



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
MICHIGAN OFFICE OF ADMINISTRATIVE HEARINGS AND RULES

ORLENE HAWKS
DIRECTOR

[REDACTED] MI [REDACTED]

Date Mailed: April 5, 2021
MOAHR Docket No.: 21-001107
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 April 1, 2021. Petitioner appeared and testified on her own behalf. Desma Boyd, Appeals and Grievance Specialist, appeared and testified on behalf of Molina Healthcare of Michigan, the Respondent Medicaid Health Plan (MHP). Dr. Jacinto Beard, Dental Director, also testified as a witness for Respondent.

During the hearing, Respondent submitted an evidence packet that was admitted into the record as Exhibit A, pages 1-37. Petitioner did not submit any exhibits.

ISSUE

Did Respondent properly deny Petitioner's request for a partial upper denture?

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 enrolled in Medicaid through the Healthy Michigan Plan and authorized for services through Respondent. (Exhibit A, pages 10-13)
2. On November 25, 2020, Respondent received a prior authorization request for a partial upper denture submitted on Petitioner's behalf by her dentist. (Exhibit A, pages 16-19).
3. The information and x-rays attached as part that request indicated that Petitioner had all her upper anterior teeth and, while she was missing one

upper posterior tooth, she still had twelve posterior teeth in occlusion. (Exhibit A, pages 16-19; Testimony of Dental Director).

4. On November 30, 2020, Respondent sent Petitioner written notice that the prior authorization request was denied. (Exhibit A, pages 23-33).
5. With respect to the reason for the denial, the notice stated:

The request for the type of service listed above does not meet the Michigan Department of Medicaid guideline. Information sent in must show 1 or more front teeth missing or less than 8 teeth that are biting against each other. Wisdom teeth are not included. You would have to meet all of the rules before this could be approved. Please talk to your provider about your health care options. (CRITERIA USED FOR DECISION: Michigan Dental Provider Manual: Dental, Section 6.6.A)

Exhibit A, page 23

6. On December 8, 2020, Petitioner requested an Internal Appeal with Respondent. (Exhibit A, page 7).
7. On January 5, 2021, Respondent sent Petitioner written notice stating that Petitioner's appeal was being denied for the same reason as before. (Exhibit A, pages 7-8).
8. On March 8, 2021, 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 3-13).

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, October 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, October 1, 2020 version
Healthy Michigan Plan Chapter, page 10*

As allowed by the above policy and its contract with the Department, Respondent and its dental provider group or vendor have developed prior authorization requirements and utilization management and review criteria; and with respect to dental services,

Respondent has incorporated all applicable published Medicaid coverage and limitation policies as permitted.

The applicable published Medicaid coverage and limitation policies adopted by Respondent are found in the Medical Provider Manual (MPM) and they state in part:

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

Here, Respondent's Dental Director testified that Petitioner's prior authorization request for a partial denture was denied pursuant to the above policy. Specifically, he noted

that the request was denied because, per the documentation submitted, Petitioner has all her anterior teeth and twelve posterior teeth in occlusion.

In response, Petitioner testified regarding her difficulties in finding a dentist she can afford. She also testified that Respondent had offered to help her find a dentist that treats low-income patients, and that Petitioner could pay for out-of-pocket, but that Respondent has been no help. Petitioner did agree that Respondent never authorized or approved payment for the requested partial denture, which would just be for one missing posterior tooth, and just offered to help Petitioner find a dentist she could afford on her own.

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 policy in this case, Petitioner has failed to meet her burden of proof and Respondent's decision must be affirmed. The above policy clearly provides that a partial denture would only be authorized in this case if Petitioner has missing anterior teeth or less than eight posterior teeth in occlusion; and, here, the information provided as part of the prior authorization request demonstrated both that Petitioner has all her anterior teeth and that she has twelve posterior teeth in occlusion.

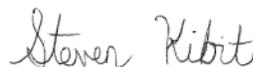
The undersigned Administrative Law Judge appreciates Petitioner's frustration in finding a dentist who can provide the requested denture at a price that Petitioner can pay for out-of-pocket, but that issue is ultimately beyond the scope of this proceeding given that it did not involve the denial of any Medicaid-covered service. Petitioner is free to continue to work with Respondent and, if appropriate, file a grievance with regarding a lack of assistance, but based on the information it had, Respondent properly denied the specific request in this case.

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.

IT IS, THEREFORE, ORDERED that:

Respondent's decision is **AFFIRMED**.



SK/sb

Steven Kibit
Administrative Law Judge
for Elizabeth Hertel, 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
MDHHS-MCPD@michigan.gov

Petitioner

 MI

Community Health Rep

Molina Healthcare of Michigan
Chasty Lay
880 W. Long Lake Rd., Suite 600
Troy, MI
48098
Chasty.Lay@molinahealthcare.com
Lisa.Johnson@MolinaHealthCare.Com