge the beneficiary for the provider's failure to obtain authorization. (Exhibit 1, page 7)

The Appellant disagrees with the denial and testified that as far as she knew the dental clinic had received prior authorization. The dental clinic told her they had the prior authorization. Otherwise, the Appellant would have had to pay up front for the dentures. The Appellant has received the dentures and had not been charged for them. (Appellant Testimony)

The policy is clear that all dentures require prior authorization. The evidence supports the Appellant's testimony that as far as she was aware, the dental provider had obtained prior authorization. The note from the dental clinic acknowledges that they made an error and misunderstood the returned prior authorization request for additional information as an approval. The Department's determination to deny the Appellant's request for [REDACTED] retroactive prior authorization for upper and lower complete dentures because prior authorization was not obtained before the denial clinic provided the service to the Appellant is in accordance with the Department's policy.

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 upper and lower complete dentures based on the available information.

¹ The radiograph submission requirements for complete and partial denture requests can be found in the Dental section of the Medicaid Provider Manual. *MDCH Medicaid Provider Manual, Dental Section, 6.1.F. RADIOGRAPHS*, Pages 11-13.

