[redacted]
[redacted]
[redacted], MI [redacted]

Date Mailed: August 16, 2021
MOAHR Docket No.: 21-003291
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 August 12, 2021. Petitioner appeared and testified on her own behalf. Alden Kellogg, Senior Associate General Counsel, appeared and testified on behalf of United Healthcare Community Plan, the Respondent Medicaid Health Plan (MHP).

During the hearing, the following exhibits were entered into the record without objection:

Exhibit #1: Request for Hearing

Exhibit #2: March 31, 2021, Letter from Dr. [redacted], D.O.

Exhibit A: Hearing Summary and Evidence Packet

ISSUE

Did Respondent properly deny Petitioner's request for reimbursement for dental services?

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] ([redacted]) year-old Medicaid beneficiary who is enrolled in the Respondent MHP and has been diagnosed with malignant neoplasm of upper-outer quadrant of left female breast. (Exhibit #2, page 1).

2. On February 21, 2020, Petitioner underwent a left lumpectomy. (Testimony of Petitioner).

3. Respondent's oncologist also determined that Petitioner needed to have some of Petitioner's teeth extracted. (Exhibit #2, page 1).

4. Petitioner attempted to locate an available dentist on an online list of network providers she was directed to by Respondent, but she was unable to find one. (Testimony of Petitioner).

5. She did not contact Respondent after failing to locate a provider on the online list. (Testimony of Petitioner).

6. Instead, she located and scheduled an appointment with a dentist that was outside of Respondent's network of providers. (Testimony of Petitioner).

7. Petitioner and the dentist did not seek prior authorization from Respondent before the teeth extractions were performed. (Testimony of Respondent's representative).

8. Between March 2, 2020 and March 5, 2020, the out-of-network dentist extracted eleven teeth. (Testimony of Petitioner).

9. Petitioner paid for the dental services out-of-pocket. (Testimony of Petitioner).

10. She also subsequently sought reimbursement for those payments from Respondent. (Testimony of Petitioner).

11. Respondent denied Petitioner's request for reimbursement. (Testimony of Petitioner).

12. Petitioner then filed an Internal Appeal with Respondent. (Exhibit A, page 5).

13. As part of her appeal, Petitioner included a letter from her oncologist dated March 31, 2021. (Exhibit #2, page 1).

14. In part, that letter stated:

> I am writing on behalf of my patient, [Petitioner], to document the medical necessity to treat her for teeth extractions.
>
> This letter serves to document my patient's medical history and diagnosis and to summarize my treatment rationale.

> My Patient [Petitioner] was seen in my office on 1/14/2020 for newly diagnosed left breast malignant neoplasm. At this time, all options were discussed with patient and follow up appointments made for Radiation Oncology and Medical Oncology.
>
> Patient proceeded with a left lumpectomy, left sentinel lymph node biopsy. Pathology did reveal a diagnosis of malignancy. She then proceeded with radiation therapy.
>
> I feel in my medical opinion that it is medically necessary for [Petitioner] to have several teeth extracted to obtain the best medical outcome and to not delay any treatment needed for breast cancer diagnosis.

Exhibit #2, page 1

15. On April 14, 2021, Respondent sent Petitioner written notice that her Internal Appeal was denied. (Exhibit A, page 5).

16. With respect to the reason for the denial the notice stated:

> We have reviewed your concerns. We looked at the information you submitted. We looked at the letter of medical necessity. The provider is out of network with your plan. Your plan benefits state you must see an in-network provider. If you want to see an out of network provider, you must have prior authorization. There is no prior authorization on file. We are unable to reimburse you for the services.

Exhibit A, page 5

17. Petitioner subsequently appealed the decision with Respondent again. (Exhibit A, page 5).

18. On May 20, 2021, Respondent sent Petitioner written notice that the second Internal Appeal had been withdrawn because Respondent had previously reviewed it. (Exhibit A, pages 5-9).

19. Respondent again notified Petitioner of the reason for its original decision as well. (Exhibit A, page 5).

20. On July 13, 2021, the Michigan Office Administrative Hearings and Rules (MOAHR) received the request for hearing filed by Petitioner in this matter regarding Respondent's decision to deny reimbursement. (Exhibit #1, pages 1-3).

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) in effect at the time of the services at issue in this case, 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.

MPM, January 1, 2020 version
Medicaid Health Plan Chapter, page 1
(underline added for emphasis)

Moreover, regarding out-of-network services, the applicable version of the MPM also states:

2.6 OUT-OF-NETWORK SERVICES

2.6.A. PROFESSIONAL SERVICES

With the exception of the following services, MHPs may require out-of-network providers to obtain plan authorization prior to providing services to plan enrollees:

- Emergency services (screening and stabilization);
- Family planning services;
- Immunizations;
- Communicable disease detection and treatment at local health departments;
- Child and Adolescent Health Centers and Programs (CAHCP) services;
- Tuberculosis services; and
- Certain MIHP services (refer to the Maternal Infant Health Program Chapter for additional information).

MHPs reimburse out-of-network (non-contracted) providers at the Medicaid fee-for-service (FFS) rates in effect on the date of service.

MPM, January 1, 2020 version
Medicaid Health Plan Chapter, page 6
(underline added for emphasis)

Pursuant to the above policies and its contract with MDHHS, Respondent has limited coverage of non-emergency out-of-network services to those approved beforehand by Respondent.

Here, Respondent denied the prior authorization request on the basis that the services were performed by a provider outside of Respondent's network of providers without prior authorization and while the service was available in-network.

Petitioner has the burden of proving by a preponderance of the evidence that Respondent erred in denying the prior 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 her burden of proof and Respondent's decision must therefore be affirmed.

Petitioner testified and argued that the necessary dental services she received were emergency services and that, while she tried to receive them through a provider within Respondent's network, none were available due to the COVID-19 pandemic and, consequently, she had to go out-of-network.

However, the record fails to support that argument and testimony. For example, while the letter of medical necessity from Petitioner's doctor generally identified the extraction of teeth as medically necessary, the letter was written over a year after the services were performed; it did not give any details as to why the extractions were necessary; and it did not identify any emergency or immediate need. Moreover, even if Petitioner was unable to locate a dentist herself from an online list of in-network providers, that alone does not mean that one was unavailable, and Petitioner never followed up with Respondent for assistance in locating a dentist for a routine procedure. Petitioner and the out-of-network provider also never sought prior authorization for the services from Respondent, which was required by the applicable policies in non-emergency circumstances, and which would have given Respondent an opportunity to respond, and perhaps identify an available dentist, before the services were provided. As further noted by Respondent, the dental services in question were also performed prior to first positive cases identified in Michigan. *See* March 10, 2020, Press Release from the Office of Governor Gretchen Whitmer, https://www.michigan.gov/whitmer/0,9309,7-387-90499_90640-521365--,00.html

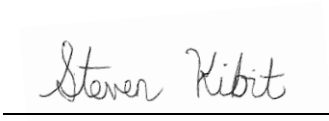
Accordingly, for the reasons discussed above, the undersigned Administrative Law Judge finds that Petitioner has failed to meet her burden of proof and that Respondent's decision must be affirmed.

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 request for reimbursement.

IT IS, THEREFORE, ORDERED that:

Respondent's decision is **AFFIRMED.**



SK/sb

Steven Kibit
Administrative Law Judge

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

Counsel for Respondent

Alden Kellogg
3838 North Causeway Boulevard, Ste. 2200
Metairie, LA
70002
alden.kellogg@uhc.com

Petitioner

[redacted]
[redacted]
[redacted], MI
[redacted]

Community Health Rep

United Healthcare Community Plan
3000 Town Center
Suite 1400
Southfield, MI
48075
jbalog@uhc.com