

**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.** 2014-34887 MSB

██████████  
Appellant.  
\_\_\_\_\_ /

**DECISION AND ORDER**

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

After due notice, a hearing was held on ██████████, Appellant's mother, appeared and testified on Appellant's behalf. ██████████, Appeals Review Officer, represented the Michigan Department of Community Health ("DCH" or "Department"). ██████████, Department Analyst, appeared as a witness for the Department.

**ISSUE**

Did the Department properly deny Appellant's request for reimbursement for costs related to jaw surgery?

**FINDINGS OF FACT**

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

1. Appellant is a ██████ year-old male who has been diagnosed with autism; bruxism; and mandibular prognathia with left deviation. (Respondent's Exhibit A, pages 14, 20).
2. Appellant has coverage through his mother's private insurance, ██████; and ██████. (Testimony of Appellant's representative).
3. Due to Appellant's bruxism and mandibular prognathia with left deviation, Appellant's doctors decided to perform a bilateral sagittal split ramus osteotomy (BSSO), a type of jaw surgery. (Testimony of Appellant's representative).

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4. However, the surgeon who was to perform the surgery did not accept any insurance and was not enrolled in either Medicare or Medicaid. (Testimony of Appellant's representative).
5. Appellant's representative contacted [REDACTED] and was informed that it would cover part of the surgery and issue a check directly to Appellant's representative following the surgery. (Testimony of Appellant's representative).
6. Appellant's representative contacted Medicare and was informed that it would also cover part of the surgery. (Testimony of Appellant's representative).
7. Appellant's representative did not contact anyone at Medicaid or obtain any prior authorization for the surgery from Medicaid. (Testimony of Appellant's representative).
8. Appellant's representative paid for the jaw surgery out-of-pocket, with the bill being [REDACTED] (Testimony of Appellant's representative).
9. The surgery was performed on [REDACTED]. (Respondent's Exhibit A, pages 20-22).
10. On [REDACTED] sent Appellant's representative a check for [REDACTED] while also indicating in its Explanation of Benefits that the remainder of the amount charged was not covered. (Respondent's Exhibit A, pages 27-28).
11. Appellant's representative then sought reimbursement through Medicare, but her request was initially denied on the basis that the surgery was not covered when performed by Appellant's surgeon. (Respondent's Exhibit A, page 13; Testimony of Appellant's representative).
12. Appellant's representative appealed that denial and, on [REDACTED], Medicare ultimately approved a claim for [REDACTED] and paid out [REDACTED]. (Respondent's Exhibit A, pages 10-12; Testimony of Appellant's representative).
13. Appellant's representative then sought reimbursement through Medicaid, where she was told to submit the bill. (Testimony of Appellant's representative).
14. However, no bill was ever submitted. (Testimony of Appellant's representative).
15. Appellant's representative was also told she could file a Beneficiary Complaint and she filed such a complaint with the Department.

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(Respondent's Exhibit A, pages 4-5; Testimony of Appellant's representative).

16. On [REDACTED] the Department sent Appellant's representative a written response to the Beneficiary Complaint. (Respondent's Exhibit A, page 8).
17. Specifically, that response provided:

Thank you for your notice regarding the difficulty you are having with unpaid medical bills. We investigated the problem with the bill from [REDACTED] [REDACTED] for date of service [REDACTED]

The reason you are receiving a bill is because the provider you went to is not enrolled with the Medicaid program. Medicaid can only make payments to providers that are enrolled with the Medicaid program. You will need to contact the provider to resolve the bill.

*Respondent's Exhibit A, page 8*

18. On [REDACTED], the Michigan Administrative Hearing System (MAHS) received a complete and signed Request for Hearing in this matter. (Respondent's Exhibit A, pages 4-28).

**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.

All claims must be submitted in accordance with the policies, rules, and procedures as stated in the Medicaid Provider Manual, which provides, in pertinent parts:

**7.2 NONENROLLED MICHIGAN AND BORDERLAND PROVIDERS**

Medicaid pays nonenrolled Michigan and nonenrolled borderland providers for emergency services and for the first claim for nonemergency services that were provided in compliance with Michigan Medicaid coverage policies.

All providers rendering, ordering, prescribing, or referring services to Michigan Medicaid beneficiaries must be

enrolled/registered in the Michigan Medicaid program. (Refer to the Directory Appendix for contact information related to the on-line application process.) Exceptions to this requirement may be made in special circumstances. These circumstances will be addressed through the Prior Authorization process.

\* \* \*

## **SECTION 10 - PRIOR AUTHORIZATION**

### **10.1 GENERAL INFORMATION**

There may be occasions when a beneficiary requires services beyond those ordinarily covered by Medicaid or needs a service that requires prior authorization (PA). In order for Medicaid to reimburse the provider in this situation, MDCH requires that the provider obtain authorization for these services before the service is rendered. Providers should refer to their provider-specific chapter for PA requirements. (Refer to the Directory Appendix for contact information for PA.)

\* \* \*

## **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.)

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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 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

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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.

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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.

*MPM, April 1, 2014 version  
General Information for Providers Chapter, pages 15, 27, 31-32  
(Underline added by ALJ)*

Pursuant to the above policy, all providers rendering services to Michigan Medicaid beneficiaries must be enrolled in the Michigan Medicaid program and, while exceptions to that requirement may be made in special circumstances, the exceptions must be approved prior to the services being provided through the prior authorization process outlined in policy. Similarly, the above policy also states that a provider may bill a beneficiary if the provider chose not to accept the beneficiary as a Medicaid beneficiary and the beneficiary had prior knowledge of the situation, and that a provider not enrolled in Medicaid does not have to follow Medicaid guidelines about reimbursement

In this case, it is undisputed that the medical provider who billed Appellant is not enrolled in Medicaid and chose not to accept Appellant as a Medicaid beneficiary. It is also undisputed that Appellant and his representative were advised that the provider was not enrolled and that Appellant was not accepted as a Medicaid beneficiary. It is further undisputed that Appellant and his representative did not request or receive prior authorization for the surgery by a non-enrolled provider through Medicaid.

Accordingly, the Department has properly denied Appellant's request for reimbursement for costs related to jaw surgery. While this ALJ sympathizes with the Appellant, this ALJ does not have any authority to require providers to enroll and bill Medicaid for the services rendered to the Appellant. Moreover, while Appellant's representative testified that there were no Medicaid-enrolled providers who could have performed the surgery and, under the above cited policy, exceptions to the required enrollment can be made in special circumstances through the prior authorization process, the Department never had a chance to address such concerns before the services were provided as no prior authorization was ever requested or granted in this case.

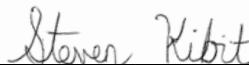
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**DECISION AND ORDER**

The Administrative Law Judge, based on the above findings of fact and conclusions of law, finds that, based on the available information, the Department properly denied Appellant's request for reimbursement for costs related to jaw surgery.

**IT IS THEREFORE ORDERED THAT:**

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



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Steven Kibit  
Administrative Law Judge  
for James K. Haveman, Director  
Michigan Department of Community Health

Date Signed: [REDACTED]

Date Mailed: [REDACTED]

SK/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.