STATE OF MICHIGAN
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
FOR THE DEPARTMENT OF COMMUNITY HEALTH
P.O. Box 30763, Lansing, MI 48909
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IN THE MATTER OF:

[redacted],

Docket No. 2011-32532 MSB
Case No. [redacted]

Appellant
_____/

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]. [redacted], the Appellant, appeared on her own behalf. [redacted], Appeals Review Manager, represented the Department. [redacted], MDCH Department Specialist, appeared as a witness for the Department.

ISSUE

Whether the Department properly denied payment for medical services provided to the Appellant on [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 has a monthly deductible, or spend down, that she must meet each month to be eligible for Medicaid coverage for the remainder of that month. (Uncontested)

2. The Appellant received medical services on [redacted]. (Uncontested)

3. The Appellant did not have active Medicaid coverage at the time services were provided on [redacted].

4. On [redacted], the Appellant turned receipts in to her Department of Human Services (DHS) Medicaid eligibility worker to show that she had met her spend down for the month. (Appellant Testimony)

5. On [redacted], the Appellant's Medicaid eligibility was updated resulting in Medicaid coverage effective [redacted], through [redacted] (Exhibit 1, page 4)

6. On [redacted] DHS issued a Notice of Case Action to the Appellant indicating her [redacted] monthly deductible was met and Medicaid coverage was effective [redacted], through [redacted]. The notice included the Appellant's rights to an administrative hearing and a Request for Hearing form that could be submitted within 90 days to contest the Medicaid eligibility determination. (Exhibit 1, pages 5-7)

7. On [redacted], a claim was submitted to Medicaid from a provider for services rendered to the Appellant on [redacted]. (Department Specialist Testimony)

8. On [redacted], the Department denied the [redacted] claim. (Department Specialist Testimony)

9. On [redacted], a claim was submitted to Medicaid from a second provider for services rendered to the Appellant on [redacted]. (Department Specialist Testimony)

10. On [redacted], the Department denied the [redacted], claim. (Department Specialist Testimony)

11. On [redacted], the Department denied the initial [redacted], claim a second time. (Department Specialist Testimony)

12. On [redacted], the Appellant filed a Hearing Request form indicating she was trying to get insurance coverage for [redacted], as she had very large hospital bills for this time period. (Exhibit 1, page 2)

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 Appellant's hearing request indicates she is seeking Medicaid coverage for [redacted]. (Exhibit 1, page 2) However, the notice of that Medicaid eligibility determination was issued to the Appellant on [redacted]. The Notice of Case Action included the Appellant's rights to an administrative hearing and a Request for Hearing form that could be submitted within 90 days to contest the Medicaid eligibility determination. (Exhibit 1, pages 5-7) If the Appellant had filed this form or any other written hearing request with DHS

within 90 days of the [redacted], Notice of Case Action, a hearing could have been scheduled with DHS to address that Medicaid eligibility determination. (*Bridges Administrative Manual (BAM) 600, Hearings, July 1, 2011, pages 1-4 of 36)* This ALJ can not review the Medicaid eligibility determination.

The evidence indicates that the only action taken within 90 days of the Appellant's [redacted], Request for Hearing, was the [redacted], denial of a second claim for medical services provided to the Appellant on [redacted]. (Department Specialist Testimony) This is the only action this ALJ can review in the present case.

The Medicaid Provider Manual, General Information for Providers addresses when a beneficiary can be billed by a provider:

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 and to the provider specific chapters for additional information about copayments. However, a provider cannot refuse to render service if the beneficiary is unable to pay the required copayment 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. 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 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 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.
- 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 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, 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.
- 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, April 1, 2011, Pages 21-22.
(Emphasis added by ALJ)

The Department introduced the Appellant's Medicaid eligibility history into evidence. The Appellant's [redacted] Medicaid eligibility was only effective for [redacted]. (Exhibit 1, page 4) The Department Specialist testified that on [redacted], the second submission of a claim for services rendered to the Appellant on [redacted], was denied because she did not have Medicaid coverage for the date of service.

The Appellant disagrees with the denial and testified that she turned in the receipts showing she had paid her deductible for the month as soon as she could. Due to the holiday on [redacted], the DHS office was closed for the day, and the receipts were submitted on [redacted]. (Appellant Testimony and Exhibit 2) Several valid points regarding possible errors in how the DHS Eligibility Specialist processed the Appellant's spend down were raised during the hearing proceedings. However, as noted above, this ALJ can not review the DHS eligibility determination.

The Department's [redacted], denial of the claim for medical services rendered to the Appellant on [redacted], was proper based on the available information. The Appellant does not have Medicaid coverage for this date of service.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, finds that the Department properly denied payment for medical services rendered to the Appellant on [redacted].

IT IS THEREFORE ORDERED that:

The Department's decision is AFFIRMED.

Colleen Lack
Administrative Law Judge
for Olga Dazzo, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed 8/3/2011

**** NOTICE *****

The Michigan Administrative Hearing System 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 Michigan Administrative Hearing System 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.