

**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

File No. 109973-001

v

Physicians Health Plan of Mid-Michigan  
Respondent

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**Issued and entered**  
**this 5<sup>th</sup> day of January 2011**  
**by Ken Ross**  
**Commissioner**

**ORDER**

**I**  
**BACKGROUND**

On February 11, 2010, 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 February 18, 2010, after a preliminary review of the material submitted, the Commissioner accepted the request.

Physicians Health Plan of Mid-Michigan (PHP) was notified of the request for external review and on February 26, 2010, furnished the information used in making its final adverse determination.

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's group health care benefits as a member of PHP are defined in the certificate of coverage (the certificate).

Approximately ten years ago, the Petitioner began orthotic therapy by wearing a bite splint at night. In October 2008, she began to experience left maxillary pain and her general dentist referred her to an endodontist. The pain ceased on its own, but in January 2009 the Petitioner began having pain in her ears, tinnitus, sleeplessness, nausea, and episodic vertigo.

In April 2009, the Petitioner's primary care physician referred her to an otolaryngologist who diagnosed her with temporomandibular joint (TMJ) dysfunction and referred her to an oral and maxillofacial surgeon, XXXXX, DDS. Dr. XXXXX began treating the Petitioner for TMJ dysfunction in May 2009, and referred her to Dr. XXXXX for orthotic therapy. Between June 4, 2009, and December 17, 2009, the Petitioner had seven office visits with Dr. XXXXX and he made a mandibular orthotic repositioning device for the Petitioner. Dr. XXXXX is not in PHP's network of providers.

The Petitioner appealed and at the conclusion of PHP's internal grievance process she received PHP's final adverse determination letter dated December 29, 2009.

## III ISSUE

Did PHP properly deny the claims for Dr. XXXXX's services?

## IV ANALYSIS

### Petitioner's Argument

In her November 27, 2009, letter of appeal to PHP, the Petitioner expressed her belief that Dr. XXXXX's services should be covered because they are medical, not dental, and Dr. XXXXX is "affiliated" with Dr. XXXXX. She also noted with respect to PHP's reasons for denying coverage:

The explanations given are Out-of-Network Provider not covered and Notification not obtained prior to rendering service (code 833), and also Clinical Daily Maximum Exceeded (code N29).

\* \* \*

It was my understanding that Dr. XXXXX and Dr. XXXXX were professionally affiliated since my first visit with Dr. XXXXX was delayed because he was assisting Dr. XXXXX in surgery. Assuming they were affiliated, there was no need to obtain prior approval.

In regard to the second explanation, code N29, a review of the Benefit Materials produced no information of the explanation.

The symptoms and treatment are medical, not dental. Since the appliance has been used, the various aches and pains have decreased. Adjustments are still required periodically to complete the realignment.

Dr. XXXXX, in a December 21, 2009, letter, explained the Petitioner's treatment:

Treatment was initiated on 06/30/2009 by the fitting of a custom-made intraoral orthotic to decompress the tissues of the temporomandibular joints and to restore the normal architecture and function to as great a degree as possible.

\* \* \*

[The Petitioner] was recently seen on 12/17/2009 at which time she reported that her chief symptoms were reduced. I have enclosed a progress report which she completed during this appointment indicating subjective appraisal of treatment results to date. Permanent stabilization of the jaw will be accomplished through likely negative and positive coronoplasty.

The [Petitioner's] prognosis is good. Permanent impairment will be determined when the [Petitioner] reaches maximum medical improvement. A joint which has suffered soft tissue damage with resultant disc dysfunction will never be normal again. It can be anticipated that [the Petitioner] will have exacerbations throughout her lifetime which will require additional evaluation and treatment.

The Petitioner's primary care physician, XXXXX, DO, wrote in support of Dr. XXXXX's treatment in a July 22, 2009 letter part:

[The Petitioner] has been suffering from cervicalgia, otalgia, tinnitus, headache, and vertigo and has been seen in our office on 1/28/09, 03/17/09, 04/15/09 and 06/09/09 regarding these symptoms. Based on the evaluations of Dr. XXXXX [an otolaryngologist] and Dr. XXXXX, I feel that their recommendation for [the Petitioner's] further treatment is reasonable. Hopefully the orthotic therapy offered by Dr. XXXXX will provide her with successful, non-invasive treatment for her problem.

The Petitioner contends that Dr. XXXXX's services, including the orthotic therapy, are medically necessary to treat her medical condition. She therefore wants PHP to provide coverage.

Respondent's Argument

In its December 29, 2009, final adverse determination, PHP based its denial on the following provision in the certificate:

**Section 2: What's Not Covered—Exclusions**

\* \* \*

**D. Dental**

\* \* \*

9. Services for the evaluation and treatment of temporomandibular joint syndrome (TMJ), when the services are considered to be dental in nature, as determined by us.

However, PHP also noted in its February 26, 2010, position paper that the Petitioner's certificate (and those of all PHP's commercial plans) was amended in 2009:

***This Policy is amended as described in the changes to the Certificate of Coverage below effective 2/1/09:***

1. Section 2: What's Not Covered -- Exclusions is revised as follows:

\* \* \*

- b. Under segment entitled, *Dental*, the exclusion, "Services for the evaluation and treatment of temporomandibular joint syndrome (TMJ), when the services are considered dental in nature, as determined by us" will be revised as follows:

"Services for the evaluation and treatment of temporomandibular joint syndrome (TMJ), when the services are provided as part of a treatment for documented dental conditions."

- c. Under segment, *All Other Exclusions*, the following exclusions shall be added.
  - Services for the treatment of an overbite or underbite. Maxillary and mandibular osteotomies unless Medically Necessary.
  - Mouth orthotics, splints, prosthetics and appliances.
  - Medical and surgical services for the evaluation and treatment

of temporomandibular joint syndrome (TMJ), unless Medically Necessary.

In its position paper, PHP went on to say:

While the member's initial diagnosis through her Primary Care Physician [PCP] did not include TMJ, this member has a history of TMJ and was given this diagnosis again by the specialists she saw through her PCP's referral. The treatment she received is specifically excluded and was provided by a dentist that is not in the PHPMM network.

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

#### Commissioner's Review

On June 4, 2009, the Petitioner sought treatment from Dr. XXXXX. The Petitioner argues that Dr. XXXXX's services were medical, not dental, in nature. It was Dr. XXXXX's assessment (in a June 10, 2009, letter to Dr. XXXXX) that the Petitioner had a "cranial base to mandible discrepancy." He proposed treating the Petitioner by use of a "mandibular orthopedic positioning device, resulting in the orthopedic realignment of the mandible." The Commissioner concludes that this treatment is excluded under the terms of the certificate as amended.

Initially, the Commissioner notes that a health maintenance organization (HMO) like PHP is required to provide "basic health services." MCL 500.3519(3). However, "basic health services" does not include dental care. MCL 500.3501. Thus, it is permissible for PHP to exclude "services for the evaluation and treatment of temporomandibular joint syndrome (TMJ), when the services are provided as part of a treatment for documented dental conditions."

An independent reviewing physician might conclude from evidence in the record that the Petitioner's TMJ treatment was not provided "as part of a treatment for documented dental conditions" and was therefore a covered benefit. It is possible that the Petitioner's TMJ treatment related to a covered medical condition as she asserts. The Petitioner complained of earaches, headaches, neck aches, dizziness, sleeplessness, and nausea -- symptoms that do not commonly suggest dental problems.

However, the specific treatment the Petitioner received is unquestionably not covered under the amended certificate. The Petitioner received a “mandibular orthopedic positioning device,” an intraoral orthotic designed “to decompress the tissues of the temporomandibular joints and to restore the normal architecture” according to Dr. XXXXX. The amended certificate excludes “Mouth orthotics, splints, prosthetics and appliances.” Thus, the Commissioner concludes that PHP’s denial of coverage was consistent with its certificate.

**V**  
**ORDER**

The Commissioner upholds PHP’s December 29, 2009, final adverse determination. PHP is not required to cover the services the Petitioner received from Dr. XXXXX.

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.