[redacted]
[redacted], MI [redacted]

Date Mailed: June 11, 2020
MOAHR Docket No.: 20-001256
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 May 27, 2020. Petitioner appeared and testified on his own behalf. Katie Feher, Manager of Appeals, appeared and testified on behalf of Meridian Health Plan, the Respondent Medicaid Health Plan (MHP).

During the hearing, Respondent submitted an evidence packet that was admitted into the record as Exhibit A, pages 1-51. Petitioner did not submit any exhibits.

ISSUE

Did Respondent properly deny Petitioner's prior authorization request for osseous surgery?

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, page 15; Testimony of Respondent's representative).

2. On December 10, 2019, Respondent's dental vendor, DentaQuest, received a prior authorization request submitted on Petitioner's behalf by his dentist for services. (Exhibit A, pages 12-16).

3. As part of that request, Petitioner and his dentist requested osseous surgery for Petitioner, with the dentist identifying that service by

procedure code D4260. (Exhibit A, page 13).

4. DentaQuest then reviewed the request and determined that it should be denied on the basis that the requested service is not covered for Petitioner. (Exhibit A, pages 15-16).

5. On December 10, 2019, Respondent sent Petitioner written notice that the prior authorization request had been denied. (Exhibit A, pages 12-16).

6. On December 26, 2019, Petitioner filed an Internal Appeal with Respondent regarding the denial of the prior authorization request. (Exhibit A, pages 21-23).

7. On December 31, 2019, Respondent sent Petitioner written notice that Petitioner's appeal had been reviewed and that the authorization request was again denied. (Exhibit A, pages 26-32).

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

> **Your appeal letter says that you have gum disease that has progressed to the point of needing surgical intervention. You said that your gums are infected and that you have been on many different antibiotics that are not helping. The reason for the the [sic] decision is because the request for you to have a procedure to reshape your jaw bone (osseous surgery) does not meet the Michigan Department of Health and Human Services, Medicaid Provider Manual, Dental Services, 6.5 Periodontics. The Michigan Department of Health and Human Services, Medicaid Provider Manual which is based off the Michigan dental fee schedule says that the procedure (D4260) is not a covered benefit under your dental plan. Please follow-up with Dr. Raymond Maks for further care options.**
>
> *Exhibit A, pages 38-39*

9. On February 25, 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 1-6).

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.

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 code used on the prior authorization request is not covered benefit under Petitioner's dental plan, the MPM, or the Michigan dental fee schedule. Respondent's representative also testified that the denial was for administrative/coverage reasons, and that no determination was made regarding medical necessity.

In response, Petitioner testified that the surgery is medically necessary and that the law allows for non-covered benefits to be covered in certain circumstances like his. He also testified that he has medical reasons for the procedure and that Respondent ignored some of those reasons when denying the request.

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 uncontradicted by Petitioner, the requested service is not a covered benefit for Petitioner and a requested service may be denied for coverage reasons regardless of medical necessity. Moreover, while Petitioner now identifies additional medical reasons for the requested surgery, the request at issue in this case was solely made by his dentist and Petitioner's claims regarding other medical reasons are unsupported. To the extent Petitioner believes that the requested surgery is necessary as a medical procedure, then he and his doctor can submit a prior authorization request on that basis if and when appropriate.

The undersigned Administrative Law Judge is limited to reviewing what was requested and denied, and Respondent's decision was proper based on the information that was available at the time of the denial.

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

[redacted], MI

Community Health Rep

Meridian Health Plan of Michigan Inc.
Appeals Section
PO Box 44287
Detroit, MI
48244