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. 14-016813 MSB
Case No.

,

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 telephone hearing was held on . Appellant was represented at the hearing by .

, Appeals Review Officer, represented the Department. , Departmental Analyst, appeared as a witness..

ISSUE

Did the Department and Appellant come to an agreed upon settlement at the administrative hearing?

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 an year old female Medicaid beneficiary under the MA-Extended Care category. At all relevant times herein, Appellant has resided in a Nursing Home.

2. On Appellant filed a hearing request disputing the denial of a nursing home bill for $ when she in fact had active Medicaid. The bill was for the month . Appellant was active Medicaid no later than .

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. The General Information for Providers chapter states in part:

> **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. (Note deleted by ALJ)
> - 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 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.)

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].

MCL 24.278 allows for disposition to be made of a contested case hearing by stipulation or agreed upon settlement. At the evidentiary hearing held on [redacted], Appellant and the

Department came to an agreed upon stipulation, the terms of which are set forth as follows:

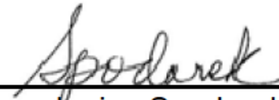
> The Department agreed to assist Appellant in exploring why Appellant's bill for $ was not paid. Based on the information the Department brought up at the administrative hearing, Appellant was active MA and the bill should not have been denied. Appellant and the Department witness exchanged contact information and the Department witness agreed to contact Appellant within 24 hours after researching the nonpayment. The Department agreed to issue a written notice to Appellant regarding the outcome of its inquiry. Appellant shall retain a right to an administrative hearing should she dispute the outcome of the Department's inquiry for 90 days from the date of the new notice.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, ORDERS that the Department initiate the actions agreed upon herein.

IT IS SO ORDERED that:

> The agreement between the Department's and Appellant is UPHELD.



Janice Spodarek
Administrative Law Judge
for Nick Lyon, Director
Michigan Department of Community Health

Date Signed:

Date Mailed:

JS/

cc:

***** 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.