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

Date Mailed: June 27, 2025
Docket No.: 25-018806
Case No.: [redacted]
Petitioner: [redacted]

[redacted]
[redacted] MI [redacted]

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

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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.

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Case No.: [redacted]
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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 June 24, 2025. Petitioner appeared and testified 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.

Exhibits:

Petitioner	None
Respondent	A. Hearing Summary

ISSUE

Did Respondent properly deny Petitioner's request 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 Medicaid beneficiary enrolled in a Medicaid Health Plan (MHP) who is eligible for dental services through Respondent pursuant to the Healthy Michigan Plan and Respondent's contract with Petitioner's MHP. (Exhibit A; Testimony).

2. On January 27, 2025, a Painless Dental Center PC submitted a claim to Respondent related to a dental crown for Petitioner. (Exhibit A).

3. The documentation submitted along with that claim did not indicate that Petitioner had tooth loss of at least 50%, of tooth structure for caries or fracture. (Exhibit A, Testimony).

4. On February 5, 2025, Respondent denied that claim on the basis that Petitioner did not meet the criteria for a crown. (Exhibit A; Testimony).

5. On March 4, 2025, Petitioner filed an Internal Appeal with Respondent. (Exhibit A).

6. On March 5, 2025, Respondent sent Petitioner a written Notice of Internal Appeal Decision – Denial stating that Petitioner's Internal Appeal had been denied. (Exhibit A; Testimony).

7. With respect to the reason for the denial, the notice stated in part:

> Your appeal was reviewed by an Appeals and Grievance Research Specialist and a consulting dentist. The consultant is a Licensed Dentist Peer Reviewer, D.D.S., General Dentist. The appeal review is complete. Crowns are only covered when medically necessary. Your plan does not cover services that are not medically necessary. All dental benefit plans have limitations. They are created when the plan is made. Delta Dental cannot change these. A dentist may suggest treatment for a patient that is not covered. The fact that a service is not covered should not stop you from having the service. You should have the service if you believe it has value to you. The Healthy Michigan Plan Dental Handbook says on page 3-4:
>
> "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%."[1]

8. On May 19, 2025, MOAHR received the request for hearing filed in this matter. (Hearing File).

[1] Exhibit A, p 37.

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.

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 (MHPs).

Respondent is a dental provider and vendor contracted with Petitioner's MHP, and as provided in the Medicaid Provider Manual (MPM), is responsible for providing covered services pursuant to a contract with the Department and the MHP:

> 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 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

* * *

2.2 DENTAL SERVICES

Adult 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.[2]

As allowed by the above policy and its contract with the Department, Respondent has chosen to use its own prior authorization requirements, utilization management, and review criteria.

In part, Respondent's Medicaid Dental Handbook states:

[2] MPM, Medicaid Health Plans, January 1, 2025, pp 1-2, 5.

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%.

- **Crown buildup, including pins**[3]

The policies in Respondent's handbook are also consistent with the provisions of the Department's MPM:

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

[3] Exhibit A.

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 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 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.[4]

[4] MPM, Dental, January 1, 2025, pp 1, 3, 12, 20-21.

Here, Respondent denied Petitioner's request for a crown placement 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% for caries or fracture; and the record does not demonstrate that Petitioner met such criteria here.

Respondent's witness credibly testified that the information submitted along with the request in this case did not indicate tooth loss of at least 50% or medical necessity for the requested crown or accompanying direct core build-up.

Moreover, while Petitioner argued she has updated x-rays as well as Petitioner testifying herself that her tooth was causing discomfort, neither Petitioner's testimony nor the unsubmitted x-rays is sufficient to meet Petitioner's burden of proof given the specific criteria that must be met and the credible testimony of Respondent's witness.

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 request for dental services.

IT IS, THEREFORE, ORDERED that:

Respondent's decision is **AFFIRMED**.

COREY A. ARENDT

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 MOAHR-BSD-Support@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 First Class and Electronic Mail:

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[redacted] MI [redacted]
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Via Electronic Mail:

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