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Date Mailed: March 9, 2020
MOAHR Docket No.: 20-000062
Agency No.: [redacted]
Petitioner: [redacted]

**ADMINISTRATIVE LAW JUDGE: Steven Kibit**

## DECISION AND ORDER

This matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9 and upon the Petitioner's request for a hearing.

After due notice, a telephone hearing was held on February 20, 2020. Petitioner appeared and testified on his own behalf. Katie Feher, Manager of Appeals, appeared and testified on behalf of MeridianHealth, the Respondent Medicaid Health Plan (MHP).

During the hearing, Respondent submitted an evidence packet that was admitted into the record as Exhibit A, pages 1-237. Petitioner did not submit any exhibits.

## ISSUE

Did the MHP properly deny Petitioner's prior authorization request for dental services?

## FINDINGS OF FACT

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

1. Petitioner is a Medicaid beneficiary who is enrolled in the Respondent MHP through the Healthy Michigan Plan (HMP). (Exhibit A, pages 12-13; Testimony of Respondent's representative).

2. On November 21, 2019, Respondent's dental vendor, DentaQuest, received a prior authorization request submitted on Petitioner's behalf by his dentist for dental services. (Exhibit A, pages 14-21).

3. As part of that request, Petitioner and his dentist requested both gum surgery/implants and sinus augmentation for Petitioner, with the dentist identifying those services by procedure codes D4266, D6010, and D7951. (Exhibit A, page 14).

4. DentaQuest then reviewed the request and determined that the request for those services should be denied on the basis that the requested services were not covered for Petitioner. (Exhibit A, pages 19-21).

5. On November 22, 2019, Respondent sent Petitioner written notice that the prior authorization request had been denied. (Exhibit A, pages 22-31).

6. Petitioner then filed an Internal Appeal with Respondent regarding the denial of the prior authorization request. (Exhibit A, pages 32-34).

7. On December 16, 2019, Respondent sent Petitioner written notice that Petitioner's appeal had been reviewed and that the authorization request was again denied. (Exhibit A, pages 37-43).

8. With respect to the reason for its decision, Respondent wrote in part:

> Your appeqal [sic] letter said you need these services because your teeth were decayed and you had them removed which is causing you issues whem [sic] chewing your food. You also said that you are not a candidate for partial dentures so you need the implants. The reason for the decision is because the request for you to have of a [sic] gum surgery on tooth #14 (D4266), tooth implants for teeth #14, 15, 18, 19 (D6010), and a procedure that adds bone to your upper jaw called sinus augmentation (D7951) does not meet the 2019 Michigan Department of Health and Human Servueas [sic] and the Medicaid Provider Manual which is based off the Medicaid Dental Fee Schedule because the requested services are not covered under your dental plan. Please follow-up with Dr Stefanac for further care options.
>
> Your appeal and all clinical information were reviewed by a DentaQuest Dental specialist and not involved in the original decision. Following this review, a MeridianHealth Medical Director is upholding the original decision.
>
> *Exhibit A, pages 38-39*

9. On January 10, 2020, the Michigan Office Administrative Hearings and Rules (MOAHR) received the request for hearing filed by Petitioner in this matter regarding Respondent's decision. (Exhibit A, pages 1-8).

## 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.

In 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 MHPs and, as provided in the Medicaid Provider Manual (MPM), is responsible for providing covered services pursuant to its contract with the Department:

> The Michigan Department of Health and Human Services (MDHHS) contracts with Medicaid Health Plans (MHPs), selected through a competitive bid process, to provide services to Medicaid beneficiaries. The selection process is described in a Request for Proposal (RFP) released by the Office of Purchasing, Michigan Department of Technology, Management & Budget. The MHP contract, referred to in this chapter as the Contract, specifies the beneficiaries to be served, scope of the benefits, and contract provisions with which the MHP must comply. Nothing in this chapter should be construed as requiring MHPs to cover services that are not included in the Contract. A copy of the MHP contract is available on the MDHHS website. (Refer to the Directory Appendix for website information.)
>
> MHPs must operate consistently with all applicable published Medicaid coverage and limitation policies. (Refer to the General Information for Providers and the Beneficiary Eligibility chapters of this manual for additional information.) Although MHPs must provide the full range of covered services listed below, MHPs may also choose to provide services over and above those specified. MHPs are allowed to develop prior authorization requirements and utilization management and review criteria that differ from Medicaid requirements. The following subsections describe covered services, excluded services, and prohibited services as set forth in the Contract.

* * *

> The covered services provided to Healthy Michigan Plan enrollees under the contract include all those listed above and the following additional services:
>
> - Additional preventive services required under the Patient Protection and Affordable Care Act as outlined by MDHHS
> - Habilitative services
> - Dental services

*MPM, October 1, 2019 version*
*Medicaid Health Plan Chapter, pages 1-2*
*(internal highlighting omitted)*
*(underline added for emphasis)*

With respect to dental services through the HMP, the MPM further states in part:

> **1.1.D. HEALTHY MICHIGAN PLAN DENTAL**
>
> Beneficiaries enrolled in a health plan will receive their dental coverage through their health plan. Each health plan contracts with a dental provider group or vendor to provide dental services administered according to the contract. The contract is between the health plan and the dental provider group or vendor, and beneficiaries must receive services from a participating provider to be covered. Questions regarding eligibility, prior authorization or the provider network should be directed to the beneficiary's health plan. It is important to verify eligibility at every appointment before providing dental services. Dental services provided to an ineligible beneficiary will not be reimbursed.
>
> For those beneficiaries who are not enrolled in a health plan, dental services will be provided by enrolled dental providers on a FFS basis.

*MPM, October 1, 2019 version*
*Dental Chapter, pages 2-3*
*(underline added for emphasis)*

As allowed by the above policy and its contract with the Department, the MHP and its dental provider group or vendor have developed prior authorization requirements and utilization management and review criteria, and have limited coverage of dental services

to those consistent with all the Department's applicable published Medicaid coverage and limitation policies.

Moreover, with respect to the dental coverage through the Department, the MPM states in part:

> **SECTION 6 – COVERED SERVICES**
>
> This section provides information on Medicaid covered services and is divided into the following subsections that correspond to the categories of services in Current Dental Terminology (CDT) as published by the American Dental Association.
>
> - Diagnostic Services
> - Preventive Services
> - Restorative Treatment
> - Endodontics
> - Periodontics
> - Prosthodontics (Removable)
> - Oral Surgery
> - Adjunctive General Services
>
> Providers must use the current CDT procedure codes published by the American Dental Association (ADA) when completing both the claim and PA form. Refer to the Additional Code/Coverage Resource Materials subsection of the General Information for Providers Chapter for additional information regarding coverage parameters.

* * *

## 6.5 PERIODONTICS

Full mouth debridement is performed as a therapeutic, not preventive, treatment for beneficiaries to aid in the evaluation and diagnosis of their oral condition. It is the removal of subgingival and/or supragingival plaque and calculus.

Full mouth debridement is a benefit for beneficiaries age 14 and over once every 365 days. It is not covered when a prophylaxis is completed on the same day.

No other periodontal procedures are considered to be covered benefits.

* * *

## 6.7 ORAL SURGERY

Oral surgical procedures are benefits for all beneficiaries.

The extraction of teeth for orthodontic purposes is not a benefit. Reimbursement for operative or surgical procedures includes local anesthesia, analgesia, and routine postoperative care.

Surgical procedures such as surgeries of the jaw or facial bones are considered a medical benefit, not a dental benefit.

### 6.7.A. EXTRACTIONS

An extraction of an erupted tooth includes elevation and/or forceps removal. It includes minor contouring of the bone and closure if needed.

A surgical extraction requires the removal of bone and/or sectioning of a tooth and may require the elevation of the mucoperiosteal flap. Minor contouring of the bone and closure of the tissue is included.

The extraction procedure code submitted for reimbursement must follow the CDT guidelines and is not based on the amount of time required, the difficulty of the extraction, or any special circumstances. An extraction is not a covered benefit if exfoliation is imminent.

> Multiple extractions in the same quadrant for preparation of complete dentures are not considered surgical extractions unless guidelines for surgical extractions are met.
>
> The extraction of an impacted tooth is not covered for prophylactic removal of asymptomatic teeth that exhibit no overt pathology.
>
> **6.7.B. TOOTH REPLANTATION AND FIXATION**
>
> Tooth replantation and fixation is a benefit for beneficiaries under age 21 when permanent anterior teeth are avulsed or displaced due to traumatic injury.
>
> **6.7.C. ALVEOLOPLASTY**
>
> Alveoloplasty is a covered benefit for all beneficiaries.
>
> Alveoloplasty performed in conjunction with extractions is a separate procedure performed at the time of the extractions in the surgical preparation of the ridge for complete or partial dentures.
>
> Alveoloplasty in an edentulous area not performed in conjunction with extractions (secondary alveoloplasty) is not covered if recent extractions have been performed in that quadrant.
>
> *MPM, October 1, 2019 version*
> *Dental Chapter, pages 10-24*
> *(underline added for emphasis)*

Here, Respondent and its dental vendor denied the prior authorization request for the dental services at issue in this case pursuant to the above policies and coverage limitations, with Respondent's representative also testifying that the specific procedure codes used on the prior authorization request are not covered under the Department's Dental Fee Schedule either.

In response, Petitioner testified that he knows that the requested services are not covered, but that he cannot afford the services he needs and is not a candidate for other services that are covered, such as dentures. Petitioner also asked that Respondent approve what it can and have Petitioner pay the cost difference between what is covered and what would be provided.

Petitioner has the burden of proving by a preponderance of the evidence that the MHP erred in denying his authorization request. Moreover, the undersigned Administrative Law Judge is limited to reviewing Respondent's decision in light of the information that was available at the time the decision was made.

Given the above policy and evidence in this case, Petitioner has not met his burden of proof and Respondent's decision must therefore be affirmed. As demonstrated by Respondent, and undisputed by Petitioner, the requested services are not a covered benefit for Petitioner. Moreover, while Petitioner seeks to make an arrangement with Respondent regarding Respondent approving different services than what were requested and Petitioner paying the cost difference, that request is beyond the scope of this proceeding and the undersigned Administrative Law Judge is limited to reviewing what was requested and denied.

## DECISION AND ORDER

The Administrative Law Judge, based on the above Findings of Fact and Conclusions of Law, decides that Respondent properly denied Petitioner's authorization request.

**IT IS, THEREFORE, ORDERED** that:

Respondent's decision is **AFFIRMED.**

Steven Kibit

SK/sb

**Steven Kibit**
Administrative Law Judge
for Robert Gordon, Director
Department of Health and Human Services

**NOTICE OF APPEAL**: A party may appeal this Order in circuit court within 30 days of the receipt date. A copy of the circuit court appeal must be filed with the Michigan Office of Administrative Hearings and Rules (MOAHR).

A party may request a rehearing or reconsideration of this Order if the request is received by MOAHR within 30 days of the date the Order was issued. The party requesting a rehearing or reconsideration must provide the specific reasons for the request. MOAHR will not review any response to a request for rehearing/reconsideration.

A written request may be mailed or faxed to MOAHR. If submitted by fax, the written request must be faxed to (517) 763-0155; Attention: MOAHR Rehearing/Reconsideration Request.

If submitted by mail, the written request must be addressed as follows:

Michigan Office of Administrative Hearings and Rules
Reconsideration/Rehearing Request
P.O. Box 30763
Lansing, Michigan 48909-8139

**DHHS -Dept Contact**

Managed Care Plan Division
CCC, 7th Floor
Lansing, MI
48919

**Petitioner**

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**Community Health Rep**

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