**STATE OF MICHIGAN**
**STATE OFFICE OF ADMINISTRATIVE HEARINGS AND RULES**
**FOR THE DEPARTMENT OF COMMUNITY HEALTH**
P.O. Box 30763, Lansing, MI 48909
(877) 833-0870; Fax: (517) 334-9505

IN THE MATTER OF:

[redacted]

Appellant
_____/

Docket No. 2009-30687 MSB
Case No. [redacted]

## DECISION AND ORDER

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

After due notice, a hearing was held [redacted]. The Appellant represented herself. [redacted], represented the Department. [redacted], appeared as a witness for the Department.

## ISSUE

Is the Appellant entitled to Medicaid coverage for the medical bill from [redacted] for services provided [redacted]?

## FINDINGS OF FACT

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

1. The Appellant was an Adult Medical Program beneficiary beginning [redacted].

2. The Appellant had a medical service performed [redacted].

3. The Appellant presented a bill for services rendered [redacted], to the Department of Community Health for payment, asserting she is entitled to Medicaid coverage of the bill.

4. There is no evidence of record indicating the Appellant had Medicaid coverage at the time the medical service at issue was rendered.

5. There is no record of evidence the Appellant's program benefits extended to the medical service she had on [redacted].

6. The Department denied payment of the bill and notified her of same.

7. The Appellant sought an Administrative hearing [redacted].

## 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.

The Medicaid Provider Manual contains explanation of the Adult Benefits Program. Pertinent sections follow below:

> This chapter applies to all providers.
>
> The Adult Benefits Waiver (ABW) provides health care benefits for Michigan's childless adult residents (age 18 through 64) with an annual income at or below 35 percent of the Federal Poverty Level (FPL). Covered services and maximum co-payments for beneficiaries in this eligibility category are detailed in the following sections. Unless noted in Medicaid provider-specific chapters, service coverage and authorization requirements for the fee-for-service (FFS) beneficiaries enrolled in the ABW program mirror those required for Medicaid. Only those providers enrolled to provide services through the Michigan Medicaid Program may provide services for FFS ABW beneficiaries.
>
> ### 1.1 COUNTY-ADMINISTERED HEALTH PLANS
>
> ABW beneficiaries enrolled in County-Administered Health Plans (CHPs) are subject to the requirements of the respective CHP. In those counties operating nonprofit CHPs, all covered services for ABW beneficiaries must be provided through the health plan. CHPs administering the ABW program are required to provide the services noted in the Coverage and Limitations Section of this chapter to ensure that benefits are consistent for all ABW beneficiaries across the FFS and CHP programs.

An up-to-date list of CHPs is maintained on the Michigan Department of Community Health (MDCH) website. (Refer to the Directory Appendix for website information.) CHPs may:

- Require that services be provided through their contracted provider network and may institute prior authorization (PA) requirements beyond those required for the FFS ABW program.
- Require beneficiaries to obtain certain services from the Local Health Departments (LHDs) or other community resources. When such referrals are made, the CHP is responsible for the beneficiary's share of the fee minus any applicable co-payments.

CHP providers rendering services to ABW beneficiaries enrolled in a CHP are not required to enroll as providers in the Medicaid program, but they must comply with all Medicaid provider requirements as detailed in this manual. This includes the prohibition on balance billing beneficiaries for the difference between the provider's charge and the CHP reimbursement.

**1.2 ABW ELIGIBILITY DETERMINATION AND VERIFICATION**

The local office of the MDHS determines eligibility for the ABW beneficiaries who are identified with a scope/coverage code 3G. Level of Care (LOC) code 11 identifies ABW beneficiaries enrolled in a CHP. No LOC code is used to identify the FFS ABW beneficiary. Once eligibility is determined, the beneficiary is issued a **mihealth** card. CHPs may also issue membership cards to their enrollees.

Before providing service, providers must verify eligibility using the Eligibility Verification System (EVS). (Refer to the Beneficiary Eligibility Chapter of this manual for additional information.) Individuals with scope/coverage code 3E are eligible only for emergency services and are not enrolled in a CHP.

Medical authorization from the local MDHS office for individual services is not required for ABW beneficiaries.

Questions regarding ABW coverage and FFS billing should be directed to MDCH Provider Inquiry. (Refer to the Directory Appendix for contact information.)

**1.3 REIMBURSEMENT [CHANGE MADE 7/1/09]**

Services provided to beneficiaries enrolled in CHPs are billable to the CHP except for:

- H7Z class psychotropic drugs
- Anti-retroviral classes
- Anti-psychotic classes

A list of the specific medications is maintained on the MDCH pharmacy benefit manager's website and is subject to change without notice. (Refer to the Directory Appendix for website information.) These medications should be billed through the MDCH pharmacy benefit manager's point-of-sale reimbursement system for all ABW beneficiaries. Providers billing for these services must be Medicaid enrolled.

Reimbursement for services rendered to FFS ABW beneficiaries is the current Medicaid fee screens or the provider's charge, whichever is less. Services for ABW beneficiaries enrolled in a CHP are reimbursed at a rate negotiated by the CHP with its network providers. Services provided to ABW beneficiaries by Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC) are not subject to the prospective payment reimbursement rate.

**(text deleted 7/1/09)** ABW beneficiaries may not be billed for services except in the following situations:

- A co-payment is required. However, a provider cannot refuse to render service if the beneficiary is unable to pay the required co-payment on the date of service.
- If the beneficiary requests a service not covered by the ABW, the provider may charge the beneficiary for the service if the beneficiary has been told prior to rendering the service that it was not covered by the ABW. If the beneficiary is not informed of the ABW noncoverage until after the services have been rendered, the provider cannot bill the beneficiary.
- The provider chooses not to accept the beneficiary as an ABW 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. For additional information about billing the beneficiary, refer to the Billing Beneficiaries Section of the General Information for Providers Chapter.



**SECTION 2 – COVERAGE AND LIMITATIONS**

The table below outlines beneficiary coverage under ABW. Special instructions for CHP beneficiaries are noted when applicable.

| Service | Coverage |
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| Ambulance | Limited to emergency ground ambulance transport to the hospital Emergency Department (ED). |
| Case Management | Noncovered |
| Chiropractor | Noncovered |
| Dental | Noncovered, except for services of oral surgeons as covered under the current Medicaid physician benefit for the relief of pain or infection. |
| Emergency Department | Covered per current Medicaid policy.<br>For CHPs, PA may be required for nonemergency services provided in the emergency department. |
| Eyeglasses | Noncovered |
| Family Planning | Covered. Services may be provided through referral to ocal Title X designated Family Planning Program. |
| Hearing Aids | Noncovered |
| Home Health | Noncovered |
| Home Help (personal care) | Noncovered |
| Hospice | Noncovered |
| Inpatient Hospital | Noncovered |
| Lab & X-Ray | Covered if ordered by an MD, DO, or NP for diagnostic and treatment purposes. PA may be required by the CHP. |
| Medical Supplies/Durable Medical Equipment (DME) | Limited coverage.<br>• Medical supplies are covered except for the following noncovered categories: gradient surgical garments, formulas and feeding supplies, and supplies related to any noncovered DME item.<br>• DME items are noncovered except for glucose monitors |
| Mental Health Services | Covered: Services must be provided through the PIHP/CMHSP. (Refer to the Mental Health/Substance Abuse Coverage section of this chapter.) |
| Nursing Facility | Noncovered |
| Optometrist | Noncovered |
| Outpatient Hospital (Nonemergency Department) | Covered: Diagnostic and treatment services and diabetes education services. PA may be required for some services. A $3 co-payment for professional services is required.*<br>Noncovered: Therapies, labor room and partial hospitalization. |
| Pharmacy | Covered:<br>• Products included on the Michigan Pharmaceutical Products List (except enteral formulas) that are prescribed by an MD, DO, NP or type 10-enrolled oral surgeon. PA may be required. Products must be |

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| | billed to MDCH or CHP, as appropriate.<br>• Psychotropic medications are provided under the FFS benefit. (Refer to the MDCH Pharmacy Benefits Manager (PBM) website for a list of psychotropic drug classes to be billed to MDCH. Refer to the Directory Appendix for website information.) The list of drugs covered under the carveout is updated as necessary. Drugs are added and deleted on a regular basis so it is imperative that the provider review this website frequently.<br><br>Noncovered: Injectable drugs used in clinics or physician offices.<br><br>Co-payment: $1 per prescription |
| Physician<br>Nurse Practitioner (NP)<br>Oral Surgeon<br>Medical Clinic | The following services are covered per current Medicaid policy:<br>• Annual physical exams (including a pelvic and breast exam, and pap test). Women who qualify for screening/services under the Breast and Cervical Cancer Program administered by the LHD may be referred to that program for services as appropriate.<br>• Diagnostic and treatment services. May refer to LHD for TB, STD, or HIV-related services, as available.<br>• General ophthalmological services (procedure codes 92002-92014)<br>• Immunizations per current Advisory Committee on Immunization Practices (ACIP) guidelines. May be referred to LHD. Travel immunizations are excluded.<br>• Injections administered in a physician's office per current Medicaid policy. CHPs may require PA for some injections. Specific psychotropic injectable drugs administered through a PIHP/CMHSP clinic to an ABW beneficiary are reimbursed by MDCH on a fee-for-service basis when the following criteria is met:<br>➢ The beneficiary has an open case with the PIHP/CMHSP; and<br>➢ The beneficiary receives the injections on a scheduled or routine basis as part of the PIHP/CMHSP treatment/support regimen; and<br>➢ The PIHP/CMHSP physician has determined that the beneficiary may not comply with the medication regimen if the infections were not administered through the PIHP/CMHSP clinic |

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| | and that this non-compliance could adversely affect the beneficiary; and<br>➢ The PIHP/CMHSP clinic notifies the beneficiary's CHP or primary care physician that this service is being rendered; or<br>➢ The injectable drug is listed on the MH/CHP/SA (PIHP/CMHSP/Children's Waiver) Injectable Drugs Billable to MDCH database.<br><br>Injectables that do not meet the above criteria remain the responsibility of the CHP, and CHP's prior authorization requirements must be followed.<br><br>The specific injectable drugs are only covered by MDCH through fee-for-service basis **if** provided by a physician as part of his affiliation with a PIHP/CMHSP and must be billed using the NPI number associated with the PIHP/CMHSP. Payments made to a physician for injectable drugs administered to an ABW beneficiary that are not billed under the NPI number not associated with a PIHP/CMHSP physician group will be subject to recovery.<br><br>PA may be required for some services. A $3 co-payment is required for office visits (professional services).*<br><br>Noncovered: Services provided in an inpatient hospital setting. |
| Podiatrist | Noncovered |
| Prosthetics/ Orthotics | Noncovered |
| Private Duty Nursing | Noncovered |
| Substance Abuse | Covered through the Substance Abuse Coordinating Agencies (CAs). (Refer to the Mental Health/Substance Abuse Coverage section of this chapter.) |
| Therapies | Occupational, physical, and speech therapy evaluations are covered when provided by physicians or in the outpatient hospital setting. Therapy services are not covered in any setting. |
| Transportation (nonambulance) | Noncovered |

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| Urgent Care Clinic | Professional services provided in a freestanding facility are covered. CHPs may require authorization by the primary care physician or plan administrator. A $3 co-payment is required. |

* Professional services requiring a co-payment are defined by the following Evaluation and Management (E&M) procedure codes. 92002-92014, 99201-99205, 99211-99215, 99241-99245, 99341-99345, 99347-99350, 99385-99387, 99395-99397. No co-payment may be charged for family planning or pregnancy related services.

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In this case the Appellant states on her hearing request form she was eligible for Adult Benefits Waiver program. The policy above specifies the program benefits are limited and many require prior authorization. In this case, the Appellant had a procedure in [redacted]. She has presented a bill for the procedure. Her testimony is that originally this bill was paid but when "Medicaid" discovered she had Medicare, "Medicaid" took back payment and said she had refused Medicare part B coverage, therefore this bill was ineligible for payment. She presented no evidence supporting the testimony the bill had ever been paid. It is not known who she refers to when she cites "Medicaid" as having taken back payment. She presented no proof the bill had ever been paid in the first place or proof (in the form of a Notice) that payment had actually been rescinded by any entity. Presumably, if payment had been rendered at or near the time of the service and rescinded some years later, she would have gotten some type of notice informing her payment was rescinded. Her testimony alone is insufficient to find the events testified to are material facts. Some documentation consistent with the events described by the Appellant should have been provided as corroborating evidence. The testimony of the Appellant alone is insufficient to find reliable. Additionally, the Appellant is asserting payment privileges under the ABW program and has not presented any evidence she was eligible for coverage of the procedure she had under this program. Policy set forth above specifies ABW coverages and also limits who may provide the covered services in certain circumstances. The Appellant presented no evidence she had a covered service performed by an authorized practitioner for ABW services. She has failed to meet her burden of proof that she was entitled to coverage for the procedure at issue.

The Department witness addresses the issue as a Medicaid/Medicare issue and asserted the Appellant was eligible for Medicare Part B and refused it, thus is not entitled to coverage of the bill dating to [redacted]. While this ALJ does not see any evidence this Appellant was actually eligible for Medicare Part B and refused it in the record, it does not appear to be material to the disposition of the case at issue. The Appellant was not a Medicaid recipient, she was a participant in the Adult Benefits Waiver program. The coverage and benefits are not the same. This ALJ finds the Policy Manual

specifies what services are covered for Adult Benefits Waiver participants. In this case, the laboratory/x-ray obtained by the Appellant may or may not have been a covered service. It may or may not have been provided by a provider with a contract. It is not in evidence whether the Appellant was enrolled in a county health plan and subject to their prior authorization procedures or not. The Appellant provided no evidence that she is entitled to have either the Medicaid or the Adult Benefits Waiver program provide coverage for the medical service she obtained on [redacted]. She did have the burden of establishing she was wrongfully denied payment coverage to which she was entitled. She did not meet her burden of proof.

## DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, finds that the Department properly rejected the Appellant's claim she was entitled to Medicaid coverage for the medical bill presented.

**IT IS THEREFORE ORDERED** that:

The Department's decision is AFFIRMED.

Jennifer Isiogu
Administrative Law Judge
for Janet Olszewski, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed 10/6/2009

**** NOTICE *****

The State Office of Administrative Hearings and Rules for the Department of Community Health 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 State Office of Administrative Hearings and Rules for the Department of Community Health 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 mailing date of the Decision and Order or, if a timely request for rehearing was made, within 30 days of the mailing date of the rehearing decision.