

**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. 2014-34292 MSB

██████████

██████████

██████████

Appellant.

_____ /

DECISION AND ORDER

This matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9 and MCL 400.37, and upon Appellant's request for a hearing.

After due notice, a hearing was held on ██████████. Appellant appeared and testified on his own behalf. ██████████ Appeals Review Officer, represented the Michigan Department of Community Health ("DCH" or "Department"). ██████████ Department Analyst, appeared as a witness for the Department.

ISSUE

Did the Department properly deny payment for medical services provided to Appellant between ██████████ and ██████████?

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 was a Medicaid beneficiary with a deductible or spend-down of approximately ██████████ per month as of ██████████ (Respondent's Exhibit A, page 11).
2. On ██████████ Appellant had a medical emergency and incurred medical bills in the amount of ██████████ (Respondent's Exhibit A, page 8).
3. Over the next two days, Appellant also incurred medical bills in the amount of ██████████. (Respondent's Exhibit A, page 8).
4. Appellant was not billed at the time he was discharged from the hospital on ██████████ and he therefore contacted his caseworker at the Department of Human Services (DHS) as to how he should submit the bills in order to have them covered. (Testimony of Appellant).

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5. Appellant's case worker advised him that there was no issue with coverage, given that the spend-down was met, and that Appellant should simply submit his bills as they came in. (Testimony of Appellant).
6. On [REDACTED] Appellant paid for a prescription at the pharmacy, was billed for over [REDACTED], and submitted the bill to his case worker. (Testimony of Appellant).
7. Case notes from DHS reflect that, in the morning of [REDACTED] Appellant's case worker received the pharmacy bill and determined that Appellant's spend-down was met as of [REDACTED] (Testimony of [REDACTED]).
8. The case notes also reflect that, later that day, Appellant's case worker received the bills regarding the earlier services provided to Appellant between [REDACTED] and [REDACTED]. (Testimony of [REDACTED]).
9. However, Appellant's case worker did not change the start date of Appellant's Medicaid eligibility at that time. (Testimony of [REDACTED]).
10. The Department subsequently denied payments for the bills submitted for services provided to Appellant between [REDACTED] and [REDACTED] due to the fact that its records reflected that Appellant did not have active Medicaid on those dates. (Respondent's Exhibit A, page 8).
11. Appellant worked with his case worker and his case worker's supervisor to get the date of Medicaid eligibility changed, but they were unsuccessful. (Testimony of Appellant).
12. Appellant then filed a beneficiary complaint regarding the start date of Medicaid eligibility in [REDACTED] and the unpaid bills. (Testimony of Appellant).
13. Appellant ultimately began working with the Problem Resolution Unit within the Department and, while it appeared that the matter was resolved at one point, DHS declined to change the start date of Medicaid eligibility. (Testimony of Appellant; Testimony of [REDACTED]).
14. In [REDACTED], the DCH Problem Resolution Unit sent Appellant a letter indicating that it had tried to resolve this matter, but DHS was unwilling to change the start date of Medicaid eligibility. (Testimony of Appellant; Testimony of [REDACTED]).

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15. On [REDACTED], the Michigan Administrative Hearing System (MAHS) received the Request for Hearing filed by Appellant. (Respondent's Exhibit A, pages 4-6).
16. Based on the indication that he was appealing an action taken by DCH regarding unpaid bills, the matter was docketed as an MSB case involving the Department.

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 Medicaid Provider Manual (MPM) addresses when a beneficiary can be billed by a provider:

SECTION 11 - BILLING BENEFICIARIES

11.1 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

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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.

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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

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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.

MPM, January 1, 2014 version
General Information for Providers Chapter, pages 31-32

Here, pursuant to the above policy, the Department denied payments for the medical bills submitted regarding services provided to Appellant between [REDACTED] and [REDACTED] on the basis that DHS had determined that Appellant's Medicaid was inactive on those dates due to an unmet deductible or spend-down.

The record also reflects that the DCH Problem Resolution Unit tried to have DHS correct the date Appellant's spend-down was met and his Medicaid became active. As indicated by both the Department's witness and Appellant, Appellant's initial medical bills as of [REDACTED] would have easily met his small spend-down, but he did not immediately receive those bills. Appellant also testified that his worker informed him that it would not be a problem and that he should just submit his bills as they came in. However, after the DHS worker received a pharmacy bill dated [REDACTED] and determined that Appellant's spend-down was met as of that date, DHS refused to amend the start date of eligibility after the earlier bills were received. Moreover, despite initial indications that the matter was resolved, DHS ultimately declined to change the date Appellant's spend-down was met after being contacted by the DCH Problem Resolution Unit.

This Administrative Law Judge was designated to conduct an administrative hearing and resolve any issues which involved a denial, suspension, reduction or termination of a Medicaid covered service by DCH. To the extent any such issues are before the undersigned Administrative Law Judge, the Department's decision must be affirmed. DHS declined to change the date Appellant's spend-down was met and, given the information it had, the Department had no choice but to deny payments for the disputed bills in this case.

The evidence in the record establishes that Appellant's primary issues are with DHS as DHS, not DCH, is responsible for determining a client's monthly Medicaid deductible/spend-down amount and when that amount was met. This Administrative Law Judge also advised Appellant during the hearing that this Administrative Law Judge is without jurisdiction to adjudicate Appellant's complaints against DHS, but that Appellant does have a right to file an appeal with DHS with regards to any issues involving Appellant's deductible/spend-down.

Accordingly, while Appellant's DCH appeal must be denied to the extent any such issues are in dispute, his "Request For Hearing" will be forwarded to DHS for scheduling of a DHS administrative hearing. Moreover, while there may be an issue regarding the timing of any such appeal, that is also an issue for DHS to address.

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DECISION AND ORDER

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

IT IS THEREFORE ORDERED THAT:

The Department's decision is **AFFIRMED**.

Steven Kibit

Steven Kibit
Administrative Law Judge
for James K. Haveman, Director
Michigan Department of Community Health

Date Signed: [REDACTED]

Date Mailed: [REDACTED]

SK/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.