Michigan Office of Administrative Hearings and Rules
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Date Mailed: November 17, 2025
Docket No.: 25-032380
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।

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。

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Date Mailed: November 17, 2025
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Case No.: [redacted]
Petitioner: [redacted]

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 October 21, 2025. Petitioner appeared and testified on his own behalf. Jennifer Murphy, Supervisor of Appeals Department, appeared and testified on behalf of Respondent Blue Cross Complete of Michigan (Respondent), a Medicaid Health Plan (MHP). Dr. Evan Blackwell, a Dental Representative from DentaQuest, also testified as a witness for Respondent.

During the hearing, Respondent submitted twelve proposed exhibits that were admitted into the record without objection as Exhibits A-M. No other proposed exhibits were submitted.

ISSUE

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

FINDINGS OF FACT

The ALJ, based upon the competent, material and substantial evidence on the whole record, finds as material fact:

1. Petitioner is a Medicaid beneficiary enrolled with Respondent and who is eligible for dental services through Respondent, with his dental benefits administered by DentaQuest pursuant to its contract with Respondent. (Exhibit D, page 1; Testimony of Respondent's representative).

2. On July 22, 2025, a dental provider submitted a request to Respondent for dental services for Petitioner, including core buildup and a crown for Petitioner's Tooth #19. (Exhibit D, page 1).

3. The request was reviewed by a dentist from DentaQuest, who recommended that it be denied. (Exhibit F, pages 1-4).

4. On July 25, 2025, Respondent sent Petitioner written notice stating that Petitioner's request for core buildup and a crown for Tooth #19 had been denied. (Exhibit G, pages 1-12).

5. With respect to the reason for the denial, the notice stated:

> You have a cap on your tooth. Your dentist has asked to put a new cap on the same tooth. The x-rays of your tooth do not show that you have a cavity under the old cap. It is not medically necessary to replace the cap on your tooth. We have told your dentist this also. Please talk to your dentist.
>
> This applies to
> - a hard material (filling) put in a tooth to strengthen the tooth to hold a crown , Tooth 19
> - high gold content crown, Tooth 19
>
> This decision was based on the DentaQuest Clinical Criteria for Crowns
>
> This decision was based on the Michigan Department of Health and Human Services, Medicaid Provider Manual, Dental Services, 6.3.B Indirect Restorations
>
> This decision was based on the Michigan Department of Health and Human Services, Medicaid Provider Manual, Dental Services, 6.3 Restorative Treatment

Exhibit G, page 3

6. On July 19, 2025, Petitioner filed an appeal with Respondent with respect to that decision. (Exhibit H, pages 1-4).

7. On July 30, 2025, Respondent sent Petitioner written notice that his appeal had been denied. (Exhibit L, pages 1-5).

8. With respect to the reason for the decision, the notice stated:

> **Your appeal is denied.** Blue Cross Complete denied your appeal because You are [redacted] years old. You have a dental disorder. The tooth does not appear to have significant breakdown due to decay or trauma. You have a cap on your tooth. Your dentist has asked to put a new cap on the same tooth. The x-rays of your tooth show that you do not have a cavity under the old cap. It is not medically necessary to replace the cap on your tooth. The denial is upheld.
>
> Michigan Department of Health and Human Services, Medicaid Provider Manual, DentalServices, 7.3 Restorative Treatment, 7.3.C Indirect Restorations,

> BCC Michigan Office Manual DentaQuest, Exhibit A page 89 and Clinical Criteria for Crowns 14.02 pg 44 were used in making the decision.
>
> Our decision is final. If you don't agree with our final decision, you have the right to request an external review or Medicaid Fair Hearing. Your request for a Medicaid Fair Hearing must be made within 120 calendar days of receiving our final decision.

Exhibit L, page 3

9. On September 12, 2025, MOAHR received the request for hearing filed in this matter with respect to the denial of Petitioner's request for dental services. (Exhibit M, pages 1-3).

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 Petitioner's MHP and, as provided in the Medicaid Provider Manual (MPM), is responsible for providing covered services through its dental vendor, DentaQuest, pursuant to a 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 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.

MPM, July 1, 2025 version
MHP Chapter, pages 1-2, 5

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.

With respect to crowns, Respondent's and DentaQuest's policy states in part:

14.02 CRITERIA FOR CAST CROWNS

Documentation needed for authorization of procedure:

- Appropriate radiographs clearly showing the adjacent and opposing teeth should be submitted for authorization review: bitewings, periapicals or panorex.

- Treatment rendered without necessary authorization will still require that sufficient and appropriate radiographs clearly showing the adjacent and opposing teeth be submitted with the claim for review for payment.

Criteria

- In general, criteria for crowns will be met only for permanent teeth needing multi-surface restorations where other restorative materials have a poor prognosis.

- Permanent molar teeth must have pathologic destruction to the tooth by caries or should involve four or more surfaces and two or more cusps.

- Permanent bicuspid teeth must have pathologic destruction to the tooth by caries or trauma, and should involve three or more surfaces and at least one cusp.

- Permanent anterior teeth must have pathologic destruction to the tooth by caries or trauma, and must

involve four or more surfaces and at least 50% of the incisal edge.

A request for a crown following root canal therapy must meet the following criteria:

- Request should include a dated post-endodontic radiograph.

- Tooth should be filled sufficiently close to the radiological apex to ensure that an apical seal is achieved, unless there is a curvature or calcification of the canal that limits the ability to fill the canal to the apex.

- The filling must be properly condensed/obturated. Filling material does not extend excessively beyond the apex.

To meet criteria, a crown must be opposed by a tooth or denture in the opposite arch or be an abutment for a partial denture.

- The patient must be free from active and advanced periodontal disease.

- The fee for crowns includes the temporary crown that is placed on the prepared tooth and worn while the permanent crown is being fabricated for permanent anterior teeth.

- Cast Crowns on permanent teeth are expected to last, at a minimum, five years.

Authorizations for Crowns will not meet criteria if:

- A lesser means of restoration is possible.

- Tooth has subosseous and/or furcation caries.

- Tooth has advanced periodontal disease.

- Tooth is a primary tooth.

- Crowns are being planned to alter vertical dimension.

- An existing crown is present with an open margin without decay.

- An existing crown is present with chipped or fractured porcelain without decay.

Exhibit J, pages 3-4

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 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.)

* * *

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, April 1, 2025 version
Dental Chapter, pages 1, 12, 20-21

Here, Respondent denied Petitioner's request for a core buildup and a crown for Petitioner's Tooth #19 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 ALJ 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 his burden of proof, and Respondent's decision must be affirmed.

As clearly provided in the criteria outlined in Respondent's policy, criteria which Respondent is permitted to develop and that is consistent with Medicaid policy, the requested dental services must be both generally medically necessary and meet the applicable specific criteria; and the record does not demonstrate that Petitioner met such criteria here. As credibly testified to by Dr. Blackwell, the limited information submitted in support of the request did not support either a finding of medical necessity or that the applicable specific criteria had been met.

In response, Petitioner testified that, while he understands that only x-rays were submitted first, and that those x-rays alone were insufficient to demonstrate medical necessity, his dental surgeon was supposed to submit additional information. Petitioner also testified that he did not know if additional information was submitted, but that he needs the dental services.

However, while the undersigned ALJ appreciates Petitioner's testimony, it is unsupported by any other evidence in the record and therefore insufficient to meet Petitioner's burden of proof given the specific criteria that must be met and the credible

testimony of Respondent's witness regarding what was received and why it did not demonstrate medical necessity.

To the extent Petitioner has additional or updated information to provide, he 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**.

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.

Via First Class & Electronic Mail:

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