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Date Mailed: December 22, 2020
MOAHR Docket No.: 20-007026
Agency No.: [redacted]
Petitioner: [redacted]

ADMINISTRATIVE LAW JUDGE: Corey Arendt

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 December 17, 2020. Petitioner appeared and testified on her own behalf. Michele Champine, Operations Manager for Healthy Michigan Dental, appeared on behalf of Respondent, Total Health (Department). Jennifer Berschbach appeared as a witness for Department.

ISSUE

Did the Department properly deny Petitioner's prior authorization request for upper partial 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 is enrolled in the Department Medicaid Health Plan. (Testimony.)

2. On September 17, 2020, Ronald Livingston DDS, submitted on behalf of Petitioner, an authorization request for upper partial dentures. (Testimony.)

3. As of September 17, 2020, Petitioner had eight teeth in occlusion. The teeth in occlusion were #2 and #31, #4 and #29, #12 and #21, and #14 and #19. (Testimony.)

4. On October 2, 2020, Department sent Petitioner a Notice of Denial. The notice indicated the Petitioner's request for upper partial dentures were denied because Petitioner had at least 8 posterior (back) teeth in

occlusion (i.e. biting together). (Testimony.)

5. On October 20, 2020, Petitioner appealed the October 2, 2020 determination. (Testimony.)

6. On November 6, 2020, Department sent Petitioner a denial notice which upheld the October 2, 2020 determination. (Testimony.)

7. On November 18, 2020, the Michigan Office of Administrative Hearings and Rules (MOAHR) received from Petitioner, a request for hearing. (Hearing File.)

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[1]

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.[2]

[1] Medicaid Provider Manual, Medicaid Health Plan, October 1, 2020, pp 1-2.
[2] MPM, Dental Chapter, October 1, 2020, pp 2-3.

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.[3]

[3] *Id* at p10.

Under the general policy instructions for Medicaid related dental services the MPM sets replacement schedules for denture repair and replacement:

> **SECTION 2 – PRIOR AUTHORIZATION**
>
> Prior authorization (PA) is only required for those services identified in the Dental Chapter and the Medicaid Code and Rate Reference tool. (Refer to the Directory Appendix for website information.)
>
> * * *
>
> **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.)[4]

The general instructions for Medicaid coverage for complete and partial dentures during the period when the PA request and denial were made are set forth in the following policy from the Medicaid Provider Manual:

> **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 teeth.
>
> Complete or partial dentures are authorized when one or more of the following conditions exist:
>
> - One or more anterior teeth are missing.

[4] *Id* at p 4.

- 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 upper 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 rebasing will make a prosthesis 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 followup 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.)[5]

Here, Department 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. Specifically, that Petitioner had eight posterior teeth in occlusion[6].

In response, Petitioner testified that several different dentists and an individual from the Department had told her that she qualified for dentures. The Petitioner's statements, however, are for the most part considered hearsay and Petitioner failed to present any other evidence indicating she had less than eight posterior teeth in occlusion. Moreover, Petitioner not once disagreed with the Department's conclusions she had eight posterior teeth in occlusion. As for the argument that one of the Department's own staff members indicated Petitioner's insurance coverage covered dentures, the statement alone is accurate. Based on the information presented, Petitioner's insurance does in fact cover dentures. But to be approved for dentures, Petitioner still needed to meet other prequalification criteria. In this case, Petitioner needed less than eight posterior teeth in occlusion.

Petitioner has the burden of proving by a preponderance of the evidence that the Department erred in denying her authorization request. Moreover, the undersigned Administrative Law Judge is limited to reviewing Department's decision considering 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 her burden of proof and the Department's decision must therefore be affirmed.

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[5] *Id* at pp 20-21.
[6] See MPM, Dental, Section 6.6.A., October 1, 2020, p 21.

DECISION AND ORDER

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

IT IS, THEREFORE, ORDERED that:

Department's decision is **AFFIRMED.**

CA/dh

Corey Arendt
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] [redacted] [redacted] MI [redacted]
Community Health Rep	Total Health Care 3011 W. Grand Blvd Suite 1600 Detroit, MI 48202