

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. 2014-35963 MSB

██████████

██████████

██████████

Appellant.

_____ /

DECISION AND ORDER

This matter is before the undersigned Administrative Law Judge (ALJ) 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.¹ ██████████, Appellant's aide, also testified as a witness for Appellant. ██████████, Appeals, Review Officer, represented the Michigan Department of Community Health ("DCH" or "Department"). ██████████ Section Manager, appeared as a witness for the Department.

ISSUE

Did the Department properly deny Appellant's complaint regarding outstanding 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. Appellant is a ██████ year-old Medicaid Beneficiary who has been diagnosed with acute glaucoma and is legally blind. (Respondent's Exhibit A, page 16).
2. Through ██████████, Appellant was enrolled in the ██████████ ██████████, a Medicaid Health Plan ("MHP"). (Testimony of Appellant; Testimony of ██████████).
3. During the time Appellant was enrolled in the MHP, it reimbursed him for services from a number of medical providers, including ██████████

¹ The request for hearing identified an Authorized Hearing Representative for Appellant, but none appeared at the hearing and Appellant stated on the record that he was appearing on his own behalf.

Docket No. 2014-35963 MSB
Decision and Order

- [REDACTED], which is located in [REDACTED]. (Respondent's Exhibit A, pages 19-26).
4. On [REDACTED], Appellant acquired a Medicaid deductible and his scope of coverage changed. Due to that change, he was also excluded from enrolling in the MHP and enrolled in fee-for-service Medicaid. (Testimony of [REDACTED])
 5. On [REDACTED] Appellant was treated for severe right eye pain by [REDACTED] at the [REDACTED] in [REDACTED]. (Respondent's Exhibit A, pages 10-18).
 6. In discharging Appellant, [REDACTED] advised Appellant to follow-up with Appellant's eye surgeon in [REDACTED], the next day. (Respondent's Exhibit A, page 16).
 7. On [REDACTED], Appellant was treated by [REDACTED] at [REDACTED] [REDACTED] [REDACTED] [REDACTED] in [REDACTED]. (Respondent's Exhibit A, pages 19-29).
 8. As part of that treatment, [REDACTED] performed a YAG laser peripheral iridotomy on Appellant's right eye. (Respondent's Exhibit A, page 28).
 9. However, that procedure was unsuccessful and [REDACTED] then referred Appellant to [REDACTED]. (Respondent's Exhibit A, page 29).
 10. Between [REDACTED] and [REDACTED], Appellant was treated by [REDACTED], of [REDACTED] [REDACTED] [REDACTED]), located in [REDACTED]. (Respondent's Exhibit A, pages 30-43).
 11. That treatment included vitrectomy surgery and related services from both the [REDACTED] [REDACTED]) and the [REDACTED] [REDACTED] (Respondent's Exhibit A, pages 30-43).
 12. Subsequently, at Appellant's direction, the medical providers located in Wisconsin billed Appellant's former MHP for their services. (Testimony of Appellant).
 13. The MHP denied payments for those bills because Appellant was not enrolled in the MHP at the time the services were performed. (Testimony of [REDACTED]).
 14. The out-of-state providers then billed Appellant directly. (Respondent's Exhibit A, pages 10-43; Testimony of Appellant).

Docket No. 2014-35963 MSB
Decision and Order

15. Appellant made some partial payments on the medical bills. (Respondent's Exhibit A, pages 20-27, 31, 40-42).
16. He also filed a beneficiary complaint with the Department's Problem Resolution Unit, in which he sought reimbursement for the payments he had made and payment of the outstanding medical bills he had not paid. (Testimony of Appellant; Testimony of [REDACTED]).
17. The Department reviewed the complaint and found that no claims or bills had ever been submitted to Medicaid by the out-of-state providers. (Respondent's Exhibit A, pages 46-47; Testimony of [REDACTED]).
18. It also contacted [REDACTED], [REDACTED] and the [REDACTED] [REDACTED] directly, only to be told that none of those providers were in enrolled in the Michigan Medicaid Program or were willing to enroll in or bill the program. (Respondent's Exhibit A, pages 46-47; Testimony of [REDACTED]).
19. [REDACTED] and the [REDACTED] did indicate that they would pull Appellant's account from collections and adjust his balance to zero. [REDACTED] also indicated that it would discount Appellant's account by [REDACTED] (Respondent's Exhibit A, pages 46-47; Testimony of [REDACTED]).²
20. On [REDACTED], the Department's Problem Resolution Unit sent a letter to Appellant regarding its findings. (Respondent's Exhibit A, pages 46-47).
21. That letter also stated that Appellant would need to resolve any remaining bills with his providers as Michigan Medicaid can only process payments to enrolled Michigan Medicaid providers and Medicaid policy does not obligate the provider to enroll or bill the Michigan Medicaid program. (Respondent's Exhibit A, pages 46-47).
22. On [REDACTED], the Michigan Administrative Hearing System (MAHS) received the request for hearing filed in this matter. (Petitioner's Exhibit 1, pages 1-40; Respondent's Exhibit A, pages 3-43).

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.

² Appellant testified that the medical providers had already agreed to take those steps prior to being contacted by the Department. (Testimony of Appellant).

All claims must be submitted in accordance with the policies, rules, and procedures as stated in the Medicaid Provider Manual, which provides, in pertinent parts:

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 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.

* * *

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.)

Docket No. 2014-35963 MSB
Decision and Order

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.

MPM, April 1, 2014 version
General Information for Providers Chapter, pages 4, 15-16, 31-32
(Emphasis added by ALJ)

Here, the Department witness testified that Appellant submitted a Beneficiary Complaint to the Department requesting that the Department pay for medical bills incurred in the [REDACTED] between [REDACTED] and [REDACTED]. The Department witness also testified that, in response to the complaint, the Department reviewed the complaint and found that no claims or bills had ever been submitted to Medicaid by the out-of-state providers. It also contacted the out-of-state medical providers and was informed in each case that the provider was not enroll in the Michigan Medicaid program and is not willing to enroll or bill Michigan Medicaid for the services rendered to Appellant.

In response, Appellant testified that the services he received were emergency services and that Medicaid had covered out-of-state services in the past, including services through one of the medical providers who had not been reimbursed in this case.

However, to the extent that one of the out-of-state providers received payments in the past, it is clear that such payments were through the MHP Appellant was enrolled in at the time and that his circumstances have now changed. By the time of the services in this case, Appellant was excluded from enrolling in the MHP, due to his Medicaid

Docket No. 2014-35963 MSB
Decision and Order

deductible, and he was enrolled in fee-for-service Medicaid. Accordingly, whatever payments were made by the MHP in the past and how such payments were approved are immaterial.

With respect to Appellant's current Medicaid coverage, federal regulations and state policy prohibit payment by Medicaid without a claim. Here, Appellant received services through out-of-state providers in [REDACTED] who are 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 services in [REDACTED]

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, finds that, the Department properly denied Appellant's complaint regarding outstanding medical bills.

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.