[redacted]
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[redacted], MI [redacted]

Date Mailed: September 1, 2021
MOAHR Docket No.: 21-003351
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 31, 2021. Petitioner appeared and testified on her own behalf. Camille Butler, Compliance Analyst, appeared on behalf of Blue Cross Complete, the Respondent Medicaid Health Plan (MHP). Jennifer Berschbach, Licensed Dental Hygienist, testified as a witness for Respondent.

During the hearing, Petitioner's Request for Hearing was entered into the record as Exhibit #1. Respondent also submitted nine exhibits that were entered into the record as Exhibits A-I.

ISSUE

Did Respondent properly deny in part Petitioner's request for a periodontal scaling and root planing?

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. (Testimony of Petitioner).

2. On December 8, 2020, Respondent received a prior authorization request for periodontal scaling and root planing submitted on Petitioner's behalf by her dentist. (Exhibit A, pages 1-6).

3. On December 21, 2020, Respondent sent Petitioner written notice that the prior authorization request was denied. (Exhibit B, pages 1-2).

4. With respect to the reason for the denial, the notice stated that periodontal deep cleaning for advanced periodontal gum disease was not a covered benefit under Respondent's Policy 3.2. (Exhibit B, page 1).

5. On February 10, 2021, Petitioner requested an Internal Appeal with Respondent. (Exhibit D, pages 1-2; Exhibit E, pages 1-10).

6. On March 12, 2021, Respondent sent Petitioner written notice that Respondent had decided to overturn the denial with respect to Quadrants 3 and 4 of Petitioner's mouth. (Exhibit G, pages 1-10).

7. That day, Respondent also sent Petitioner written notice that the denial of scaling and root planing for Quadrants 1 and 2 was being upheld. (Exhibit F, pages 1-12).

8. With respect to the reason for the appeal decision, the notice stated: "Treatment for advanced periodontal gum disease, with pocket depths over 6mm and /or bone loss greater than 50%, is not a covered benefit on the healthy Michigan Plan. [Policy 3.2]". (Exhibit F, page 1).

9. On July 15, 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 #1, pages 1-23).

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.

In particular, with respect to periodontic dental services, Respondent's policy states in part:

> 1.8 Periodontal deep cleaning cannot be performed within (6) months of another dental cleaning.

1.9 Periodontal maintenance cleanings are only covered twice a lifetime.

* * *

1.23 Periodontal deep cleaning is only covered once per lifetime, per quadrant

* * *

3.2 Treatment for advanced periodontal gum disease, with pocket depths over 6 mm and/or bone loss greater than 50% is not covered benefit on the Healthy Michigan Plan.

3.3 Periodontal maintenance cleanings must be performed within twenty-four (24) months after a deep cleaning below the gum line.

3.4 Periodontal maintenance cleanings cannot be performed less than three (3) months after a deep cleaning, and maintenance visits cannot be performed less than three (3) months apart.

Exhibit I, pages 1-3
(Underline added for emphasis)

As required by the MPM, Respondent's policies on periodontic dental services are consistent with all applicable published Medicaid coverage and limitation policies:

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.

MPM, October 1, 2020 version

Here, Respondent's witness, a licensed dental hygienist, testified that Petitioner's prior authorization request for periodontal scaling and root planing was denied with respect to Quadrants 1 and 2 pursuant to the above policies and on the basis that Petitioner's teeth in those quadrants had greater than 50% bone loss. She also testified that the determination regarding the amount of bone loss, both for those quadrants and for the other quadrants for which the requested service was approved, was based on the x-rays submitted along with the prior authorization request.

In response, Petitioner testified she has periodontal disease and that the requested scaling and root planing is needed in all four quadrants. She also went through Respondent's policies providing that periodontal care is covered and noted that, both before and after the denial in this case, Respondent has sent her information about periodontal care. She further testified that she has received the requested care for Quadrants 3 and 4, and that there is no reason not to approve it for the other two. In particular, she noted that, to her untrained eye, the x-rays did not show any difference in bone loss for the teeth where the services were approved and where they were not.

Petitioner also testified that her dentist provided a note regarding Petitioner's infection and the medical necessity for the requested services, but did concede that the note was unsigned and that it did not address bone loss at all, despite her dentist being notified of the reason for the denial in this case.

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.

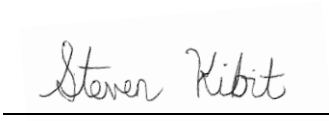
Given the record and applicable policy in this case, Petitioner has failed to meet her burden of proof and Respondent's decision must be affirmed. The above policy, which is consistent with the limited coverage for periodontal care required by the MPM, clearly states that treatment for advanced periodontal gum disease with bone loss greater than 50% is not a covered benefit and the licensed dental hygienist credibly testified that, based on the x-rays that were submitted, Petitioner's teeth in Quadrants 1 and 2 had bone loss greater than 50%. Moreover, while Petitioner testified that the bone loss in teeth in Quadrants 1 and 2 looks no different to her than the bone loss in teeth in Quadrants 3 and 4, where the requested services were approved, she is just a lay person, and her opinion carries little weight. Similarly, while Petitioner correctly notes that her dentist has found the services to be necessary, the dentist's note did not address bone loss at all or suggest that Petitioner's circumstances meet the applicable policy. Accordingly, while the request periodontal services may be covered in some circumstances, Petitioner has not shown that she meets the applicable criteria and Respondent's decision must therefore 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.

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
Community Health Rep	Blue Cross Complete Blue Cross Complete of Michigan 4000 Town Center, STE 1300 Southfield, MI 48075 crbutler@mibluecrosscomplete.com rkaji@mibluecrosscomplete.com
Petitioner	[redacted]