STATE OF MICHIGAN
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
FOR THE DEPARTMENT OF COMMUNITY HEALTH
P.O. Box 30763, Lansing, MI 48909
(877) 833-0870; Fax: (517) 334-9505

IN THE MATTER OF:

[redacted],

Docket No. 2011-18662 MSB
Case No. [redacted]

Appellant
_____/

DECISION AND ORDER

This matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9 and MCL 400.37, following the Appellant's request for a hearing.

After due notice, a hearing was held [redacted]. [redacted], the Appellant, represented herself. [redacted], represented the Department of Community Health (MDCH or Department). [redacted], appeared as a witness for the Department.

ISSUE

Did the Department properly deny payment of the Appellant's dental bill for having a crown placed?

FINDINGS OF FACT

The Administrative Law Judge, based on the competent, material, and substantial evidence on the whole record, finds as material fact:

1. The Appellant is [redacted].
2. The Appellant received dental services [redacted]. She had a crown placed.
3. The Appellant had a Medicaid deductable (formerly spend down) on the date of service.
4. The Appellant had satisfied the deductable for the [redacted], date of dental service, thus was eligible for Medicaid covered services at the date of service.
5. The Appellant's dental work is not a Medicaid covered service.

6. The Appellant's dentist has sought payment for services rendered [redacted], from the Appellant.

7. The Appellant has requested the Department of Community Health provide coverage for the dental services rendered on the date at issue. The Department has denied the payment sought.

8. The Department notified the Appellant payment would not be made for the dental services provided [redacted].

9. The Appellant appealed the determination [redacted].

CONCLUSIONS OF LAW

The Medical Assistance Program 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.

> Providers cannot bill beneficiaries for services except in the following situations:
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> - A co-payment for chiropractic, dental, hearing aid, pharmacy, podiatric, or vision services is required. However, a provider cannot refuse to render service if the beneficiary is unable to pay the required co-payment on the date of service.
>
> - A monthly patient-pay amount for inpatient hospital or nursing facility services. The local DHS determines the patient-pay amount. Non-covered services can be purchased by offsetting the nursing facility beneficiary's patient-pay amount. (Refer to the Nursing Facility Chapter for more information.)
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> - For nursing facility (NF), state-owned and -operated facilities or CMHSP-operated facilities determine a financial liability or ability-to-pay amount separate from the DHS patient-pay amount. The state-owned and -operated facilities or CMHSP-operated facilities liability may be an individual, spouse, or parental responsibility. This responsibility is determined at initiation of services and is reviewed periodically. The beneficiary or his authorized representative is responsible for the state-

owned and -operated facilities or CMHSP ability to pay amount, even if the patient-pay amount is greater.

- The provider has been notified by DHS that the beneficiary has an obligation to pay for part of, or all of, a service because services were applied to the beneficiary's Medicaid deductible amount.

- If the beneficiary is enrolled in a MHP and the health plan did not authorize a service, and the beneficiary had prior knowledge that he was liable for the service. (It is the provider's responsibility to determine eligibility/enrollment status of each beneficiary at the time of treatment and to obtain the appropriate authorization for payment. Failure of the provider to obtain authorization does not create a payment liability for the beneficiary.)

- Medicaid does not cover the service. If the beneficiary requests a service not covered by Medicaid, the provider may charge the beneficiary for the service if the beneficiary has been told prior to rendering the service that it was not covered by Medicaid. If the beneficiary is not informed of Medicaid non-coverage until after the services have been rendered; the provider cannot bill the beneficiary.

- The beneficiary refuses Medicare Part A or B.

- Beneficiaries may be billed the amount other insurance paid to the policyholder if the beneficiary is the policyholder.

- The beneficiary is the policyholder of the other insurance and the beneficiary did not follow the rules of the other insurance (e.g., utilizing network providers).

- The provider chooses not to accept the beneficiary as a Medicaid beneficiary and the beneficiary had prior knowledge of the situation. The beneficiary is responsible for payment.

It is recommended that providers obtain the beneficiary's written acknowledgement of payment responsibility prior to rendering any non-authorized or non-covered service the

beneficiary elects to receive.

Some services are rendered over a period of time (e.g., maternity care). Since Medicaid does not normally cover services when a beneficiary is not eligible for Medicaid, the provider is encouraged to advise the beneficiary prior to the onset of services that the beneficiary is responsible for any services rendered during any periods of ineligibility. Exceptions to this policy are services/equipment (e.g., root canal therapy, dentures, customized seating systems) that began, but were not completed, during a period of eligibility. (Refer to the provider-specific chapters of this manual for more information regarding exceptions.)

When a provider accepts a patient as a Medicaid beneficiary, the beneficiary cannot be billed for:

- Medicaid-covered services. Providers must inform the beneficiary before the service is provided if Medicaid does not cover the service.

- Medicaid-covered services for which the provider has been denied payment because of improper billing, failure to obtain PA, or the claim is over one year old and has never been billed to Medicaid, etc.

- The difference between the provider's charge and the Medicaid payment for a service or for missed appointments.

- Copying of medical records for the purpose of supplying them to another health care provider.

If a provider is not enrolled in Medicaid, they do not have to follow Medicaid guidelines about reimbursement, even if the beneficiary has Medicare as primary.

If a Medicaid-only beneficiary understands that a provider is not accepting him as a Medicaid patient and asks to be private pay, the provider may charge the beneficiary its usual and customary charges for services rendered. The beneficiary must be advised prior to services being rendered that his **mihealth** card is not accepted and that he is responsible for payment. It is recommended that the provider obtain the beneficiary's acknowledgement of payment responsibility in

writing for the specific services to be provided.

Medicaid Provider Manual,
General Information for Providers Section,
July 1, 2010, pages 21-22

In this case the Appellant is requesting payment for dental services rendered when she did have full coverage Medicaid, on [redacted]. The Department has denied payment for the services. The denial is not because the Appellant lacked Medicaid at the time of service, rather because the service she received is not a Medicaid covered service. Specifically, she received placement or a crown from her dentist. The Medicaid Provider Manual states in pertinent part:

6.3 Crowns
Crowns are benefits only for beneficiaries under age 21.

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Medicaid Provider Manual
Dental chapter page 15
Version date: April 1, 2011

The Appellant's dentist has billed her for the service. There are stipulations in the Medicaid Provider Manual (found above) indicating a provider is not authorized to bill a Medicaid beneficiary except under certain circumstances. Here, however, the Appellant stated on the record she had not informed her provider she was seeking Medicaid coverage or intended Medicaid to provide coverage of the service. From her testimony at hearing, there was apparently no discussion of how the services rendered would be paid for or insurance coverage of any type. The Appellant asserts she needed the crown thus believed it would be covered by Medicaid since she was never informed of any coverage limitations. She stated she had never received any pamphlet or booklet explaining coverages or limitations.

The Department cannot issue payment for non-covered services. Here, The Appellant received dental services that are not covered. The Department is not responsible for them. While it is true the Appellant was not provided a copy of the Medicaid Provider Manual itself. As stated at hearing, it is several thousand pages in length and it is not provided to beneficiaries or medical service providers except as made available online. Medicaid beneficiaries are advised to telephone the number provided on the MIHealth cards for information pertaining to providers and coverage when they are notified of eligibility. The Department properly denied payment for the service rendered.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that it was proper for the Department to deny payment for the dental bill incurred by the Appellant [redacted].

IT IS THEREFORE ORDERED that:

The Department's decision is AFFIRMED.

Jennifer Isiogu
Administrative Law Judge
for Olga Dazzo, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 5/4/2011

***** NOTICE *****

The Michigan Administrative Hearing System for the Department of Community Health may order a rehearing on either its own motion or at the request of a party within 30 days of the mailing date of this Decision and Order. The Michigan Administrative Hearing System for the Department of Community Health will not order a rehearing on the Department's motion where the final decision or rehearing cannot be implemented within 90 days of the filing of the original request. The Appellant may appeal the Decision and Order to Circuit Court within 30 days of the mailing date of the Decision and Order or, if a timely request for rehearing was made, within 30 days of the mailing date of the rehearing decision.