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

IN THE MATTER OF:

Docket No. 2012-13638 MSB
Case No. [redacted]

[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 on [redacted]. The Appellant appeared without representation. She had no witnesses. [redacted] Appeals Review Manager, represented the Department. Her witness was [redacted], Problem Specialist/MSA.

ISSUE

Did the Department properly deny the Appellant's claim for payment of Medical bills?

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 is a [redacted]-year-old Medicaid beneficiary [as of [redacted], "activated to [redacted]."] (Appellant's Exhibit #1 and Department's Exhibit A, p. 1)

2) The Department (Problem Resolution Unit) received the instant complaint for unpaid medical bills, generated between [redacted] and [redacted], on [redacted]. (Department's Exhibit A, p. 1)

3) The Problem Resolution Unit investigation showed that the provider attempted to verify the Appellant's Medicaid status – but she was not covered. They advised further that they were not notified of her retroactive eligibility generated in [redacted], even though it was known to both the Appellant and her authorized representative, [redacted]. (Department's Exhibit A, p. 1)

4) Medicaid denied payment for the Appellant's services. No claim was submitted for services rendered in [redacted].

5) The provider was unaware of the Appellant's later Medicaid eligibility and was thus unable to bill Medicaid before a year had elapsed.

6) The instant appeal of Problem Resolution Unit denial was received by the Michigan Administrative Hearing System for the Department of Community Health on [redacted]. (Appellant's Exhibit #1)

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.

All claims must be submitted in accordance with the policies, rules, and procedures as stated in the Medicaid Provider Manual.

> 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. (Note deleted by ALJ)
> - 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 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.

. . .

Medicaid Provider Manual, (MPM), §11.1, General Information for Providers Section, January 1, 2012, page 27[1]

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The Department provided evidence that the Appellant was eligible for Medicaid in [redacted] - and then had a retroactive application back to [redacted] – however, neither the Appellant nor her authorized agent advised the provider of this development.

Unaware of the Appellant's Medicaid status the provider was within its right to bill the Appellant. In turn, Medicaid (the Department) could not satisfy a claim never made – particularly when the billing submitted by the Appellant was stale, i.e., over 12-months old.

[1] This section of the MPM is identical to the version in place at the time of PRU review.

The Appellant may have a dispute with her authorized agent, but Medicaid has no duty to pay for a claim that was never filed.[2]

The Appellant's reliance on serendipitous error while understandable was misplaced. As explained by [redacted], the MSA Specialist, there was no legal duty for the Department to pay

The record shows that the Appellant was a Medicaid beneficiary. At some point prior to appeal the Appellant was confronted with her Medicaid application which clearly alerts her of her duty to report items such as coverage changes:

> **PLEASE KEEP THIS PAGE.**
> **INFORMATION ABOUT MEDICAID**
> **Rules may have changed since this was printed. Check with your local FIA office.**
>
> Medicaid helps people pay for medical care. A person may have Medicare, Health Insurance, and Medicaid. Medicaid may help with expenses **not paid by Medicare or Health Insurance.**
>
> Further in the application it requires the recipient to inform the agency within ten days if there are changes in Medicare coverage:
>
> **PLEASE KEEP THIS PAGE.**
> **ACKNOWLEDGMENTS**
> State of Michigan Family Independence Agency
>
> **This is your copy of your rights and responsibilities as an applicant for or recipient of assistance benefits. By signing the application you acknowledge that you understand your rights and responsibilities.**
>
> **2. Reporting Changes**. I understand that the agency needs to know of any changes in income or assets of all persons listed on the application form. I will report any change in my living arrangement, such as address change, persons coming to live with me or leaving home, getting married, and so on. I will tell the agency of a change ***within ten days*** of the change. I understand that if I intentionally do **not** do this, I can be prosecuted for fraud or perjury. If I begin employment, I must report this within 10 days of my start date.
>
> The types of changes that must be reported ***within ten days*** of the date I first know about them are:
>
> • Employment starts or stops
> • Change of employer
> • Change in rate of pay
> • Hours of work change by more than 5 hours per week if it will last more than one month.
> • Unearned income starts or stops (examples: Social Security, pension, unemployment and retirement)
> • Unearned income changes by more than $50 since the last reported change

[2] Had the provider filed a claim knowing it would be rejected and then received a TCN – continuous active review would have applied. There was no evidence that this occurred. See §12 *Supra*

> Exception: For Medicaid only (except for Healthy Kids), you must report a change of more than $25.
> • Health or hospital insurance premiums or ***coverage change***
> • Child care need or provider changes
> • Change of address and shelter costs
> • Child support expenses paid
> • Change of persons in the home
>
> My specialist will notify me if my reporting requirements change. If I have any doubt about whether to report a change, I will ask my Family Independence Agency specialist.

(Emphasis supplied) DHS Assistance Application FIA 1171

Unfortunately, the ALJ's jurisdiction does not extend to equitable solutions for the Appellant. Federal regulations and state policy prohibit payment by Medicaid without a claim. The state policy must be strictly applied. . The Appellant failed to preponderate her burden of proof.

Based on the information before it, the Department of Community Health [Problem Resolution Unit] correctly denied the Appellant's claim on appeal.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the Department properly denied the Appellant's claim.

IT IS THEREFORE ORDERED that:

The Department's decision is AFFIRMED.

Dale Malewska
Administrative Law Judge
for Olga Dazzo, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 2/29/2012

***** NOTICE *****

The Michigan Administrative Hearing System 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 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 receipt of the Decision and Order or, if a timely request for rehearing was made, within 30 days of the receipt of the rehearing decision.