

**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) 373-4147

IN THE MATTER OF:

**Docket No. 2013-53314 MSB**

██████████,

██████████

Appellant

\_\_\_\_\_ /

**DECISION AND ORDER**

This matter is before the undersigned Administrative Law Judge (ALJ) pursuant to MCL 400.9 and MCL 400.37 upon the Appellant's request for a hearing.

After due notice, a hearing was held ██████████ ██████████ mother, represented the Appellant. ██████████, Appeals Review Officer, represented the Department of Community Health ("MDCH" or "Department"). ██████████ ██████████ Departmental Specialist, appeared as a witness for the Department.

**ISSUE**

Whether the Department has properly not considered payment for services rendered to the Appellant by her dental provider in November 2012?

**FINDINGS OF FACT**

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

1. The Appellant is a Medicaid ("MA") beneficiary who was active for MA-Other Healthy Kids. (Exhibit 1, page 13)
2. With the MA-Other Healthy Kids, the Appellant's dental benefit was through ██████████. (Departmental Specialist Testimony; Exhibit 1, page 18)
3. On ██████████, the Department of Human Services ("DHS") issued a Notice of Case Action indicating the Appellant's MA coverage would close ██████████. (Exhibit 1, pages 9-10)

4. DHS has acknowledged that the closure of the Appellant's MA coverage was an error. (Exhibit 1, pages 8 and 13-16; Mother Testimony)
5. On or about ██████████ the Appellant received dental services. (Exhibit 1, page 14, Mother Testimony)
6. On ██████████, DHS issued a Notice of Case Action indicating the Appellant's MA-Other Healthy Kids coverage was reinstated retroactive to ██████████. (Exhibit 1, pages 11-12)
7. The Department is not able to retroactively enroll the Appellant in ██████████ along with the retroactive MA-Other Healthy Kids enrollment. Enrollment in ██████████ can only be made prospectively and would start the month following the date of the case action reinstating her Medicaid. (Departmental Specialist Testimony; Exhibit 1, page 18)
8. Accordingly, the Appellant's dental benefit during the retroactive eligibility period is through Fee-For-Service MA, also known as straight MA. (Departmental Specialist Testimony; Exhibit 1, page 18)
9. Delta Dental has denied the claim for the dental services the Appellant received in ██████████. (Exhibit 1, page 14, Mother Testimony)
10. The Appellant requested a formal, administrative hearing on ██████████. (Exhibit 1, pages 6-7)
11. On ██████████ a DHS hearing was held regarding the Appellant's eligibility for MA coverage. ██████████ upheld the DHS determination to reinstate the Appellant's MA-Other Healthy Kids eligibility and forwarded the appeal for a MDCH hearing regarding the billing issue. (Exhibit 1, pages 13-16)
12. The Department has not considered payment for the ██████████ dental services the Appellant received because no claims for the services have been submitted to Fee-For-Service MA. (Departmental Specialist Testimony)

### **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.

The Medicaid Provider Manual, General Information for Providers addresses when a beneficiary can be billed by a provider:

## **SECTION 11 - BILLING BENEFICIARIES**

### **11.1 GENERAL INFORMATION**

Providers cannot bill beneficiaries for services except in the following situations:

- A Medicaid copayment is required. (Refer to the Beneficiary Copayment Requirements subsection of this chapter and to the provider specific chapters for additional information about copayments. However, a provider cannot refuse to render service if the beneficiary is unable to pay the required copayment 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. Noncovered services can be purchased by offsetting the nursing facility beneficiary's patient-pay amount. (Refer to the Nursing Facility Chapter for additional information.)
- 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 is told prior to rendering the service that it is not covered by Medicaid. If the beneficiary is not informed of Medicaid noncoverage 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 nonauthorized or noncovered 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, custom-fabricated seating systems) that began, but were not completed, during a period of eligibility. (Refer to the provider-specific chapters of this manual for additional 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.
- 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,  
October 1, 2012, Pages 28-29.*

The Bridges Administrative Manual, MA/AMP Benefits section addresses retroactive enrollment in MA-Other Healthy Kids dental benefit:

### **Retroactive Enrollment**

Enrollment in Healthy Kids Dental is not retroactive even if MA coverage goes back to the beginning of a month (or earlier). Enrollment is prospective.

If a client's MA is opened in the middle of the month, the client has Medicaid fee-for-service dental until the following month when the file is sent to Delta Dental.

Bridges Administrative Manual (BAM) 402,  
MA/AMP Benefits,  
Page 6 of 20, October 1, 2012

In the present case, the Appellant asserts that the Department has failed to pay a medical bill for dental services she received in [REDACTED]. On [REDACTED] DHS issued a Notice of Case Action indicating the Appellant's MA-Other Healthy Kids coverage would close [REDACTED] (Exhibit 1, pages 9-10) DHS has acknowledged that the closure of the Appellant's MA coverage was an error. It appears that it took DHS longer to correct the error than what the Appellant's mother understood would occur from talking with DHS. (Exhibit 1, pages 8 and 13-16; Mother Testimony) On [REDACTED], the Appellant received dental services. The Appellant's mother had expected the error would be corrected by this time and the dental coverage would still be with [REDACTED] based on her conversations with DHS. (Exhibit 1, page 14, Mother Testimony) [REDACTED] has denied the claim for the dental services the Appellant received in [REDACTED]. (Exhibit 1, page 14, Mother Testimony)

It was not until [REDACTED], that DHS issued a Notice of Case Action indicating the Appellant's MA-Other Healthy Kids coverage was reinstated retroactive to [REDACTED] (Exhibit 1, pages 11-12)

The Department is not able to retroactively enroll the Appellant in [REDACTED] along with the retroactive MA-Other Healthy Kids enrollment. Enrollment in [REDACTED] can only be made prospectively and would start the month following the date of the case action notice reinstating her Medicaid. (Departmental Specialist Testimony; Exhibit 1, page 18) Accordingly, the Appellant's dental benefit during the retroactive eligibility period is through Fee-For-Service MA. (Departmental Specialist Testimony; Exhibit 1, page 18)

The Department has yet to receive any claims for the Appellant's [REDACTED] services submitted to Fee-For-Service MA. It was also unknown at the [REDACTED] telephone hearing proceedings if the dental provider is already enrolled and as a participating provider for Fee-For Service MA or if they are willing to enroll to bill the Department for the services provided to the Appellant. (Department Specialist Testimony)

While this ALJ sympathizes with the Appellant, this ALJ does not have any authority to require the dental provider to bill Fee-For-Service MA for the dental services rendered to the Appellant in [REDACTED]. There has been no evidence presented that the Department has denied any claims submitted to Fee-For-Services MA by the dental provider that rendered services to the Appellant in [REDACTED]. Accordingly, the Department has properly not considered payment for these services thus far.

The Appellant may wish to follow up with her dental provider about billing Fee-For-Service MA for the [REDACTED] dental services.

[REDACTED]  
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Decision and Order

**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 not consider payment for services rendered to the Appellant by the dental provider in [REDACTED] because thus far no claims have been submitted to Fee-For-Service MA for the [REDACTED] dental services.

**IT IS THEREFORE ORDERED** that:

The Department's decision is **AFFIRMED**.

/s/

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Colleen Lack  
Administrative Law Judge  
for James K. Haveman, Director  
Michigan Department of Community Health

Date Signed: [REDACTED]

Date Mailed: [REDACTED]

CL/db

cc: [REDACTED]

**\*\*\* NOTICE \*\*\***

The Michigan Administrative Hearing System 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 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 receipt of the Decision and Order or, if a timely request for rehearing was made, within 30 days of the receipt of the rehearing decision.