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

Date Mailed: November 5, 2025
Docket No.: 25-033454
Case No.: [redacted]
Petitioner: [redacted]

[redacted]
[redacted] MI [redacted]

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

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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 October 23, 2025. Petitioner appeared and testified on his own behalf. Assistant General Counsel Austin Fassett appeared and testified on behalf of Respondent Delta Dental of Michigan, Inc. (Respondent). Dr. Michelle Kohler, Chief Dental Officer, also testified as a witness for Respondent.

During the hearing process, the following exhibits were admitted into the record without objection:

Petitioner's Exhibit:

Exhibit #1: Request for Hearing

Respondent's Exhibit:

Exhibit A: Evidence Packet

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 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, page 1; Testimony of Respondent's representative).

2. On April 8, 2025, a dental provider submitted a pre-treatment estimate for an upper partial dental for Petitioner to Respondent. (Exhibit A, page 14).

3. On April 17, 2025, Respondent sent Petitioner a Notice of Adverse Benefit Determination stating that the request for an upper partial denture was denied. (Exhibit A, pages 6-9).

4. With respect to the reason for the denial, the notice stated that the information provided did not show that an upper partial denture was the right care for Petitioner because Petitioner's remaining teeth are not healthy enough to support the denture. (Exhibit A, page 6).

5. Petitioner then filed an Internal Appeal with Respondent. (Testimony of Respondent's representative).

6. On April 25, 2025, Respondent sent Petitioner a written Notice of Internal Appeal Decision – Denial stating that Petitioner's Internal Appeal had been denied. (Exhibit #1, pages 39-50).

7. 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 #1, pages 1-26).

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.
>
> *MPM, April 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 dentures, Respondent's Medicaid Dental Handbook states in part:

> The benefit for partial dentures includes all of the following items and services:
>
> - Model work and articulation.
> - Baseplate/biterim.
> - Duplicate model for processing.
> - Teeth setup for try-in.
> - Premium quality hardened plastic teeth (see below).
> - Resetting of teeth (unlimited).
> - Appropriately designed and fabricated, regarding acrylic and clasp type.
> - Any reline/rebase, adjustment or repair required within six months of delivery except in the case of immediate dentures.
>
> Removable Partial Dentures: To be eligible for a removable partial denture, the following conditions must be met:

- Partial dentures are only a benefit once per five (5) years per arch.

- Providers must attest to the expected prognosis of the partial denture in the remarks section of the claim. Expected prognosis must be at least five (5) years.

- Medical necessity of the partial denture, including replacement of one or more missing anterior teeth, or replacement of multiple missing posterior teeth in the same arch (excluding third molars) when a functional deficit is present.

Required Documentation/Clinical Information for Removable Partial Denture Review:

- Full mouth x-rays or panorex with claim.

- All radiographs must be clearly marked with the patient name, date of exposure, treating dentist and an indication of the patient's right and left

- Additional documentation may be requested if necessary to understand the diagnosis or treatment

Exhibit A, page 126

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.)

* * *

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.)

* * *

7.6 PROSTHODONTICS (REMOVABLE)

7.6.A. GENERAL INSTRUCTIONS

Complete dentures, immediate complete dentures, and partial dentures are benefits for all beneficiaries. Complete and partial dentures are benefits once per five years per arch when the expected prognosis of the complete or partial denture is at least five years. Complete and partial dentures do not require PA. Providers must verify with MDHHS that the beneficiary is eligible for a complete or partial denture per the five-year rule prior to rendering service, as described in the Frequency Verification Process section of this chapter. Failure to complete the verification process may result in claim denial.

Providers must assess the beneficiary's general oral health and provide a five-year prognosis for the complete or partial denture requested. The provider is expected to evaluate whether the treatment is appropriate for the individual beneficiary, and assess the probability of delivering removable dentures and the beneficiary's compliance with follow-up care.

It is the provider's responsibility to discuss the treatment plan with the beneficiary, including any applicable frequency limits and other pertinent information related to the proposed services, and obtain the beneficiary's agreement with the proposed treatment plan. Documentation of the beneficiary's agreement must be retained in the beneficiary's dental record.

The following documentation must be retained in the beneficiary's dental record and made available to MDHHS upon request:

- Beneficiary understanding and agreement that another denture is not a covered benefit for five years.

- Beneficiary education addressing all available treatment options and documentation of the beneficiary's understanding and agreement.

> Before the final impressions are taken for the fabrication of a denture, adequate healing necessary to support the denture must take place following the completion of extractions and/or surgical procedures.
>
> When billing for a complete or partial denture, the date of service is the date the denture was delivered to the beneficiary. Reimbursement for a complete or partial denture includes all necessary adjustments, relines, repairs, duplication, etc. within six months of insertion.
>
> Complete or partial dentures are not a covered benefit when:
>
> - Medicaid or Medicaid Managed Care has reimbursed a denture in the same arch within five years.
> - An adjustment, reline, repair, or rebase will make the current denture serviceable.
> - A complete or partial denture obtained through Medicaid within five years has been lost or broken.
> - The expected prognosis of the complete or partial denture is less than five years.
>
> *MPM, April 1, 2025 version*
> *Dental Chapter, pages 1-3, 12, 25*

Here, Respondent denied Petitioner's request for an upper partial denture 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 Handbook, criteria which Respondent is permitted to develop and that is consistent with Medicaid policy, partial dentures are not a covered benefit when the expected prognosis of the partial denture is

less than five years; and the record does not demonstrate that Petitioner met such criteria here.

Respondent's Chief Dental Officer credibly testified that the information submitted along with the request in this case showed Petitioner's history of bone loss, his Stage 4 periodontal disease, and that, given the poor health of Petitioner's remaining upper teeth, that any partial denture would not last five years.

In response, Petitioner testified that his dentist is recommending the partial denture. He also testified that the problems identified by Respondent's Chief Dental Officer have been present since at least 2018 and that Petitioner's teeth, except two that were pulled, have remained in place since that time and longer than five years. Petitioner further testified that he needs the partial denture and just wants to keep the teeth he has for as long as he can.

However, while the undersigned ALJ appreciates Petitioner's testimony, it is unsupported and insufficient to meet Petitioner's burden of proof given the specific criteria that must be met and the credible testimony of Respondent's Chief Dental Officer. There is nothing in the record, beyond that testimony, suggesting that the expected prognosis of the requested partial denture would be at least five years.

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 Electronic Mail:

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