



Memorandum of Clarification

Denied Authorization of Covered Benefits

It has come to the attention of the Dental staff of AmeriHealth Caritas District of Columbia that there may be some confusion about denied benefits of covered services and the difference from non-covered services and when a member will be financially responsible for the payment of services.

Covered Benefits

Federal rules in the United States Code 42 U.S.C. 1396a(a)(25)(C) prohibits a provider from billing or seeking payment from a Medicaid beneficiary for services rendered.

(C) that in the case of an individual who is entitled to medical assistance under the State plan with respect to a service for which a third party is liable for payment, the person furnishing the service may not seek to collect from the individual (or any financially responsible relative or representative of that individual) payment of an amount for that service (i) if the total of the amount of the liabilities of third parties for that service is at least equal to the amount payable for that service under the plan (disregarding section 1396o of this title), or (ii) in an amount which exceeds the lesser of (I) the amount which may be collected under section 1396o of this title, or (II) the amount by which the amount payable for that service under the plan (disregarding section 1396o of this title) exceeds the total of the amount of the liabilities of third parties for that service;

According to the Rules cited, a provider cannot obtain any payment for services that are covered benefits under any circumstances. There is also no provision for balance billing under any circumstances. A Denied Authorization is not a Non-Covered Service.

Non-Covered Benefits

Services that are not covered under the Plan may be charged only under the following provisions found on Page 25 of the Dental Provider Supplement Manual:

Payment for Non-Covered Services

Participating providers shall hold members, the health plan, the health plan's vendors, and the state agency harmless for the payment of non-covered services except as provided in this paragraph. Provider may bill a member for non-covered services if the provider obtains a written waiver from the member prior to rendering such service that indicates:

- The services to be provided;
- The health plan, its vendors, and the state agency will not pay for or be liable for said services; and
- Member will be financially liable for such services.