

**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:

██████████,

Appellant

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Docket No. 2014-5216 MSB  
Case No. ██████████

**DECISION AND ORDER**

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

After due notice, a hearing was held ██████████. Appellant appeared on her own behalf. ██████████, Appeals Review Officer, represented the Department of Community Health (DCH or Department). ██████████, DCH Department Specialist, appeared as a witness for the Department.

**ISSUE**

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

**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 has a monthly deductible, or spend down, that she must meet each month to be eligible for Medicaid coverage for the remainder of that month. (Testimony)
2. In ██████████, Appellant began having problems being notified by the Department of Human Services (DHS) about her monthly spend-down, or deductible. Appellant spent the next several months working with DHS to get the problem rectified. (Testimony)
3. On ██████████, Appellant received a letter from DHS indicating that she would have a deductible, effective ██████████. Appellant ignored the letter because she believed DHS was still working to solve the issue with her deductible. (Testimony)

4. On ██████████, Appellant and her husband attended a diabetic training class. Following the class, Appellant attempted to fill a prescription she received during the class and was told that the prescription was not covered, due to her deductible. Appellant paid \$██████████ to get the prescription filled. (Testimony)
5. Appellant then called her DHS Eligibility Specialist and was informed that the issue with her deductible had been rectified in ██████████, but that the DHS Eligibility Specialist had not personally notified Appellant of this fact. (Testimony)
6. On ██████████, Appellant received another letter from DHS indicating that she had a deductible for ██████████, but that she had not met the deductible through the submission of the \$██████████ prescription bill referenced above, and a few other bills Appellant had submitted. (Testimony)
7. 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.

The Medicaid Provider Manual, General Information for Providers 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 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.

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 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.

*Medicaid Provider Manual,  
General Information for Providers Section,  
January 1, 2014, Pages 31-32.  
(Emphasis added by ALJ)*

Here, there is no question that Appellant has a monthly deductible, or spend down, that she must meet each month to be eligible for Medicaid coverage for the remainder of that month.

The only issue Appellant has is that she was not personally notified by her DHS Eligibility Specialist that an issue with notification of the deductible had been rectified in [REDACTED]. However, it is clear that Appellant received notice of her deductible for [REDACTED] via letter dated [REDACTED]. While Appellant chose to ignore this letter because her DHS Eligibility Specialist had not personally notified her that the issue with her deductible had been resolved, she did so at her own risk. The letter Appellant received on [REDACTED] clearly stated that Appellant had a deductible and that it would be effective [REDACTED].

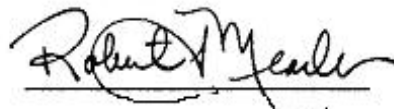
Appellant then chose to receive medical services on [REDACTED] and the cost for those services (a prescription) was properly applied to her Medicaid spend-down, or deductible. The provider in question was proper in denying Appellant coverage on [REDACTED] because she had not met her deductible.

### **DECISION AND ORDER**

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

**IT IS THEREFORE ORDERED** that:

The Department's decisions are AFFIRMED.



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

[REDACTED]  
cc: [REDACTED]

Date Signed: February 27, 2014

Date Mailed: February 27, 2014

**\*\* NOTICE \*\***

The Michigan Administrative Hearing System for the Department of Community Health 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 for the Department of Community Health 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 mailing date of the Decision and Order or, if a timely request for rehearing was made, within 30 days of the mailing date of the rehearing decision.