

**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. 2013-66650 MSB

████████████████████
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 ██████████. The Appellant appeared and testified in her own behalf. ██████████ Appeals Review Officer, represented the Department. Her witness was ██████████, Acting Section Manager/MSA.

ISSUE

Did the Department properly deny the Appellant's claim for payment of a 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) The Appellant is a ██████-year-old Medicaid beneficiary [as of ██████████ "activated for ██████████."] (Exhibit A, p. 5).
- 2) The Department (Problem Resolution Unit) received the instant complaint for an unpaid medical bill, date of service ██████████ on ██████████ (Exhibit A, p. 6).
- 3) The Problem Resolution Unit investigation showed that the Provider ██████████ attempted to verify the Appellant's Insurance status – but Appellant did not respond to numerous billings or phone calls asking for insurance information for the ██████████ service. The Appellant told the Provider at the time that she had ██████████ coverage, but that did not cover the service provided, and the Appellant was advised she would be a self-pay. One month later the Appellant was made retroactively eligible for Medicaid, but the Appellant never notified the Provider that she was eligible for Medicaid for the ██████████ service, so the Provider did not bill Medicaid for the service. (Exhibit A, p. 8)

- 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, General Information for Providers*, §11.1, July 1, 2013, p. 28].

The General Information for Providers chapter further provides:

12.3 BILLING LIMITATION

Each claim received by MDCH receives a unique identifier called a Transaction Control Number (TCN). This is an 18-digit number found in the Remittance Advice (RA) that indicates the date the claim was entered into the Community Health Automated Medicaid Processing System (CHAMPS). The TCN is used when determining active review of a claim. (Refer to the Billing & Reimbursement Chapters for additional information.)

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A claim must be initially received and acknowledged (i.e., assigned a TCN) by MDCH within 12 months from the date of service (DOS). [Medicaid Provider Manual, General Information for Providers, §12, July 1, 2013, p. 33].

The Department provided evidence that the Appellant was eligible for Medicaid in [REDACTED] - and had a retroactive application back to [REDACTED] – however, the Appellant did not advise the Provider of this development for the bill for the [REDACTED] service.

Initially, the Appellant advised the Provider that she only had [REDACTED] coverage, which did not cover the [REDACTED] service. The Provider advised Appellant at that time she would be a self-pay. The Provider advised that it considers each visit or admission as a new account and information gathered for previous visits is not carried over for a new visit. Accordingly, the Provider did not have the Appellant's Medicaid information for the [REDACTED] visit and did not bill Medicaid for the visit. Since the Provider was not made aware of the Appellant's change in Medicaid status, i.e., that she was made retroactively eligible for Medicaid back to [REDACTED] for the particular bill at issue, the Provider was within its right to bill the Appellant for the [REDACTED] service. Accordingly, the Provider never filed a claim with Medicaid for the [REDACTED] service. 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 [REDACTED]-months old. Medicaid has no duty to pay for a claim that was never filed and cannot now consider a claim that is more than [REDACTED] months from the date of service.

The Appellant testified that she had a kidney problem in [REDACTED]. She indicated she was in and out of the hospital several times. Appellant indicated that [REDACTED] called her to advise that she was eligible for Medicaid. She stated after she was made eligible for Medicaid she went back and forth with [REDACTED] to make sure all of her outstanding bills were paid. Appellant indicated that she was advised that all outstanding bills had been paid. Appellant indicated she thought everything was taken care of until she got a call from the hospital's collection agency [REDACTED] concerning the bill for the [REDACTED] service.

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 has failed to demonstrate by the preponderance of the evidence that the Department erred in denying her claim for the [REDACTED] service that was not presented to them until more than [REDACTED] months following the date of service.

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

[REDACTED]
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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**.

William D Bond

William D. Bond
Administrative Law Judge
for James K. Haveman, Director
Michigan Department of Community Health

Date Signed: [REDACTED]

Date Mailed: [REDACTED]

WDB/db

cc: [REDACTED]

***** 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.