

**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. 2013-62148 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 his own behalf. Appellant's witness was his mother, [REDACTED], Appeals Review Officer, represented the Department. Her witness was [REDACTED], Acting Section Manager.

ISSUE

Did the Department properly deny the Appellant's complaint regarding an outstanding medical bill?

FINDINGS OF FACT

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

1. Appellant is a [REDACTED]-year-old Medicaid beneficiary, born December 16, 1985. (Exhibit A; p 6)
2. On [REDACTED] Appellant submitted a Beneficiary Complaint to the Department requesting that the Department pay for medical bills incurred during an emergency room visit in [REDACTED] on [REDACTED]. (Exhibit A, p 6)
3. Appellant has been enrolled in the Medicaid Fee For Service benefit plan since [REDACTED]. (Exhibit A, p 4)
4. In response to Appellant's complaint, the Department contacted the [REDACTED] provider, who indicated that they do not accept Michigan Medicaid and are not willing to bill Michigan Medicaid. (Exhibit A, p 84 Testimony)

5. On ██████████, the Department sent Appellant a letter informing him that Michigan Medicaid could not pay the outstanding bills because the ██████ provider does not accept Michigan Medicaid and is not willing to bill Michigan Medicaid. (Exhibit A, p 10)
6. Appellant's request for hearing was received by the Michigan Administrative Hearing System on ██████████. (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, which provides, in pertinent part:

SECTION 2 - PROVIDER ENROLLMENT

An eligible provider who complies with all licensing laws and regulations applicable to the provider's practice or business in Michigan, who is not currently excluded from participating in Medicaid by state or federal sanction, and whose services are directly reimbursable per MDCH policy may enroll as a Medicaid provider. Out-of-state providers must be licensed and/or certified by the appropriate standard-setting authority in the state they are practicing. (Refer to the Beyond-Borderland Area subsection of this chapter for more information.) In addition, some providers must also be certified as meeting Medicare or other standards as specified by MDCH.

Providers (except pharmacies and managed care organizations) must have their enrollment approved through the on-line MDCH CHAMPS Provider Enrollment (PE) subsystem to be reimbursed for covered services rendered to eligible Medicaid beneficiaries. Refer to the Directory Appendix for contact information related to the on-line application process, including a CHAMPS Preparation Checklist of required information.

* * * *

SECTION 7 – SANCTIONED, NONENROLLED, BORDERLAND, AND OUT-OF-STATE/BEYOND BORDERLAND PROVIDERS

7.3 OUT OF STATE/BEYOND BORDERLAND PROVIDERS

Reimbursement for services rendered to beneficiaries is normally limited to Medicaid-enrolled providers. MDCH reimburses out of state providers who are beyond the borderland area (defined below) if the service meets one of the following criteria:

- Emergency services as defined by the federal Emergency Medical Treatment and Active Labor Act (EMTALA) and the Balanced Budget Act of 1997 and its regulations; or
- Medicare and/or private insurance has paid a portion of the service and the provider is billing MDCH for the coinsurance and/or deductible amounts; or
- The service is prior authorized by MDCH. MDCH will only prior authorize non-emergency services to out of state/beyond borderland providers if the service is not available within the state of Michigan and borderland areas.

* * * *

All providers (except pharmacies) rendering services to Michigan Medicaid beneficiaries must complete the on-line application process described in the Provider Enrollment Section of this Chapter in order to receive reimbursement. Exceptions to this requirement may be made in special circumstances. These circumstances will be addressed through the Prior Authorization process. Pharmacies must complete the enrollment process with MDCH's PBM. Refer to the Provider Enrollment Section of this Chapter for additional information.

SECTION 11 - BILLING BENEFICIARIES

11.1 GENERAL INFORMATION

* * * *

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, custom-fabricated seating systems) that began, but were not completed, during a period of eligibility. (Refer to the provider-specific chapters of this manual for additional information regarding exceptions.)

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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.

Emphasis added

*Medicaid Provider Manual
General Information for Providers Section
July 1, 2013, pp 4, 12-13, 28-29*

The Department witness testified that on [REDACTED], Appellant submitted a Beneficiary Complaint to the Department requesting that the Department pay for medical bills incurred during an emergency room visit in [REDACTED] on [REDACTED]. The Department witness indicated that Appellant has been enrolled in the Medicaid Fee For Service benefit plan since [REDACTED]. The Department witness testified that in response to Appellant's complaint, the Department contacted the [REDACTED] provider, who indicated that they do not accept Michigan Medicaid and are not willing to bill Michigan Medicaid for the services rendered to Appellant.

Appellant's mother testified that Appellant was having chest pains while in [REDACTED] and that the ambulance took him to the only nearby hospital for treatment. Appellant's mother indicated that Appellant was unconscious at the time and cannot afford to pay the outstanding bills. Appellant's mother pointed out that Medicare did pay for the majority of the visit, but not the bills at issue in this appeal. Appellant's mother testified that the ambulance would not take Appellant to another hospital and that the hospital he did go to did not inform them that they did not accept Michigan Medicaid.

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Federal regulations and state policy prohibit payment by Medicaid without a claim. Here, Appellant received services through an out of state provider in ██████████ who is not willing to participate in, or bill Michigan Medicaid. The Department cannot force a non-participating, out-of-state medical provider to accept a Michigan Medicaid beneficiary as a patient nor can the Department enforce Michigan Medicaid policy on the provider. Unless the out-of-state provider is willing to bill Michigan Medicaid for the services Appellant received, the Department cannot pay such services. As such, Appellant is responsible for the expenses related to the date of service of ██████████

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: ██████████

Date Signed: October 3, 2013

Date Mailed: October 3, 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.