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Date Mailed: April 29, 2021
MOAHR Docket No.: 21-001353
Agency No.: [redacted]
Petitioner: [redacted]

ADMINISTRATIVE LAW JUDGE: Steven Kibit

DECISION AND ORDER

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

After due notice, a telephone hearing was held on April 20, 2021. Petitioner appeared and testified on her own behalf. Allison Pool, Appeals Review Officer, represented the Respondent Michigan Department of Health and Human Services (MDHHS or Department). Edward Kincaid, Departmental 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. No other proposed exhibits were submitted.

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. Petitioner was a Medicaid beneficiary who received dental services through her provider. (Exhibit A, pages 9-13).

2. When receiving the services, Petitioner knew that they were non-covered. (Testimony of Petitioner).

3. Petitioner paid for the services out-of-pocket. (Testimony of Petitioner).

4. No claim for payment was submitted to the Department by Petitioner's dental provider. (Testimony of Petitioner; Testimony of Department's

witness).

5. On March 17, 2021, the Michigan Office Administrative Hearings and Rules (MOAHR) received the request for hearing filed in this matter. (Exhibit A, page 7).

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 applicable version of the MPM states in part:

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 for additional information about copayments.)

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

- 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, 2021 version*
> *General Information for Providers Chapter, pages 37-38*
> *(italics added for emphasis)*

Here, the facts in this case are undisputed and, as discussed above, they demonstrate that, while Petitioner had Medicaid coverage when she received the dental services in question, she elected to receive non-covered services; she paid for them out-of-pocket; and no claims have been submitted to the Department for payment from the provider.

Given the above record, the Department acted properly in this case and its actions must be affirmed.

It is undisputed that no claims for payment have ever been submitted to the Department with respect to the dental services, with federal regulations and state policy expressly prohibiting any payment by Medicaid without a claim. Moreover, even if claims for payment for the specific dental services provided had been submitted, they would have been denied given that the services provided were non-covered. The above policy also expressly allows a provider to bill a beneficiary for services in circumstances where, as in this case, the beneficiary requests a service not covered by Medicaid and was told prior to the provider rendering the service that it is not covered by Medicaid.

While conceding that the services she received were non-covered, Petitioner also testified that she just wants the Department to pay the difference between the non-covered services she received and the covered services she could have received, and which she asserts are a significant part of the non-covered services. However, she also concedes that no such request has been made to the Department to do so as part of a claim for payment and there is no denial for the undersigned Administrative Law Judge to review.

Neither Petitioner nor the Department’s witness was aware of any policy allowing the Department to pay for the difference between covered and non-covered services, but Petitioner and her provider are free to submit a request for the difference between the covered and non-covered services; and, if that request is denied, then another request for hearing may be filed with respect to that denial. In this case however, the Department’s actions must be affirmed given the lack of any claim for payment.

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 dental services provided to Petitioner.

IT IS, THEREFORE, ORDERED that:

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

Steven Kibit

SK/sb

Steven Kibit
Administrative Law Judge
for Elizabeth Hertel, 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

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