STATE OF MICHIGAN
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
FOR THE DEPARTMENT OF HEALTH AND HUMAN SERVICES
P.O. Box 30763, Lansing, MI 48909
(517) 335-2484; Fax: (517) 373-4147

IN THE MATTER OF:

[redacted],

Docket No. 15-020851 MSB
Case No. [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]. [redacted], mother, represented Appellant. [redacted], Appeals Review Officer, represented the Michigan Department of Health and Human Services (DHHS or Department). [redacted], Department Analyst, also testified as a witness for the Department.

ISSUE

Did the Department properly deny claims submitted for services provided to Appellant?

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 services from several medical providers: [redacted], [redacted], and [redacted]. (Exhibit 1, pp. 6-10)

2. On those dates of service, Appellant had Medicaid coverage. (Exhibit 2, p. 11; Department Analyst Testimony)

3. Initially, the coding in the Department's CHAMPS database indicated the Appellant had other primary insurance as well as Medicaid. This coding was updated on [redacted], to show that the other insurance was only a Vision and Dental policy. (Exhibit 3, p. 12; Department Analyst Testimony)

4. Before the insurance coding was updated, the providers billed Medicaid and the claims were denied due to the other primary insurance showing in CHAMPS. (Department Analyst Testimony)

5. On [redacted], Appellant's mother submitted a Beneficiary Complaint form regarding outstanding medical bills with the providers. The Department's Problem Resolution Unit contacted the providers informing them that the primary insurance information was corrected and they could re-bill Medicaid. The providers agreed to re-bill Medicaid. Letters were sent to Appellant's mother regarding the investigation with the providers. (Exhibit 4, pp. 13-14; Department Analyst Testimony)

6. On [redacted], Appellant's mother contacted the Department because [redacted] would not re-bill Medicaid. The Problem Resolution Unit contacted this provider again; informed the provider that the primary insurance information was corrected and to re-bill Medicaid; and the provider agreed to re-bill Medicaid. A letter was sent to Appellant's mother regarding the investigation with the provider. (Exhibit 5, p. 15; Department Analyst Testimony)

7. On [redacted], Appellant's hearing request was received by the Michigan Administrative Hearing System. (Hearing Request)

8. The Department also contacted each of the medical providers again on [redacted]. [redacted] agreed to re-bill for the services and pull the charges from collections. [redacted] agreed to adjust the balance for the dates of service [redacted], and [redacted], to zero. [redacted] stated they would pull the account from collections and make adjustments. It was communicated to the providers that beneficiary is not responsible for the charges due to Medicaid policy. (Hearing Summary Memorandum; Department Analyst Testimony; Exhibit 6, p. 16)

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, coordination of benefits section, addresses the Federal Regulations requirement that all identifiable financial resources be utilized prior to the expenditure of Medicaid funds for most health care services provided to Medicaid beneficiaries. Medicaid is considered the payor of last resort. Medicaid Provider

Manual (MPM), Coordination of Benefits, October 1, 2014, p. 1.

The Medicaid Provider Manual policy is clear that Medicaid is a payor of last resort. Accordingly, the denials of claims for Medicaid covered services when the database showed Appellant had other primary insurance coverage were appropriate based on the information available at that time.

However, the insurance coding was updated on [redacted], to show that the other insurance was a Vision and Dental policy only. (Exhibit 3, p. 12; Department Analyst Testimony)

On [redacted], Appellant's mother submitted a Beneficiary Complaint form regarding outstanding medical bills with the providers. The Department's Problem Resolution Unit contacted the providers informing them that the primary insurance information was corrected and they could re-bill Medicaid. The providers agreed to re-bill Medicaid. Letters were sent to Appellant's mother regarding the investigation with the providers. (Exhibit 4, pp. 13-14; Department Analyst Testimony)

On [redacted], Appellant's mother contacted the Department because Advanced Radiology would not re-bill Medicaid. The Problem Resolution Unit contacted this provider again; informed the provider that the primary insurance information was corrected and to re-bill Medicaid; and the provider agreed to re-bill Medicaid. A letter was sent to Appellant's mother regarding the investigation with the provider. (Exhibit 5, p. 15; Department Analyst Testimony)

On [redacted], Appellant's hearing request was received by the Michigan Administrative Hearing System. (Hearing Request)

The Department also contacted each of the medical providers again on [redacted]. [redacted] agreed to re-bill for the services and pull the charges from collections. [redacted] agreed to adjust the balance for the dates of service [redacted] and [redacted], to zero. [redacted] stated they would pull the account from collections and make adjustments. It was communicated to the providers that beneficiary is not responsible for the charges due to Medicaid policy. (Hearing Summary Memorandum; Department Analyst Testimony; Exhibit 6, p. 16)

Specifically, the Medicaid Provider Manual, general information for providers section, addresses providers accepting a patient as a Medicaid beneficiary and billing the beneficiary:

> 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 (MPM),
General Information for Providers,
October 1, 2014, p. 32

Overall, the evidence confirms that the Department has not denied any claims for these dates of service since the other insurance coding was updated on [redacted]. Further, each time the Appellant's mother contacted the Department regarding the outstanding medical bills the Department investigated and contacted the providers. Each provider has been informed that the coding has been corrected and they could re-bill Medicaid. While the evidence indicates no providers have actually re-billed Medicaid, it is noted that the Department cannot force the providers to re-bill Medicaid. However, it was also communicated to the providers that beneficiary is not responsible for the charges due to Medicaid policy. (Hearing Summary Memorandum; Department Analyst Testimony; Exhibits 4-6, pp. 13-16)

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, finds that, the Department's initial denial of claims submitted for services provided to Appellant were appropriate based on the information available at that time.

IT IS THEREFORE ORDERED THAT:

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

Colleen Lack
Administrative Law Judge
for Nick Lyon, Director
Michigan Department of Health and Human Services

Date Mailed: February 2, 2016

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.