Michigan Office of Administrative Hearings and Rules
P.O. BOX 30763
LANSING, MI 48909

Date Mailed: March 26, 2025
Docket No.: 25-001816
Case No.: [redacted]
Petitioner: [redacted]

[redacted]
MI [redacted]

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এটি একটি গুরুত্বপূর্ণ আইনি ডকুমেন্ট। দয়া করে কেউ দস্তাবেজ অনুবাদ করুন।
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Ky është një dokument ligjor i rëndësishëm. Ju lutem, kini dikë ta përktheni dokumentin.

DECISION AND ORDER

This matter is before the Michigan Office of Administrative Hearings and Rules (MOAHR) and the undersigned Administrative Law Judge (ALJ) pursuant to MCL 400.9 and upon a request for hearing filed by Petitioner [redacted] (Petitioner).

After due notice, a telephone hearing was held on March 13, 2025. At Petitioner's request on the record, her granddaughter, [redacted], appeared and testified on Petitioner's behalf. Petitioner also testified as a witness on her own behalf. Assistant General Counsel Austin Fassett appeared and testified on behalf of Respondent Delta Dental of Michigan, Inc. (Respondent). Dr. Traci Dantzler, Director of Utilization Management, also testified as a witness for Respondent.

During the hearing, Petitioner's request for hearing was admitted into the record without objection as Exhibit #1, pages 1-3. Respondent also submitted an evidence packet that was admitted into the record without objection as Exhibit A, pages 1-47.

ISSUE

Did Respondent properly deny Petitioner's prior authorization request for a dental crown placement for tooth #29?

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] year-old Medicaid beneficiary who is enrolled with Respondent through the Healthy Michigan Plan. (Exhibit A, page 11; Testimony of Respondent's representative).

2. On December 11, 2024, a dental provider submit a claim to Respondent related to a dental crown placement for Petitioner's tooth #29. (Exhibit A, pages 11-13).

3. Respondent denied that claim on the basis that Petitioner had already received the crown, and prior approval could therefore not be processed. (Testimony of Petitioner's representative; Testimony of Respondent's Director of Utilization Management).

4. In January of 2025, it was determined that a crown had not yet been placed on tooth #29. (Exhibit A, page 14).

5. Petitioner's dental provider also submitted a prior authorization request with respect to a dental crown placement for Petitioner for tooth #29. (Testimony of Respondent's Director of Utilization Management).

6. As part of the narrative a dentist completed as part of that request, he wrote that:

> Tooth #29- pre-existing restoration with recurrent decay and open margins, occupying over 60% of the tooth structure.
>
> *Exhibit A, page 11*

7. However, the radiographs submitted along with the request did not support that narrative or demonstrate at least 50% of tooth loss for tooth #29. (Exhibit A, page 12; Testimony of Petitioner's representative; Testimony of Respondent's Director of Utilization Management).

8. On January 30, 2025, Respondent sent Petitioner written notice that the prior authorization request for a crown for tooth #29 had been denied. (Exhibit A, pages 1-10).

9. Petitioner has filed a request for hearing with MOAHR with respect to that decision. (Exhibit #1, pages 1-3).[1]

[1] Petitioner's request for hearing was signed and received by MOAHR on January 13, 2025, but identifies the decision being appeal as having occurred on a date in the future, *i.e.,* January 27, 2025. Regardless,

CONCLUSIONS OF LAW

The Medical Assistance Program (MA) 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.

Petitioner is enrolled in MA through the Healthy Michigan Plan, and, with respect to MA dental services, the Medicaid Provider Manual (MPM) states:

> **SECTION 1 – GENERAL INFORMATION**
>
> This chapter applies to dental providers and dental clinics.
>
> Throughout this chapter, the term Medicaid refers to all programs administered by Michigan Department of Health and Human Services (MDHHS), including Healthy Michigan Plan (HMP), **Healthy Kids Dental (HKD)**, MIChild, and other programs, unless specifically stated otherwise. The primary objective of Medicaid is to ensure that essential health care services are made available to those individuals who would not otherwise have the financial resources to purchase them. Policies are aimed at maximizing medically necessary health care services available to eligible Medicaid beneficiaries.
>
> Dental services may be provided by Medicaid-enrolled providers when performed by properly credentialed/licensed professionals acting within their scope of practice as defined in State law, including any applicable supervision requirements. Dental services that may be provided to Medicaid beneficiaries include emergency, diagnostic, preventive, and therapeutic services for dental disease which, if left untreated, would become acute dental problems or cause irreversible damage to teeth or supportive structures. Determination of medical necessity and appropriateness of services is the responsibility of the dental provider within the scope of current accepted dental practice and the limitations of Medicaid policy.
>
> It is important to verify beneficiary eligibility at every appointment before providing dental services. Dental services provided to an ineligible beneficiary will not be reimbursed.
>
> In compliance with uniform billing, Medicaid follows the Code

neither party raised any concerns and both were prepared to address the denial on January 30, 2025, so the hearing proceeded with respect to that decision.

on Dental Procedures and Nomenclature (CDT) standard procedure codes and descriptions published by the American Dental Association (ADA). Dental providers are required to retain documentation in the beneficiary's dental record that supports the procedure code billed and any information required by the CDT procedure code description. Documentation, including narrative and operative notes, must be sufficiently detailed for audit purposes and made available to MDHHS upon request. For claims that require diagnosis reporting, ICD-10 diagnosis codes must be valid, contain the required number of characters, and be reported at the highest level of specificity based on the information available. (Refer to the General Information for Providers and the Billing & Reimbursement for Dental Providers chapters of this manual for additional information.)

* * *

Healthy Michigan Plan (HMP): HMP beneficiaries enrolled in an MHP will receive dental benefits through the MHP. The MHP becomes responsible for the beneficiary's dental services on the enrollment effective date, and dental services must be obtained through the MHP's dental provider network. Questions regarding eligibility, PA, or the provider network should be directed to the beneficiary's MHP.

Dental services for HMP beneficiaries who are not enrolled in an MHP will be provided through the Medicaid FFS program.

* * *

SECTION 3 – PRIOR AUTHORIZATION

Prior authorization (PA) is required for services identified in this chapter and the Medicaid Code and Rate Reference tool. For questions about medically necessary dental services beyond those described in this chapter, providers should contact the MDHHS Program Review Division (PRD). (Refer to the Directory Appendix for website and contact information.)

* * *

SECTION 7 – COVERED SERVICES

This section provides information on Medicaid covered services and is divided into subsections that correspond to the categories of services in the CDT published by the ADA:

- Diagnostic Services

- Preventive Services
- Restorative Treatment
- Endodontics
- Periodontics
- Prosthodontics (Removable)
- Oral Surgery
- Adjunctive General Services

Providers must use the current CDT procedure codes when completing both the claim form and MSA-1680-B. Resources are available to assist the provider in determining coverage and coding of specific services, including the Medicaid Code and Rate Reference tool via the external link in CHAMPS and the MDHHS Dental Fee Schedule located on the MDHHS website. (Refer to the Additional Code/Coverage Resource Materials subsection of the General Information for Providers chapter of this manual for additional information on code/coverage parameters and the Directory Appendix for website information. Billing information can be found in the Billing & Reimbursement for Dental Providers chapter of this manual.)

* * *

7.3 RESTORATIVE TREATMENT

Restorative treatment using amalgam or direct resin-based composite materials to restore carious lesions or fractured teeth is a covered benefit for all beneficiaries. Indirect restorations (crowns) are covered for all beneficiaries. Restorative treatment is limited to those services necessary to restore and maintain adequate dental health. The prognosis of the tooth to be restored, as well as the overall treatment plan for the beneficiary, and a reasonable projection of a successful outcome should be evaluated prior to restoration.

Replacement or repair of all restorations is the provider's responsibility for the first two years following placement. A PA for dentures and partial dentures which includes extraction of the restored tooth within the first two years following placement requires a documented reason for the extraction.
(Refer to the Additional Code/Coverage Resource Materials subsection of the General Information for Providers chapter for additional information regarding coverage parameters.)

Restorations are not covered for deciduous teeth when exfoliation is expected to occur within 180 days.

Restorations of deciduous molars and cuspids are not covered for beneficiaries age 12 and older, and restorations of deciduous incisors are not covered for beneficiaries age five and older.

* * *

7.3.C. INDIRECT RESTORATIONS

Crowns are a covered benefit for all beneficiaries. Crown coverage includes:

Stainless Steel Crowns	▪ Stainless steel crowns are covered for primary teeth and permanent molars. ▪ Stainless steel crowns with resin windows are covered for anterior primary teeth. ▪ Stainless steel crowns are covered only once per two years.
Crowns	▪ Laboratory-processed resin crown and ¾ resin crowns (indirect) – for anterior permanent teeth only. ▪ Porcelain and porcelain fused to metal crowns (indirect) are covered for permanent first and second premolars, canines, and incisors. ▪ Metal crowns only on molars. ▪ Crowns are covered once per five years on the same tooth.

The following are allowed for permanent teeth when a restorative crown will be placed:

- Direct core build-up, including any pins.
- Post and core substructures (indirectly fabricated or prefabricated).

The prognosis of the tooth to be restored, as well as the overall

treatment plan for the beneficiary and a reasonable projection of a successful outcome, should be evaluated prior to restoration.

Providers must verify with MDHHS that the beneficiary is eligible for a crown per the five-year rule as described in the Frequency Verification Process section below prior to rendering service. Failure to complete the verification process may result in claim denial.

When billing for laboratory-processed crowns, the date of service is the date the crown was delivered to the beneficiary.

MPM, January 1, 2025 version
Dental Chapter
Pages 1, 3, 12, 20-21

Consistent with the above policies and its contract with the Department, Respondent has developed its prior authorization requirements, utilization management, and review criteria. With respect to crowns, Respondent's Medicaid Dental Handbook states:

Covered services include:

* * *

- Crowns, including porcelain, metal and resin based (1 in 5 years)

Note: Crowns are payable only for extensive loss of tooth structure for caries or fracture. Tooth loss must be at least 50%.

Exhibit A, pages 17-18

Here, Respondent found that Petitioner's prior authorization request for a dental crown placement for tooth #29 pursuant to the above policies.

In appealing that decision, Petitioner has the burden of proving by a preponderance of the evidence that Respondent erred. 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 failed to satisfy her burden of proof, and Respondent's decision must be affirmed.

As clearly provided in the criteria outlined in Respondent's Handbook, criteria which Respondent is permitted to develop and that is consistent with Medicaid policy, crowns are

only covered for extensive tooth loss structure of at least 50%. Moreover, while the dentist indicated that Petitioner had such loss in tooth #29, both Respondent's Director of Utilization Management and Petitioner's representative agreed that the actual radiographs submitted along with the prior authorization request did not indicate tooth loss of at least 50% or medical necessity for the requested crown. Accordingly, the request was properly denied.

Rather than disputing what the prior authorization request showed, Petitioner's representative initially disputed the fact that Petitioner has been billed for a crown that Petitioner never received. However, Petitioner subsequently testified that she has been reimbursed for any billing and, regardless, any dispute between Petitioner and her provider is outside the scope of this proceeding.

Petitioner's representative also testified that the radiographs failed to demonstrate all of Petitioner's tooth loss and that she tried to get the dentist to retake radiographs. However, while the ALJ appreciates that Petitioner is dependent on a provider to submit documentation, and that the documentation may be incomplete, he is also limited to reviewing Respondent's decision in light of the information that was available at the time the decision was made. To the extent Petitioner has additional or updated information to provide, then Petitioner can always request services again in the future along with that information. With respect to the decision at issue in this case however, Respondent's decision must be affirmed given the available information and applicable policies.

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/sj

Steven Kibit

Steven Kibit
Administrative Law Judge

APPEAL RIGHTS: Petitioner may appeal this Hearing Decision to the circuit court. Rules for appeals to the circuit court can be found in the Michigan Court Rules (MCR), including MCR 7.101 to MCR 7.123, available at the Michigan Courts website at courts.michigan.gov. The Michigan Office of Administrative Hearings and Rules (MOAHR) cannot provide legal advice, but assistance may be available through the State Bar of Michigan at https://lrs.michbar.org or Michigan Legal Help at https://michiganlegalhelp.org. A copy of the circuit court appeal should be sent to MOAHR. A circuit court appeal may result in a reversal of the Hearing Decision.

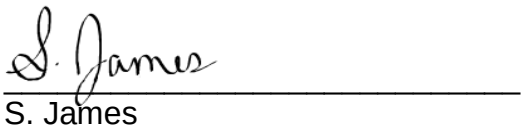
Either party who disagrees with this Hearing Decision may also send a written request for a rehearing and/or reconsideration to MOAHR within 30 days of the mailing date of this Hearing Decision. The request should include Petitioner's name, the docket number from page 1 of this Hearing Decision, an explanation of the specific reasons for the request, and any documents supporting the request. The request should be sent to MOAHR

- by email to LARA-MOAHR-DCH@michigan.gov **OR**
- by fax at (517) 763-0155, **OR**
- by mail addressed to
  Michigan Office of Administrative Hearings and Rules
  Rehearing/Reconsideration Request
  P.O. Box 30639
  Lansing Michigan 48909-8139

Documents sent via email are not secure and can be faxed or mailed to avoid any potential risks. Requests MOAHR receives more than 30 days from the mailing date of this Hearing Decision may be considered untimely and dismissed.

PROOF OF SERVICE

I certify that I served a copy of the foregoing document upon all parties, to their last known addresses in the manner specified below, this 26th day of March 2025.



S. James
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