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

Date Mailed: May 2, 2025
Docket No.: 25-011100
Case No.: [redacted]
Petitioner: [redacted]

[redacted]
MI [redacted]

This is an important legal document. Please have someone translate the document.

هذه وثيقة قانونية مهمة. يرجى أن يكون هناك شخص ما يترجم المستند.

এটি একটি গুরুত্বপূর্ণ আইনি ডকুমেন্ট। দয়া করে কেউ দস্তাবেজ অনুবাদ করুন।

Este es un documento legal importante. Por favor, que alguien traduzca el documento.

这是一份重要的法律文件。请让别人翻译文件。

Ky është një dokument ligjor i rëndësishëm. Ju lutem, kini dikë ta përktheni dokumentin.

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Case No.: [redacted]
Petitioner: [redacted]

DECISION AND ORDER

This matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9 and 42 CFR 431.200 *et seq.,* and upon Petitioner's request for hearing.

After due notice, a telephone hearing was held on May 1, 2025. [redacted] Petitioner, appeared and testified on her own behalf. Katie Singletary, Clinical Appeals, appeared on behalf of Respondent Blue Cross Complete, the Medicaid Health Plan (Respondent or MHP). Dr. Michael Sofianos, Dental Consultant, DentaQuest, and Njelle Aiken, Complaints and Grievances, DentaQuest, appeared as witnesses for Respondent.

During the hearing, Respondent submitted an evidence packet that was admitted into the record as Exhibits A-L, pages 1-127.

ISSUE

Did Respondent properly deny Petitioner's request for reimbursement for out-of-network dental work?

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 has been receiving services through Respondent MHP. (Exhibit B; Testimony).

2. In June 2024, Petitioner needed to have a crown glued back on after it fell off. (Exhibit D, p 27; Testimony). Petitioner went to Healthy Smiles, a Medicaid enrolled dental clinic, but was told they did not have anyone there who could glue the crown back on. (*Id*.) Healthy Smiles then referred Petitioner to dental clinics in Chelsea, Michigan and Flint, Michigan for the procedure. (*Id*.)

3. On June 24, 2024, Petitioner went to a local dentist and had the crown glued back on as she did not feel she could drive all the way to Chelsea or Flint for the procedure. (*Id*.) Petitioner indicated that the tooth with the missing crown was really bothering her and affecting her ability to eat. (Testimony.) Petitioner paid for the service out of pocket in the amount of $195.00. (Exhibit D, p 26; Testimony.)

4. On June 27, 2024, Petitioner called the MHP to seek reimbursement for the out of network dental expenses she incurred. (Exhibit D, p 27; Testimony.) Petitioner was told that the MHP would send her a reimbursement form, but Petitioner never received one. (*Id*.)

5. On July 22, 2024, Petitioner called the MHP because she had not received the reimbursement form. (*Id*.) Petitioner was then informed that they do not send out reimbursement forms and that Petitioner needed to send her concerns in writing to the claims processing department. (*Id*.)

6. Petitioner sent her concerns in writing to the address provided to her but never received a response. (*Id*.)

7. On September 4, 2024, after not hearing anything, she called the MHP again, who informed Petitioner that they never received the correspondence. (*Id*.) Petitioner was informed during the phone call that she needed to file a grievance and the representative indicated that she would take the grievance over the phone. (*Id*.)

8. On September 9, 2024, Petitioner received a letter from the MHP indicating that her grievance was being reviewed. (*Id*.)

9. On September 17, 2024, Petitioner received correspondence from the MHP denying her grievance. (Exhibit D, p 28; Testimony). Petitioner noted that the information in the letter did not correspond to the information she provided to the MHP. (*Id*.)

10. On September 23, 2024, Petitioner contacted the MHP regarding the incorrect information in the grievance denial letter and was told by the representative that he would refile the grievance. (*Id*.)

11. On September 25, 2024, Petitioner received a letter from Healthy Smiles indicating that due to a breakdown in the doctor-patient relationship, Petitioner was no longer welcome to be seen there. (*Id*.)

12. On September 30, 2024, Petitioner contacted the MHP to discuss the letter she received from Healthy Smiles and was told to wait for the second grievance to be processed. (*Id*.) Petitioner also contacted Healthy Smiles

to discuss the letter. (*Id*.)

13. On October 8, 2024, Petitioner received correspondence from Respondent denying the second grievance. (*Id*.) Petitioner indicated that this correspondence also included misinformation. (*Id*.)

14. On October 21, 2024, Petitioner called the MHP and was told that they would send her a State Fair Hearing form to request a hearing. (Exhibit D, p 29; Testimony.)

15. On November 4, 2024, Petitioner's first request for hearing was received by the Michigan Office of Administrative Hearings and Rules (MOAHR). (Exhibit D, p 12; Testimony.)

16. On November 12, 2024, Petitioner's request for hearing was returned to her so that the required internal appeal could be completed. (Exhibit D, p 13; Testimony.)

17. On November 15, 2024, Petitioner dropped off her request for a local appeal at the local DHS office in Lansing. (Exhibit D, p 16; Testimony.)

18. On November 22, 2024, Petitioner started making calls after not hearing anything about the local appeal. (*Id*.) Petitioner was eventually told by an MHP representative that they would take the local appeal over the phone and that she should receive a response within 7-10 business days. (*Id*.)

19. On December 6, 2024, after not hearing anything from the MHP, Petitioner called them and discovered that the "local appeal" taken over the phone on November 22, 2024 was actually treated as a grievance. (Exhibit D, p 17; Testimony).

20. On December 16, 2024, Petitioner received a letter denying this third grievance. (Exhibit D, p 18; Testimony).

21. Petitioner made further calls to the MHP on January 10, 2025, January 21, 2025, January 22, 2025, January 23, 2025, and January 27, 2025 trying to initiate an internal appeal. (Exhibit D, pp 19-23; Testimony.)

22. On February 10, 2025, an internal appeal was initiated by the MHP. (Exhibit D, p 36; Testimony.)

23. On February 24, 2025, the MHP sent Petitioner a letter indicating that it was reviewing Petitioner's internal appeal. (Exhibit J, pp 80-97; Testimony.)

24. On February 25, 2025, the MHP sent Petitioner a letter indicating that her internal appeal was denied because the services were performed by an out of network provider. (Exhibit L, pp 102-127.)

25. On March 27, 2025, MOAHR received Petitioner's second request for hearing. (Exhibit D, pp 9-44).

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 statutes, 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:

> **SECTION 1 – GENERAL INFORMATION**
>
> 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.

1.1 SERVICES COVERED BY MEDICAID HEALTH PLANS (MHPS)

The following services must be covered by MHPs:

****

- Dental services for adults

****

2.7 OUT-OF-NETWORK SERVICES

2.7.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.

Medicaid Provider Manual
Medicaid Health Plans Chapter
January 1, 2025, pp 1, 6
Emphasis added

Here, Respondent's witness testified that the MHP received a claim request for gluing a

crown back on for Petitioner from June 2024 and denied the claim because the provider was out of network.

Petitioner testified that she called Healthy Smiles when her crown fell off to see if they could glue it back on. Petitioner indicated that she had only been to Healthy Smiles once or twice after her prior dentist had retired. Petitioner indicated that Healthy Smiles told her they did not have anyone who could perform that service and referred Petitioner to dental clinics in Chelsea and Flint, Michigan.

Petitioner indicated that she could not drive that far to get the crown fixed and it was really bothering her and affecting her ability to eat so she found a local specialist who was able to do it. Petitioner testified that she told the dentist she had Blue Cross Complete and the dentist informed her that he did not accept that insurance. Petitioner testified that the tooth was really bothering her so she had the dentist perform the procedure and paid $195.00 out of pocket.

Petitioner testified that she spoke to 76 people during this ordeal after calling over 32 times. Petitioner indicated that she was repeatedly given incorrect or misleading information.

Petitioner bears the burden of proving by a preponderance of the evidence that the Respondent erred in denying the claim request. Given the record and applicable policies in this case, Petitioner has met this burden of proof so Respondent's decision must be reversed.

As indicated above, Respondent may require beneficiaries to first consider in-network providers for dental services before approving out of network providers. Here, Respondent did not include any of its internal policies regarding out-of-network providers in its evidence, so this ALJ must rely on the policy above from the Medicaid provider manual. However, MHP policy usually indicates that out-of-network providers may be approved if the service is not available locally and the beneficiary receives prior authorization to see an out-of-network provider. Policy also usually provides that prior authorization may be waived in an emergency. Again, Respondent did not include its actual policy, so this is just a generalization.

Here, Petitioner asked her Medicaid enrolled dental provider (Healthy Smiles) to glue her crown back on, but the provider informed her that they were unable to do so and Petitioner would have to go to either Chelsea or Flint, Michigan. As such, it does not appear that this particular service was available locally. Further, Petitioner indicated that the tooth without the crown really was bothering her and affecting her ability to eat, so it was an emergent situation requiring prompt attention. As such, prior authorization was unnecessary.

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

As such, Respondent should reimburse Petitioner at the Medicaid rate in effect on June 4, 2024, up to the amount of Petitioner's out-of-pocket expenses. This may be less than Petitioner's out-of-pocket expenses.

Therefore, given the above findings of fact and conclusions of law, Respondent's decision was improper and must be reversed.

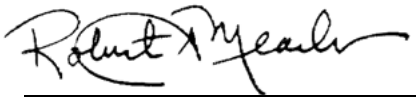
DECISION AND ORDER

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

IT IS, THEREFORE, ORDERED that:

The Respondent's decision is **REVERSED.**

Within 10 days of receipt of this Decision and Order Respondent shall certify to MOAHR that it has taken action consistent with this Decision by reimbursing Petitioner (at the rate Medicaid would have paid) for the service.



ROBERT J. MEADE
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.

Via Electronic Mail:

Community Health Representative
AMERIHEALTH CARITAS
100 GALLERIA OFFICENTRE
SOUTHFIELD, MI 48034
ACOLTRAIN@AMERIHEALTHCARITASIA.COM

Community Health Representative
BLUE CROSS COMPLETE OF MI
4000 TOWN CNTR STE 300
SOUTHFIELD, MI 48075
BCCMISFH@MIBLUECROSSCOMPLETE.COM

Department Contact
MDHHS-MANAGED CARE PLAN DIVISION
400 S PINE ST 7TH FL
LANSING, MI 48933
MDHHS-MCPD@MICHIGAN.GOV

Via First Class Mail:

Petitioner
[redacted]
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