

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
OFFICE OF FINANCIAL AND INSURANCE REGULATION
Before the Commissioner of Financial and Insurance Regulation

In the matter of

XXXXX

Petitioner

v

File No. 119410-001

Aetna Life Insurance Company

Respondent

Issued and entered
this 8th day of July 2011
by R. Kevin Clinton
Commissioner

ORDER

I. PROCEDURAL BACKGROUND

On February 3, 2011, XXXXX, authorized representative of 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.* The Commissioner reviewed the request and accepted it on February 10, 2011.

The Commissioner notified Aetna of the external review and requested the information used in making its adverse determination. Aetna submitted the information on February 28, 2011.

This case involves issues that can be decided by a contractual analysis. The Commissioner reviews contractual issues pursuant to MCL 550.1911(7). This matter does not require a medical opinion from an independent review organization.

II. FACTUAL BACKGROUND

The Petitioner receives group dental care coverage from Aetna Life Insurance Company as an eligible dependent through XXXXX. The benefits are defined in XXXXX certificate of coverage (the certificate).

On June 25, 2010, Petitioner received a dental implant and the amount the dentist charged for the implant was \$1,600.00. Aetna denied coverage ruling that dental implants are not a covered benefit under Petitioner's benefit plan. Aetna offered to provide coverage for a crown (which would apparently complete the dental implant). The Petitioner sought to have Aetna pay an amount equivalent to what it would pay for a dental bridge, which is a covered procedure. Aetna declined to pay this amount. Aetna upheld its original determination and sent Petitioner its final determination dated January 6, 2011.

III. ISSUE

Did Aetna correctly deny a bridge as an alternate benefit for the implant?

IV. ANALYSIS

Petitioner's Argument

The Petitioner agrees that her implant is not a covered benefit. However, she believes that Aetna is obligated to provide coverage in an amount equal to a bridge (a dental alternative to an implant). In support of this argument, Petitioner cites the "alternate treatment" provision of her group coverage plan.

Respondent's Argument

In its January 6, 2010, final adverse determination Aetna stated:

This dental plan is based on a closed list of eligible dental procedures. Under this plan, if a procedure is not on the closed list, the procedure is not covered by the plan.

A review of the plan booklet by the appeal committee confirmed implants are not on the closed list of eligible services. In addition, this particular plan does not have a provision to allow an alternative benefit for the non-covered endosteal implant.

The appeal committee determined that the crown which will be placed over the endosteal implant may be eligible for coverage. The recommendation was for the dental provider to submit an advance claim for review (Predetermination of Benefits) to determine what benefits would be available. The claim would be reviewed in accordance with the terms and limitations that apply to the plan at that time.

Aetna contends its benefit determination for Petitioner's claim was in compliance with the terms of the certificate.

Commissioner's Review

The certificate lists covered services in three categories:

Type A: visits and x-rays, space maintainers

Type B: visits and exams, x-ray and pathology, oral surgery, restorative dentistry

Type C: oral surgery, periodontics, endodontics, restorative, prosthodontics, general anesthesia and intravenous sedation, orthodontics

Dental implants are not among the services listed in these categories and are therefore not among the certificate's listed services. However, the certificate includes an additional provision on page 3 which states:

Alternate Treatment

The next sentence applies if:

- a charge is made for an unlisted service given for the dental care of a specific condition; and
- the list includes one or more services that, under standard practices, are separately suitable for the dental care of that condition.

In that case, the charge will be considered to have been made for a service in the list that Aetna determines would have produced a professionally accepted result.

In its final adverse determination, Aetna claimed that this provision was not a part of the Petitioner's benefit plan. However, the provision appears on page 3 of the certificate that Aetna provided to the Commissioner and which Aetna represented as the Petitioner's coverage. The Commissioner therefore rejects that portion of the final adverse determination that asserts that the Petitioner is not covered by the "alternate treatment" provision.

The provision obligates Aetna to pay an amount equal to what it would pay for a bridge since a bridge is both a listed service and is a treatment "suitable for the dental care" of Petitioner's condition and which would produce "a professionally acceptable result."

The Commissioner finds that Aetna's denial of coverage for a replacement of Petitioner's abscessed tooth is not consistent with the terms of the certificate.

V. ORDER

The Commissioner reverses Aetna's January 6, 2011, final adverse determination. Aetna is required to provide coverage equivalent to coverage for a dental bridge for the replacement of

the Petitioner's tooth. Aetna shall provide this coverage within 60 days of the date of this Order and shall, within seven days of providing coverage, provide the Commissioner with proof it has implemented this Order.

To enforce this Order, the Petitioner may report any complaint regarding implementation to the Office of Financial and Insurance Regulation, Health Plans Division, toll free (877) 999-6442.

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 60 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.

R. Kevin Clinton
Commissioner