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Date Mailed: December 16, 2020
MOAHR Docket No.: 20-006542
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 November 25, 2020. Petitioner appeared and testified on her own behalf. Nicole Sandstrom, Registered Nurse (RN)/Clinical Services Manager, appeared and testified on behalf of Upper Peninsula 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 1-40.

ISSUE

Did the Respondent MHP properly deny Petitioner's prior authorization request for lower 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. Petitioner is a Medicaid beneficiary who has been enrolled in the Respondent MHP through the Healthy Michigan Plan (HMP) since March 1, 2017. (Testimony of Respondent's representative).

2. On October 3, 2017, Petitioner received lower dentures covered by Respondent. (Exhibit A, pages 5-7).

3. On September 29, 2020, Respondent received a prior authorization request submitted on Petitioner's behalf by her dentist for new lower

dentures. (Exhibit A, page 3).

4. When making that request, Petitioner's dentist indicated that Petitioner's old dentures had been eaten by her roommate's dog. (Exhibit A, page 3).

5. On September 30, 2020, Respondent sent Petitioner written notice that the prior authorization request had been denied on the basis that the applicable criteria provides that dentures are only a covered benefit once every five years. (Exhibit A, pages 29-33).

6. On October 1, 2020, Petitioner filed an Internal Appeal with Respondent regarding the denial of the prior authorization request. (Exhibit A, page 36).

7. On October 9, 2020, Respondent sent Petitioner written notice that Petitioner's appeal had been reviewed and that the authorization request was again denied. (Exhibit A, pages 36-40).

8. On October 20, 2020, the Michigan Office Administrative Hearings and Rules (MOAHR) received the request for hearing filed by Petitioner in this matter regarding Respondent's decision.

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
- Hearing aids for persons 21 and over

MPM, July 1, 2020 version
Medicaid Health Plan Chapter, pages 1-2
(underline added for emphasis)

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

SECTION 5 – SPECIAL COVERAGE PROVISIONS

This section provides general information regarding Healthy Michigan Plan coverage requirements for certain services.

Additional information regarding these services may be contained in other relevant chapters of this manual, as applicable.

5.1 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 through the Medicaid FFS program.

For dental program coverage policy, refer to the Dental Chapter of this manual. The Dental Chapter also contains information on the Healthy Kids Dental benefit, as applicable.

MPM, July 1, 2020 version
Healthy Michigan Plan Chapter, page 10
(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 with respect to dental services, those prior authorization requirements state in part:

Dental Services

UPHP MI Health Link will pay for the following services:

- Examinations and evaluations are covered once every six months

- Cleaning is a covered benefit once every six months

- Silver diamine fluoride treatment is covered with a maximum of six applications per lifetime

- X-rays

    - Bitewing x-rays are a covered benefit only once in a 12-month period

    - A panoramic x-ray is a covered benefit once every five years

    - A full mouth or complete series of x-rays is a covered benefit once every five years

- Fillings

- Tooth extractions

- Complete or partial dentures are covered once every five years

Exhibit A, page 11
(underlined added for emphasis)

Moreover, Respondent's policy with respect to dentures is consistent with the Department's own coverage and limitations policies for dentures found in the MPM:

6.6 PROSTHODONTICS (REMOVABLE)

6.6.A. GENERAL INSTRUCTIONS

Complete and partial dentures are benefits for all beneficiaries. All dentures require prior authorization (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 maxillary teeth.

Complete or partial dentures are authorized when one or more of the following conditions exist:

- One or more anterior teeth are missing.

- There are less than eight posterior teeth in occlusion (fixed bridges and dentures are to be considered occluding teeth).

If an existing complete or partial denture can be made serviceable, the dentist should provide the needed restorations to maintain use of the existing removable prosthesis. This includes extracting teeth, adding teeth to the existing prosthesis, and removing hyperplastic tissue as necessary to restore the functionality of the complete or partial denture.

Before the final impressions are taken for the fabrication of a complete or partial denture, adequate healing necessary to support the prosthesis must take place following the completion of extractions and/or surgical procedures. This includes the posterior ridges of any immediate denture. When an immediate denture is authorized involving the six anterior teeth (cuspid to cuspid), this requirement is waived.

Reimbursement for a complete or partial denture includes all necessary adjustments, relines, repairs, and duplications within six months of insertion. This also includes such services necessary for an immediate complete denture when authorized. If any necessary adjustments or repairs are identified within the six month time period but are not provided until after the six month time period, 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.

- A complete or partial denture has been lost or broken beyond repair within five years, whether or not the existing denture was obtained through Medicaid.

> When denture services have commenced but irreversible circumstances have prevented delivery, the dentist should bill using the Not Otherwise Classified (NOC) procedure code. A copy of the lab bill and an explanation in the Remarks section of the claim must be included. Providers are paid a reduced rate to offset a portion of the costs incurred. It is the expectation that the probability of removable appliances being delivered and follow-up treatment completed is assessed prior to the initiation of treatment to evaluate whether the treatment is appropriate for the specific patient. Contact the Program Review Division (PRD) regarding the requirements for incomplete dentures. (Refer to the Directory Appendix for contact information.)

MPM, July 1, 2020 version
Dental Chapter, pages 20-21
(underline added for emphasis)

Here, Respondent's representative testified that Petitioner's prior authorization request for dentures was denied pursuant to the above policies. Specifically, she noted that the request was denied because, as established by Respondent's records, Petitioner had been previously provided such dentures within the past five years.

In response, Petitioner testified that the dentures she received in October of 2017 were destroyed by her roommate's dog in September of 2020. She also testified that she cannot talk or eat without them, which is especially important since she is a diabetic who needs to eat four small meals a day.

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

Given the record and applicable policies in this case, Petitioner has failed to meet her burden of proof and Respondent's decision must be affirmed. Respondent is allowed to develop utilization management and review criteria pursuant to the above policies; it has done so in this case; and, pursuant to that criteria and consistent with the Department's own coverage policies in the MPM for dentures, Respondent limits coverage of complete or partial dentures to once every five years. Accordingly, as it is undisputed that Petitioner had dentures placed within the past five years, her prior authorization request did not meet the criteria for approval and Respondent's decision must be affirmed.

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 prior authorization request for dentures.

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

Community Health Rep

Upper Peninsula Health Plan
853 W. Washington St
Marquette, MI
49855

Petitioner

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