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

[redacted]

Appellant
_____/

Docket No. 2010-9866 MSB
[redacted]

DECISION AND ORDER

This matter is before the undersigned Administrative Law Judge (ALJ) 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]. [redacted] appeared on the Appellant's behalf. [redacted] Appeals Review Officer, represented the Department of Community Health (MDCH or Department). [redacted] Departmental Specialist Program Liaison Medical Services Administration, appeared as a witness for the Department.

ISSUE

Whether the Department properly denied payment for services rendered to the Appellant by [redacted] in [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 a Medicaid beneficiary enrolled in [redacted] from [redacted] (Exhibit 1, page 2)

2. The Appellant started receiving occupational therapy services at [redacted]. in [redacted] (Testimony)

3. The Appellant's Medicaid eligibility terminated on [redacted]. (Exhibit 1, page 2)

4. The Appellant's Medicaid eligibility was reinstated on [redacted], with

retroactive coverage to [redacted] (Exhibit 1, page 2)

5. Health plan enrollments can only be made prospectively. The Appellant was re-enrolled in [redacted] effective [redacted] (Exhibit 1, page 2)

6. The Appellant was entitled to Fee For Service Medicaid benefits for the period of [redacted] through [redacted]. (Exhibit 1, page 2)

7. The Appellant received medical services at Rehabilitation Associates Inc., on [redacted] and [redacted]. (Exhibit 1, page 6)

8. Rehabilitation Associates Inc. is a [redacted] enrolled Medicaid provider, but is not a Fee For Service Medicaid enrolled provider.

9. The Appellant requested a formal, administrative hearing [redacted], regarding denial of payment for the Rehabilitation Associates Inc. bills for services rendered in [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.

Medicaid Provider Manual, General Information for Providers Section, July 1, 2009, Pages 17-18

At issue in the present case is the billing and payment for services rendered to the Appellant by [redacted]. The Department witness explained that [redacted] is a Medicaid enrolled provider for [redacted] but is not a Fee For Services Medicaid enrolled provider.

The Appellant's representative testified that the Appellant's Medicaid redetermination was not timely completed by the Department of Human Services (DHS). The Appellant's Medicaid eligibility terminated effective [redacted]. (Exhibit 1, page 2) The Department's witness explained that the Appellant's enrollment in the [redacted] Plan terminated with her Medicaid eligibility on [redacted].
The Appellant's Medicaid eligibility was reinstated [redacted] with retroactive coverage to

[redacted] (Exhibit 1, page 2) The Department witness explained that because health plan enrollments can only be made prospectively, the Appellant was not re-enrolled in [redacted] until [redacted]. Accordingly, the Appellant is entitled to Fee For Service Medicaid for the period of [redacted]. (Exhibit 1, page 2)

Once a provider accepts a patient as a Medicaid beneficiary, the beneficiary can not be billed for Medicaid-covered services. *Medicaid Provider Manual, General Information for Providers Section, July 1, 2009, Page 18.* The Appellant's representative testified that the Appellant began receiving occupational therapy services at [redacted] in [redacted] A review of the Appellant's eligibility history confirms that the Appellant was in fact a Medicaid beneficiary, participating in the [redacted] in [redacted] (Exhibit 1, page 2) The Appellant continued to receive services from this provider through [redacted], when her Medicaid eligibility changed.

Rehabilitation Associates Inc. has improperly billed the Appellant for the services rendered in June and July 2009. The provider accepted the Appellant as a Medicaid beneficiary in November 2008 and therefore can not bill the Appellant for Medicaid covered services or for services for which the provider has been denied payment because of improper billing. The Appellant does have Fee For Service Medicaid eligibility for the dates of service at Rehabilitation Associates Inc. at issue in June and July 2009.

The Department can not issue payments to non-enrolled providers. [redacted] is a Medicaid enrolled provider for [redacted] but not a Fee For Services Medicaid enrolled provider. The Department witness testified that [redacted] was given the opportunity to enroll as a Fee For Service Medicaid provider, but the provider refused to participate or submit a claim. Accordingly, the Department has properly failed to consider payment to [redacted]. for the services rendered to the Appellant in [redacted].

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 to [redacted] for services rendered to the Appellant in [redacted]

IT IS THEREFORE ORDERED that:

The Department's decision is AFFIRMED.

Colleen Lack
Administrative Law Judge
for Janet Olszewski, Director

[redacted]
Docket No. 2010-9866 MSB
Decision and Order

Michigan Department of Community Health

cc: [redacted]

Date Mailed: 2/9/2010

***** 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.