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) 373-4147

IN THE MATTER OF:

Docket No. 2013-31420 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]. Appellant appeared and testified on her own behalf. [redacted], Appeals Review Officer, represented the Department. Her witness was [redacted], Department Specialist.

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, born [redacted]. (Exhibit A; Testimony)

2. Appellant originally applied for Medicaid in [redacted] but was denied by the Department of Human Services, who found that she was not disabled. Appellant appealed the denial and was subsequently determined to be disabled and eligible for Medicaid on [redacted], effective retroactively to [redacted]. Appellant was assigned to the Fee-for-Service Medicaid benefit plan. (Exhibit A, pp 2, 22; Testimony)

3. The Department received the instant complaint for unpaid medical bills on [redacted]. (Exhibit A, pp 5-6; 8-22)

4. The Department investigation showed that only one of the providers from the medical bills submitted by Appellant accepted Fee-for-Service Medicaid during the time of Appellant's retroactive Medicaid eligibility. The Department witness has contacted that provider and requested that it submit a bill to Medicaid for payment. (Exhibit A; Testimony)

5. The Department determined that the other providers of the services for the billings Appellant submitted do not accept Fee-for-Service Medicaid. Those providers have also not submitted the bills in question to Medicaid for payment. (Exhibit A, Testimony)

6. The instant appeal was received by the Michigan Administrative Hearing System on [redacted]. (Exhibit A, pp 4-5)

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, 2013, pp 28-29

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The Department provided evidence that the Appellant was found eligible for Medicaid in [redacted], with retroactive eligibility back to [redacted], and that Appellant was assigned to Fee-for-Service Medicaid, per Department policy. Unfortunately, most of the providers for whom Appellant submitted billings did not accept Fee-for-Service Medicaid when they provided the services to Appellant. (The Department is attempting to contact the one provider who did accept Fee-for-Service Medicaid at the time he provided services to Appellant in order to request that the provider submit the billings for payment).

Appellant argues that had she been initially approved for Medicaid eligibility when she first applied in [redacted], she would have been able to choose the HMO that the providers in question do accept and these bills would have been covered by Medicaid. While the

undersigned can sympathize with the Appellant's situation, her argument, while true, is not what occurred here. Appellant was initially denied Medicaid eligibility and persons who receive Medicaid retroactive are assigned to Fee-for-Service Medicaid, per Department policy.

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. Here, no claims have been submitted by the providers who do not accept Fee-for-Service Medicaid. The state policy must be strictly applied. The Appellant failed to preponderate her burden of proof.

Based on the information before it, the Department 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.

Robert J. Meade
Administrative Law Judge
for James K. Haveman, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 4/18/2013

***** 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.