STATE OF MICHIGAN
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
FOR THE DEPARTMENT OF HEALTH AND HUMAN SERVICES
P.O. Box 30763, Lansing, MI 48909
(517) 335-3997; Fax: (517) 373-4147

IN THE MATTER OF:

Docket No. 15-006991 MSB

[redacted],

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 telephone hearing was held on [redacted] Appellant appeared and testified on her own behalf. [redacted], Appeals Review Officer, represented the Michigan Department of Health and Human Services (DHHS or Department). [redacted], Analyst, also testified as a witness for the Department.

ISSUE

Did the Department properly deny payment for Appellant's unpaid 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. Between [redacted] and [redacted], Appellant received medical services from [redacted]; and [redacted]. (Exhibit A, pages 6-23).

2. Appellant did not have Medicaid coverage at the time the services were provided. (Testimony of Appellant; Testimony of [redacted]).

3. However, in [redacted] Appellant was approved for Medicaid coverage with a retroactive start date and she therefore had full coverage on each date of service. (Testimony of Appellant; Testimony of [redacted]

4. Both before and after the retroactive approval of Medicaid, Appellant received bills from the providers. (Exhibit A, pages 8-23; Testimony of Appellant).

5. For the time period of [redacted] through [redacted], only [redacted] i ever submitted claims to Medicaid for services provided to

Appellant, but those claims were denied each time due to a billing error. (Exhibit A, pages 28-29; Testimony of [redacted]

6. Appellant also received services at [redacted] in [redacted]. (Exhibit A, pages 6-23).

7. On [redacted], Appellant filed in a Beneficiary Complaint with respect to unpaid bills from the [redacted] providers. (Exhibit A, page 24).

8. The Department's Problem Resolution Unit then investigated the complaint. (Testimony of [redacted]

9. With respect to [redacted] it found that, by billing Medicaid, [redacted] had accepted Appellant as a Medicaid patient and therefore cannot bill Appellant directly for the services when the claims were denied by Medicaid for improper billing. (Exhibit A, pages 25-26; Testimony of [redacted]

10. The Department also advised [redacted] office of the applicable Medicaid policy. (Testimony of [redacted]).

11. With respect to [redacted], the Department found that the hospital had not accepted Appellant as a Medicaid beneficiary at the time the services were provided and that the time period for billing Medicaid has passed, which meant that Appellant was responsible for the services. (Exhibit A, page 26; Testimony of [redacted]).

12. On [redacted], the Department sent Appellant written notice of its findings regarding [redacted] and [redacted]. (Exhibit A, pages 25-26).

13. On [redacted], the Michigan Administrative Hearing System (MAHS) received the request for hearing filed in this matter. (Exhibit A, page 2).

14. With respect to [redacted], the Department found that, while one bill from [redacted] was resolved and paid by Medicaid, the medical provider had not accepted Appellant as a Medicaid beneficiary at the time the earlier services were performed and that the time period for billing Medicaid for those services had passed, which meant that Appellant was responsible for services provided between [redacted] and [redacted]. (Exhibit A, page 27; Testimony of [redacted].

15. The Department also found that [redacted] was not enrolled with Medicaid in [redacted] and that Medicaid could not make payments for services on that date because it can only make payments to providers that are enrolled with the program. (Exhibit A, page 27; Testimony of [redacted]).

16. On [redacted] the Department sent Appellant written notice of its findings regarding [redacted] (Exhibit A, page 27).

17. Appellant has not received any bills from [redacted] office since filing her beneficiary complaint. (Testimony of Appellant).

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 requests or claims through Medicaid must be submitted in accordance with the policies, rules, and procedures as stated in the Medicaid Provider Manual (MPM). Moreover, with respect to providers billing beneficiaries, the MPM states in part:

> ### 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 MDHHS 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 MDHHS 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 MDHHS 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).

- <u>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.</u>

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, 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.)

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.
>
> *MPM, July 1, 2015 version*
> *General Information for Providers Chapter, pages 31-32*
> *(Underline added by ALJ)*

Here, Appellant filed a Beneficiary Complaint regarding unpaid bills from [redacted] medical providers. Each provider will be addressed in turn and, for the reasons discussed below, the undersigned Administrative Law Judge finds that the Department properly responded to Appellant's complaint in each case.

[redacted]

This request for hearing arises in part from bills Appellant received from [redacted] for services provided between [redacted] and [redacted]. It is undisputed that Appellant did not have Medicaid coverage at the time the services were performed, but that she was subsequently approved for retroactive coverage that included all the dates of service.

It is also undisputed that the Department investigated the issue and discovered that it had denied claims submitted [redacted] on two occasions due to improper billing. The Department also informed the provider that, by billing Medicaid, it had accepted Appellant as a Medicaid patient and therefore cannot bill directly Appellant for the service when the claims were denied for improper billing. The Department further advised Appellant of its findings.

As indicated by [redacted] cannot bill Appellant for the services. The MPM provides that, when a provider accepts a patient as a Medicaid beneficiary, the beneficiary cannot be billed for Medicaid-covered services for which the provider has been denied payment because of a provider error. *See* MPM, July 1, 2015 version, General Information for Providers Chapter, page 32. Here, Appellant was accepted as a Medicaid beneficiary, she received Medicaid-covered services, and the claims for payment were denied because of provider error.

It appears that the provider has acknowledged that it was improper to bill Appellant as Appellant has not received a bill from [redacted] since the Beneficiary Complaint was filed. However, whatever issues remain between the Appellant and her medical provider regarding the bill, the Department has no control over a private matter between Appellant and her provider regarding billing and all it can do is inform and advise both Appellant and the medical provider of its findings in this matter. It has properly done so in this case and any actions it took must be affirmed.

[redacted]

This request for hearing arises in part from bills Appellant received from [redacted] for services provided in [redacted] It is undisputed that Appellant did not have Medicaid coverage at the time the services were performed, but that she was subsequently approved for retroactive coverage that included the [redacted] date of service.

The Department investigated Appellant's complaint and determined that the medical provider had not accepted Appellant as a Medicaid beneficiary at the time the services were performed and that the time period for billing Medicaid for those services had passed, which meant that Appellant was responsible for services provided between [redacted] and [redacted]. As provided in the above policy, the beneficiary is responsible for payment when the provider chooses not to accept the beneficiary as a Medicaid beneficiary and the beneficiary had prior knowledge of the situation. *See* MPM, July 1, 2015 version, General Information for Providers Chapter, page 31.

Appellant first testified that she never informed [redacted] of her retroactive Medicaid coverage, but she later testified that she did inform the provider, only to be told it was too late to bill Medicaid. To the extent that Appellant claims that she timely informed [redacted] of her retroactive Medicaid coverage once she did receive it, [redacted] credibly testified that it received no claims from the medical provider for services in [redacted] and federal regulations and state policy prohibit payment by Medicaid without a claim. Accordingly, whatever issues remain between the Appellant and her medical provider regarding the ultimate responsibility between them for the bill, the Department must be affirmed.

[redacted]

This request for hearing arises in part from bills Appellant received from [redacted] for services provided between [redacted] through [redacted] and services provided in [redacted]

With respect to the first set of bills, is undisputed that Appellant did not have Medicaid coverage at the time the services were performed, but that she was subsequently approved for retroactive coverage that included all the dates of service.

The Department investigated Appellant's complaint and determined that the medical provider had not accepted Appellant as a Medicaid beneficiary at the time the services were performed and that the time period for billing Medicaid for those services had passed, which meant that Appellant was responsible for services provided between [redacted] and [redacted]. As provided in the above policy, the beneficiary is responsible for payment when the provider chooses not to accept the beneficiary as a Medicaid beneficiary and the beneficiary had prior knowledge of the

situation. *See* MPM, July 1, 2015 version, General Information for Providers Chapter, page 31.

Moreover, to the extent that Appellant testified that she did inform [redacted] of her retroactive Medicaid coverage once she did receive it, [redacted] credibly testified that it received no claims from the medical provider for the time period of [redacted] through [redacted] and federal regulations and state policy prohibit payment by Medicaid without a claim. Accordingly, whatever issues remain between the Appellant and her medical provider regarding the ultimate responsibility between them for the bills, the Department must be affirmed.

With respect to the services provided in [redacted] also credibly testified and Appellant does not dispute, that the medical provider was not enrolled in Medicaid as of that date of services. With the exception of special circumstances not applicable here, all providers rendering services to [redacted] Medicaid beneficiaries must be enrolled/registered in the [redacted] Medicaid program. Additionally, the Department cannot force a non-participating medical provider to accept a Medicaid beneficiary as a patient nor can the Department enforce Michigan Medicaid policy on the provider. Unless the provider is willing to reenroll in Medicaid and bill Medicaid for the services Appellant received, the Department cannot pay such services. As such, Appellant is responsible for the bill.

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 Appellant's unpaid medical bills.

IT IS THEREFORE ORDERED THAT:

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

Steven Kibit

Steven Kibit
Administrative Law Judge
for Nick Lyon, Director
Michigan Department of Health and Human Services

Date Signed: [redacted]

Date Mailed: [redacted]

SK/db

[redacted]
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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.