

STATE OF MICHIGAN
DEPARTMENT OF ENERGY, LABOR & ECONOMIC GROWTH
OFFICE OF FINANCIAL AND INSURANCE REGULATION
Before the Commissioner of Financial and Insurance Regulation

In the matter of

XXXXX

Petitioner

V

File No. 104781-001

Priority Health

Respondent

_____/

**Issued and entered
this 26th day of June 2009
by Ken Ross
Commissioner**

ORDER

**I
BACKGROUND**

On May 7, 2009, XXXXX (Petitioner) filed a request for external review with the Commissioner of Financial and Insurance Regulation under the Patient's Right to Independent Review Act, MCL 550.1901 *et seq.* On May 14, 2009, after a preliminary review of the material submitted, the Commissioner accepted the request for external review.

The Commissioner notified Priority Health of the external review and requested the information used in making its adverse determination. Priority Health submitted the information on May 19, 2009.

The issue in this external review can be decided by an analysis of the contract that defines the Petitioner's health care benefits. The Commissioner reviews contractual issues under MCL 500.1911(7). This matter does not require a medical opinion from an independent review organization.

II FACTUAL BACKGROUND

The Petitioner is a member of Priority Health. Her health care benefits are defined in the Certificate of Coverage and Medical Policy Nos. 91542-R1 Oral Surgery and 91523-R1 Dental Extractions.

The Petitioner has Sjogren's syndrome, an autoimmune disorder which causes decreased saliva that results in increased bacteria. Beginning in 2004, this caused Petitioner dental problems including decay, which in turn required extensive dental work including root canals, tooth extractions, and crowns.

The Petitioner requested coverage for several dental procedures which resulted from the lack of saliva. Priority Health denied the request and the Petitioner appealed. At the conclusion of Priority Health's internal grievance process the Petitioner received Priority Health's final adverse determination letter dated May 1, 2009.

III ISSUE

Did Priority Health properly deny the Petitioner coverage for dental procedures under the terms of the certificate?

IV ANALYSIS

Petitioner's Argument

The Petitioner says her need for dental procedures is caused by Sjogren's syndrome and therefore her care does not constitute "routine dental services" and should be covered under her plan.

The Petitioner says her physicians believe that her dental treatment is medically necessary due to her diagnosis of Sjogren's syndrome. In a letter to Priority Health dated May 5, 2008, Petitioner's general dentist, XXXXX, DDS, wrote:

[Petitioner] has been a patient of record in this dental office since January 24, 2008. Due to her medical diagnosis her dental treatment needs to be handled aggressively as it has escalated into rampant decay.

She is committed to having treatment completed so that she may be placed into a maintenance phase where her "diseased state" may be controlled.

In an undated letter, XXXXX, MD, of XXXXX, stated:

I am writing this letter on behalf of my patient [Petitioner] who as you know was recently diagnosed with Sjorgens syndrome by Dr XXXXX of Rheumatology on April 24, 2007. . . . [Petitioner] had been suffering from these symptoms of dry mouth and other mucous membranes for some time. She had been regularly been seen by her dentist Dr XXXXX as well as a periodontist but the damage from her Sjorgens syndrome had significantly affected her teeth. She has needed significant dental work to keep her teeth healthy, which has caused significant financial stress and strain.

The Petitioner contends the dental work should be covered based on medical necessity. She therefore wants Priority Health to provide coverage as a benefit under her health coverage.

Respondent's Argument

In its May 1, 2009, final adverse determination, Priority Health denied coverage for the services because "Dental services are not a covered benefit as outlined by Priority Health Medical Policy 91542-R1 for Oral Surgery, Medical Policy 91523-R1 for Dental Extractions, the Schedule of Copayments and Deductibles, and the Certificate of Coverage. . . ." Relevant portions of those provisions are reprinted below.

From the Priority Health certificate of coverage:

SECTION 6. Covered and Non-Covered Services

* * *

H. Dental, Vision And Hearing Services

1. Dental Services

* * *

Non-Covered Services

Unless you have a dental rider to this Certificate, dental services are not Covered, including among other things:

- (a) Routine dental services.
- (b) Dental x-rays.

(c) Dental surgery, such as root canals and tooth extractions, even when provided in conjunction with other treatment or surgery.

* * *

(f) Dental prostheses, including implants and dentures and reparation of the bone to receive implants or dentures.

* * *

(j) Treatment, services and supplies related to periodontal/inflammatory gum disease.

From Priority Health's medical policies:

Medical Policy No. 91523-R1 titled Dental Extractions

* * *

II. Policy/Criteria

Priority Health will pay for dental extractions of sound, natural teeth if extractions of the sound, natural teeth are required in preparation or as part of another medically necessary treatment. . . . If the teeth are not sound teeth then Priority Health will not pay to have them removed. The definition of a sound tooth is a tooth without evidence of current dental decay or other pathology. Dental extractions require prior authorization and must be provided by a participating provider.

Medical Policy No. 91542-R1 Oral Surgery

I. Description

Oral and maxillofacial surgery encompasses the diagnosis, surgical and related management of diseases, injuries and defects of both the functional and aesthetic aspects of the oral and maxillofacial regions. This includes preventive, reconstructive or emergency care for the teeth, mouth, jaws and facial structures.

* * *

II. Policy/Criteria

* * *

B. The following are not covered benefits. Most of the listed treatment/procedures are considered to be dental and therefore not covered under the medical benefit.

1. Services which are not medically necessary
2. Orthodontic, periodontic, endodontic, prosthodontic services
3. Dental services, including but not limited to the following:
 - (a) restorative care to the dentition including crowns, fillings, bridges, partial and full dentures
 - (b) adjustments, selective grinding or occlusal equilibration to the teeth
 - (c) dental applications including bite splints and metal based occlusal appliances

* * *

6. Extraction of unerupted or partially erupted, malpositioned or impacted teeth, with or without the attached follicular tissue
7. Surgical preparation of the mouth for dentures
8. Surgery for gum disease

* * *

- 13 Tooth implants
- 14. Services associated with a non-medical oral surgery procedure or treatment, i.e. surgical pathology biopsy reports
- 15. Services (e.g. radiology, anesthesia) associated with any non-covered benefit.

In its May 19, 2009, position paper prepared for this review, Priority Health notes that the Petitioner is requesting retroactive coverage for dental services (dental evaluations, x-rays, root canals, extractions, prefabricated posts and cores, crowns, resin composites, occlusal adjustments, and endodontic and periodontal restorations) as a medical benefit. The services were provided January 28, 2008, through February 9, 2009, by XXXXX, DDS, a non-participating provider and XXXXX, M.D. XXXXX, Petitioner's dental insurance carrier, considered the requested services to be dental and paid the claims up to her applicable dental benefit level.

Priority Health argues that the requested services do not meet its criteria for coverage and therefore its denial was appropriate.

Commissioner's Review

Priority Health's certificate covers some dental-related services but only in very limited situations (e.g., when required because of fractures or traumatic injuries). The certificate is clear that dental services generally (extractions, restorations, root canals, and implants) are not covered even when the need arises from an underlying medical condition.

As an HMO, Priority Health must provide benefits for basic health services. However, Chapter 35 of the Michigan Insurance Code does not include dental services as a basic health service. As a result, HMO's are free to determine whether they will offer benefit plans that include dental services as a covered benefit. Priority Health's Certificate covers only very limited dental-related care, as the Certificate language quoted shows. Furthermore, a fundamental premise of an HMO is the centralization of health care delivery within a network of providers. If an HMO member uses an out-of-network provider, payment for the out-of-network

services may be greatly reduced or even excluded entirely by the HMO.

Section 3519 of the Michigan Insurance Code, MCL 500.3519, requires HMOs to cover “basic health services” which are defined in section 3501 of the Insurance Code, MCL 500.3501, as:

- Physician services
- Ambulatory services
- Inpatient hospital services
- Emergency health services
- Outpatient mental health services
- Intermediate and outpatient care for substance abuse
- Diagnostic laboratory and radiological services
- Home health services
- Preventive health services

There is no statutory requirement for HMOs to provide dental care as a basic health service. Priority Health’s general exclusion of dental care is permissible.

It is unfortunate that the Petitioner’s underlying medical condition of Sjogren’s syndrome has caused serious dental problems. Nevertheless, the requested extractions and other services do not meet the criteria for coverage under the terms of the Priority Health certificate. While there is no dispute that the proposed care is medically necessary, the extractions, restorations, and replacements are dental services, not covered under the certificate.

The Commissioner finds Priority Health’s denial is consistent with the terms and conditions of the certificate and Michigan law.

**V
ORDER**

The Commissioner upholds Priority Health’s May 1, 2009, final adverse determination. Priority Health is not required to cover the Petitioner’s extractions and other dental services.

This is a final decision of an administrative agency. Under MCL 550.1915, any person aggrieved by this Order may seek judicial review no later than sixty days from the date of this

Order in the circuit court for the county where the covered person resides or in the circuit court of Ingham County. A copy of the petition for judicial review should be sent to the Commissioner of Financial and Insurance Regulation, Health Plans Division, Post Office Box 30220, Lansing, MI 48909-7720.