

## ISSUE

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

## FINDINGS OF FACT

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

1. On REDACTED, 2024, Petitioner received medical services at Yousif Orthopedic Surgery. (Exhibit A, page 8; Testimony of Petitioner).
2. At that time, he did not have Medicaid coverage. (Testimony of Petitioner; Testimony of Specialist).
3. The medical provider did not bill the Department. (Testimony of Specialist).
4. Petitioner did receive a bill eventually. (Testimony of Petitioner).
5. Petitioner then filed a Beneficiary Complaint with respect to the bill he received. (Testimony of Petitioner; Testimony of Specialist).
6. On October 20, 2025, the Department sent Petitioner a written response to his Beneficiary Complaint. (Exhibit A, page 8).
7. In part, that response stated:

After speaking with the health care provider, we determined that you are responsible for this bill.

Medicaid cannot pay this bill because you did not have Medicaid coverage on the date of service.

*Exhibit A, page 8*

8. On January 27, 2026, MOAHR received the request for hearing filed in this matter. (Exhibit A, pages 4-7).
9. Following the filing of the request for hearing, the Department's Economic Stability Administration (ESA) retroactively approved Petitioner for Medicaid coverage during all of September of 2024. (Testimony of Specialist).

10. The Department also contacted Yousif Orthopedic Surgery advising it that it could now bill the Department for services provided on REDACTED , 2024, with the Department willing to waive the requirement that a claim be filed within one year of the date of service. (Testimony of Specialist).
11. The provider indicated that it would pull Petitioner's bill from collections and bill the Department. (Testimony of Specialist).
12. As of the date of the hearing, the provider has not submitted a claim to the Department for payment for services provided on REDACTED 2024. (Testimony of Specialist).

## **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 identified in the Medicaid Provider Manual (MPM). Moreover, with respect to a providers billing beneficiaries, the MPM states in part:

### **SECTION 10 - BILLING BENEFICIARIES**

#### **10.1 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 their 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 they were 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 them 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 their **miHealth** card is not accepted and that they are 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, January 1, 2026 version  
General Information for Providers Chapter, pages 31-32*

Here, as discussed above, Petitioner requested a hearing with respect to a bill he has received from a medical provider.

In requesting a hearing, Petitioner bears the burden of proving by a preponderance of the evidence that the Department erred. Moreover, the undersigned ALJ is limited to reviewing Department's actions in light of the information available at the time any action was taken.

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 bill in this case is for services provided on REDACTED 2024, but no claim has ever been submitted to the Department. Accordingly, the Department acted properly, and its actions must be affirmed. Federal regulations and state policy expressly prohibit any payment by Medicaid without a claim.

Moreover, if a claim had been submitted prior to Petitioner's Beneficiary Complaint and the Department's response to that complaint, the claim would have been properly denied as Petitioner would not have the required Medicaid coverage on the date of service identified.

Since the request for hearing was filed in this case, Petitioner has been retroactively approved for Medicaid coverage; the provider has been advised that it can now bill the Department for the services in question; and the provider has indicated it will do so. Accordingly, it appears that this matter is resolved. However, to the extent it is not, the Department cannot force the provider to submit a claim or to retroactively accept Petitioner as a Medicaid patient, and Petitioner would remain responsible for the bill in the absence of a claim to the Department.

## 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 medical services provided to Petitioner.

**IT IS, THEREFORE, ORDERED** that:

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