STATE OF MICHIGAN
STATE OFFICE OF ADMINISTRATIVE HEARINGS AND RULES
FOR THE DEPARTMENT OF COMMUNITY HEALTH
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IN THE MATTER OF:

Docket No. 2010-52482 MSB

[redacted]

Appellant

_____/

DECISION AND ORDER

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

After due notice, a hearing was held on [redacted]. The Appellant, [redacted], appeared on her own behalf. [redacted], Appeals Review Officer, represented the Department of Community Health (MDCH or Department). [redacted], Departmental Specialist for the Medical Services Administration, appeared as a witness for the Department. At the hearing, it was discovered that a bill had recently been submitted to the Department for payment. However, the Department was unable to address its merits at that time. So a continued hearing was conducted on [redacted], with all of the original parties present.

ISSUE

Did the Department properly deny payment for the Appellant's gynecological examination performed by [redacted] on [redacted]

FINDINGS OF FACT

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

1. [redacted] is a waiver program that provides family planning services to women who would not otherwise be covered. (Exhibit 1, page 9)

2. [redacted] application explicitly states that the [redacted] covers family planning services only. (Exhibit 1, page 14)

3. The Appellant was enrolled in the [redacted] on [redacted], with a retroactive effective date of [redacted]. At that time, she was advised that the program only covers the following services: office visits for family

planning-related services, prescriptions for birth control, contraceptive (birth control) supplies/devices, lab tests, treatment for sexually transmitted infections, and some sterilizations (for women 21 years of age or older). (Exhibit 1, pages 5-8)

4. The MDCH's website specifically defines family planning services as "any medically approved means, including diagnostic evaluation, pharmaceuticals, and supplies, for voluntarily preventing or delaying pregnancy." In addition, the website states that fertility services are not a covered service. (Exhibit 1, page 10)

5. On [redacted], a fertility specialist, performed an annual gynecological examination on the Appellant at [redacted]). (Exhibit 1, page 17)

6. In [redacted] billed the Department for the services rendered to the Appellant on [redacted]. The diagnoses codes that were assigned to the services were: 2249—Hypothyroidism NOS, V7231—Routine Gyn Examination, and 6264—Irregular Menstruation. (Exhibit 1, pages 16-17)

7. The Department denied payment because the diagnosis codes do not support that the services were rendered for purposes of family planning. (Exhibit 1, pages 16-17; Testimony of [redacted]

8. The Appellant requested a formal, administrative hearing on [redacted], regarding the bill that she received from [redacted] in the amount of [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.

Providers cannot bill beneficiaries for services except in the following situations:

- A co-payment for chiropractic, dental, hearing aid, pharmacy, podiatric, or vision services 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.

- A monthly patient-pay amount for inpatient hospital or nursing facility services. The local DHS determines the patient-pay amount. Non-covered services can be purchased by offsetting the nursing facility beneficiary's patient-pay amount. (Refer to the Nursing Facility Chapter for more 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 DHS 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 DHS 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 has been told prior to rendering the service that it was not covered by Medicaid. If the beneficiary is not informed of Medicaid non-coverage until after the services have been rendered; the provider cannot bill the beneficiary.

- The beneficiary refuses Medicare Part A or B.

- 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 non-authorized or non-covered 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, customized seating systems) that began, but were not completed, during a period of eligibility. (Refer to the provider-specific chapters of this manual for more 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 or for 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.
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> *Medicaid Provider Manual,*
> *General Information for Providers Section,*
> *July 1, 2010, pages 21-22*

At issue in the present case is the billing and payment for services rendered to the Appellant by [redacted] on [redacted]. More specifically, [redacted] performed an annual gynecological examination on the Appellant. The Department witness explained that the hospital did submit a bill to the Department. However, the Department cannot pay the bill because it was not coded as a family planning service, which is the only Medicaid coverage the Appellant has. She further explained that gynecological examinations are covered by the program if they are for planning purposes, but the program does not cover routine gynecological examinations.

The Appellant testified that she enrolled in the Department's Family First! program under the assumption that it would cover her annual gynecological examination. She explained that she wanted the exam to determine if her body was healthy enough to have a baby, not for birth control purposes. She stated that she is not able to have a child on her own and that birth control would not be of any use to her. She further stated that the program is very deceiving and that she was unaware that the services had to be for the purpose of preventing pregnancy in order to be covered. She testified that she would not have applied for the program if she knew that the examination would not be covered. She further admitted that [redacted] is a fertility specialist.

The Department cannot issue payments for non-covered services. Here, the Appellant admitted that the gynecological examination was not for purposes of family planning, i.e., voluntarily preventing or delaying pregnancy, but rather to determine if her body was healthy enough to have a child. In addition, the services were not coded as being for the purpose of family planning and [redacted] is a fertility specialist. Therefore, the examination was not a covered service. Accordingly, the Department's denial of payment for the services rendered to the Appellant was proper.

However, it also appears that [redacted] has improperly billed the

Appellant for the services. The Appellant inquired with [redacted] staff regarding his acceptance of [redacted] patients, and she was advised that he did accept them. Accordingly, the Appellant should not be billed for the services because the provider accepted her as a [redacted] patient and she was not advised before services were rendered that the services would not be covered.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that it was proper for the Department to deny payment for the services rendered to the Appellant by [redacted].

IT IS THEREFORE ORDERED that:

The Department's decision is AFFIRMED.

Kristin M. Heyse
Administrative Law Judge
for Janet Olszewski, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 12/17/2010

***** 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.