[redacted]
MI [redacted]

Date Mailed: August 20, 2020
MOAHR Docket No.: 20-001818
Agency No.: [redacted]
Petitioner: [redacted]

ADMINISTRATIVE LAW JUDGE: Robert J. Meade

DECISION AND ORDER

This matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9, 42 CFR 431.200 *et seq*. and 42 CFR 438.400 *et seq*. upon Petitioner's request for a hearing.

After due notice, a hearing commenced on May 28, 2020. The May 28, 2020 hearing was continued to sort out various jurisdictional issues and reconvened on July 29, 2020. The July 29, 2020 hearing was adjourned on the record when it was determined that Petitioner had not yet received Respondent's hearing summary. Finally, a hearing was held on August 19, 2020.

Petitioner, [redacted], appeared and testified on his own behalf. Vanessa Aucar, Lead, Appeals and Grievances, appeared on behalf of Molina Healthcare, the Respondent Medicaid Health Plan (United or MHP). Dr. Jacinto Beard, Dental Director; Chasty Lay, Manager, Appeals and Grievances; Ismael Buspanape, Medicare Appeals Review; and Kim Moerke, Manager, Appeals and Grievances appeared as witnesses for the MHP.

ISSUE

Did the MHP properly deny Petitioner's prior authorization request for an Autogenous Connective Tissue Graft?

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 [redacted]-year-old dual eligible Medicare and Medicaid beneficiary, born January 5, 1983, who is eligible to receive services through Respondent, MHP. (Exhibit A, p 17, 27; Testimony)

2. On November 14, 2019, the MHP received a prior authorization request from Petitioner's provider for an Autogenous Connective Tissue Graft. (Exhibit A, pp 28-35; Testimony)

3. On November 15, 2019, the MHP sent Petitioner and his provider written notice that the prior authorization request was denied because the requested service was not a covered benefit under his plan. (Exhibit A, pp 45-53; Testimony)

4. On January 14, 2020, following an internal appeal, the MHP upheld the denial of Petitioner's prior authorization request and sent a Notice of Appeal Decision to Petitioner. (Exhibit A, pp 19-24; Testimony)

5. On February 5, 2020, the MHP's Medicare review entity Maximus sent Petitioner a notice that the denial was being upheld because the service was not a covered benefit under Medicare. (Exhibit A, pp 38-42; Testimony)

6. On March 12, 2020, the Michigan Office of Administrative Hearings and Rules (MOAHR) received Petitioner's request for hearing. (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 statutes, 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.

Medicaid Provider Manual
Medicaid Health Plan Chapter
October 1, 2019, p 1
(Emphasis added)

The Medicaid Provider Manual (MPM) provides, in pertinent 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.

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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.

Medicaid Provider Manual
Dental Chapter
October 1, 2019, pp 10, 20
(Emphasis added)

Pursuant to the above policy and its contract with the Department, the MHP has developed a prior authorization program indicating that its covered services are subject to the limitations and restrictions described in the MHP's Medicaid agreement, the MPM, Medicaid bulletins, and other directives. Under those policies, Autogenous Connective Tissue Grafts are not a covered service. Here, the MHP's Dental Director explained that Autogenous Connective Tissue Grafts are actually performed in preparation for a dental implant, which is also not a covered service under the plan. MHP's Dental Director testified that Petitioner's dental plan covers cleanings, exams, x-rays, extractions and dentures. MHP's Dental Director also indicated that a tissue graft is just one of many options available to treat Petitioner's condition and that some of those options are covered by Petitioner's plan.

Petitioner testified that he was told by his dentist that the Autogenous Connective Tissue Grafts were not a covered service under Medicaid or Medicare but that he was also told that he could appeal that decision, so that is what he did. Petitioner indicated that his dentist's office has told him that he needs this procedure and Petitioner thinks he needs the procedure. Petitioner indicated that he does have receding gum lines and has a lot of pain and discomfort when he eats and when he brushes his teeth. Petitioner testified that he has bleeding and must take Motrin for the pain. Petitioner testified that he does not want to get his teeth pulled and he wants to save his teeth. Petitioner indicated that he cannot afford this service on his own as he is on disability and a fixed income.

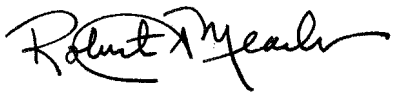
Given the above policy and evidence, Petitioner has failed to prove by a preponderance of the evidence that the MHP erred in denying the prior authorization request for an Autogenous Connective Tissue Graft. Autogenous Connective Tissue Grafts are simply not a covered benefit under Petitioner's plan. While the undersigned is sympathetic to Petitioner's situation, the undersigned has no equitable authority and no authority to ignore clear policy. Petitioner should speak to his dentist about other covered options of treatment that might ameliorate his pain.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the MHP properly denied Petitioner's prior authorization request for an Autogenous Connective Tissue Graft.

IT IS THEREFORE ORDERED that:

The Medicaid Health Plan's decision is AFFIRMED.



RM/sb

Robert J. Meade
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	Allison Repp 400 S PINE ST CAPITAL COMMONS LANSING, MI 48909
DHHS -Dept Contact	Karen Everhart 400 S. Pine St, 5th Floor Lansing, MI 48909
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