[redacted]
, MI [redacted]

Date Mailed: January 29, 2020
MOAHR Docket No.: 19-012084
Agency No.: [redacted]
Petitioner: [redacted]

ADMINISTRATIVE LAW JUDGE: Steven Kibit

DECISION AND ORDER

This matter is before the Michigan Office of Administrative Hearings and Rules (MOAHR) pursuant to MCL 400.9 and upon Petitioner's request for hearing.

After due notice, a telephone hearing was held on January 9, 2020. Petitioner appeared and testified on his own behalf. [redacted], Petitioner's friend, also testified as a witness for Petitioner. Theresa Root, Appeals Review Officer, represented the Respondent Department of Health and Human Services (DHHS or Department). Edward Kincaid, Specialist, testified as a witness for the Department.

During the hearing, the Department submitted an evidence packet that was admitted into the record as Exhibit A, pages 1-14. Petitioner did not submit any proposed exhibits.

ISSUE

Did the Department improperly fail to pay for dental services provided to Petitioner?

FINDINGS OF FACT

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

1. For the month of May of 2019, Petitioner was approved for Medicaid coverage. (Testimony of Department's Specialist).

2. As of June 1, 2019, Petitioner's Medicaid scope of coverage changed, and he acquired a Medicaid deductible/spend-down. (Exhibit A, page 5).

3. Petitioner never met that spend-down during for June of 2019 and he therefore never obtained Medicaid coverage for that month. (Exhibit A, page 5).

4. In either late May of 2019 or early June of 2019, Petitioner's dentist took an impression of Petitioner's teeth as part of the process for placing an upper partial denture. (Exhibit A, page 13; Testimony of Petitioner).

5. Petitioner paid for the upper partial denture by credit card that same day. (Testimony of Petitioner).

6. According to Petitioner, that payment occurred in May of 2019, but the receipt he received was dated June 3, 2019. (Testimony of Petitioner).

7. A subsequent account statement issued by Petitioner's dentist identified the impression as having been taken, and payment as having been made, on June 3, 2019. (Exhibit A, page 13).

8. On June 24, 2019, Petitioner received his upper partial denture. (Exhibit A, page 13; Testimony of Petitioner).

9. On July 1, 2019, Petitioner's dentist sent a prior authorization request to the Department asking for the upper partial denture for Petitioner. (Exhibit A, page 11).

10. On July 30, 2019, the Department sent written notice that the prior authorization request for an upper partial denture had been denied. (Exhibit A, pages 11-12).

11. With respect to the reason for the denial, the notice stated:

> The policy this denial is based on is Section 10, 10.2.B of the General Information, and Prior Authorization chapter of the Medicaid Provider Manual. Specifically:
>
> - General Information – Section 10 Prior Authorization, Policy 10.2.B. Prior authorization was required but was not obtained. Michigan Department of Health and Human Services requires the provider obtain prior authorization before the service is rendered. The provider cannot charge the beneficiary or the beneficiary representative for the provider's failure to obtain prior authorization. If the provider failed to obtain prior authorization for a service and the service was rendered, he/she cannot apply his/her fee for that service

in calculating other reimbursement due to him/her from Medicaid.

- An upper partial denture was delivered on 6-1-2019. The beneficiary's Benefit Plan ID was Spendown [sic].

Exhibit A, page 11

12. In September of 2019, Petitioner's dentist billed Petitioner for the upper partial denture. (Exhibit A, page 8).

13. On November 19, 2019, the Michigan Office Administrative Hearings and Rules (MOAHR) received the request for hearing filed in this matter with respect to the bill Petitioner has received. (Exhibit A, pages 6-13).

CONCLUSIONS OF LAW

The Medical Assistance Program (MA) 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 requests or claims through Medicaid must be submitted in accordance with the policies, rules, and procedures as stated in the Medicaid Provider Manual (MPM). Moreover, with respect to providers billing beneficiaries, the MPM states in part:

SECTION 11 - BILLING BENEFICIARIES

11.1 GENERAL INFORMATION [CHANGE MADE 4/1/19]

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.)

- A monthly patient-pay amount for inpatient hospital or nursing facility services. The local MDHHS 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 MDHHS 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 MDHHS 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.

- **(text removed per bulletin MSA 18-50)**

- 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.*
>
> *MPM, April 1, 2019 version*
> *General Information for Providers Chapter, pages 33-34*
> *(internal highlighting omitted)*

Moreover, regarding changes in eligibility and reimbursement for dental services, the applicable version of the MPM also states in part:

> ***2.5 LOSS OR CHANGE IN ELIGIBILITY***
>
> *No service is covered after loss of eligibility except for the following services:*
>
> - Endodontic Therapy
> - *Complete and Partial Dentures*
> - Laboratory-Processed Crowns
>
> *Reimbursement for these services is only allowed under the following circumstances:*
>
> - Services were started prior to the loss of eligibility.
> - *For complete or partial dentures and laboratory-processed crowns, impressions were taken prior to the loss of eligibility.*
> - Services are completed within 30 days of change and/or loss of eligibility.
>
> Conditions not eligible for reimbursement include:

- If a beneficiary's Medicaid eligibility is terminated after extractions were performed, but prior to the initial impressions. The extractions alone do not qualify the beneficiary for dentures.

- Immediate dentures.

The date of service on the claim is the date the endodontic therapy was started or the date of the initial impressions for complete or partial dentures and laboratory-processed crowns.

MPM, April 1, 2019 version
Dental Chapter, page 5
(italics added for emphasis)

Here, as discussed above, Petitioner requested a hearing with respect to bills he has received from his dentist.

In requesting a hearing, Petitioner bears the burden of proving by a preponderance of the evidence that the Department erred. Moreover, the undersigned Administrative Law Judge is limited to reviewing Department's decision in light of the information available at the time the decision was made.

Given the record and applicable policies in this case, Petitioner has failed to meet his burden of proof and the Department's action must be affirmed. The sole action taken by the Department in this case was a denial of the prior authorization request for an upper partial denture and it is undisputed that the denial was correct given the information the Department had at the time, which reflected both that the work had already been rendered without prior authorization being sought and that Petitioner did not have Medicaid coverage on the applicable date of service.

Petitioner's true dispute is with his dentist and whether that dentist can bill him. For example, if, as testified to by Petitioner, the impression was taken in May, then the denture would still be covered under the above policy even if it was not placed until June of 2019 and the dentist could not bill Petitioner directly after accepting him as a Medicaid beneficiary, even though the dentist was denied payment because of a failure to obtain prior authorization.

However, while the Department's representative and witness appeared to share Petitioner's concerns about Petitioner's dentist and gave Petitioner information about filing a fraud complaint, the dispute between Petitioner and his dentist over the bill does not involve any action by the Department and is beyond the scope of the undersigned Administrative Law Judge's jurisdiction.

Accordingly, whatever other avenues of relief Petitioner could pursue, this matter is limited to reviewing the Department's action and, for the reasons discussed above, the Department's sole action must be affirmed given the available information and applicable policies.

DECISION AND ORDER

The Administrative Law Judge, based on the above Findings of Fact and Conclusions of Law, decides that the Department did not improperly fail to pay for services provided to Petitioner.

IT IS, THEREFORE, ORDERED that:

The Department's actions are **AFFIRMED**.

Steven Kibit

SK/sb

Steven Kibit
Administrative Law Judge
for Robert Gordon, Director
Department of Health and Human Services

NOTICE OF APPEAL: A party may appeal this Order in circuit court within 30 days of the receipt date. A copy of the circuit court appeal must be filed with the Michigan Office of Administrative Hearings and Rules (MOAHR).

A party may request a rehearing or reconsideration of this Order if the request is received by MOAHR within 30 days of the date the Order was issued. The party requesting a rehearing or reconsideration must provide the specific reasons for the request. MOAHR will not review any response to a request for rehearing/reconsideration.

A written request may be mailed or faxed to MOAHR. If submitted by fax, the written request must be faxed to (517) 763-0155; Attention: MOAHR Rehearing/Reconsideration Request.

If submitted by mail, the written request must be addressed as follows:

Michigan Office of Administrative Hearings and Rules
Reconsideration/Rehearing Request
P.O. Box 30763
Lansing, Michigan 48909-8139

DHHS -Dept Contact

Carol Gates
Customer Service Division
P.O. Box 30479
Lansing, MI
48909

DHHS Department Rep.

M. Carrier
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PO Box 30807
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48933

Petitioner

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