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:

Docket No. 15-009636 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 his own behalf. [redacted], Appellant's wife, also testified as a witness for Appellant. [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 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. On [redacted]; and [redacted], Appellant received services at [redacted] (Exhibit A, pages 6-7; Testimony of [redacted]

2. On those dates of service, Appellant had an unmet Medicaid deductible/spend-down. (Testimony of [redacted]

3. [redacted] billed the Department for the services, but each claim was denied because Appellant's Medicaid was inactive due to his unmet deductible. (Testimony of [redacted]

4. On [redacted], the Michigan Department of Human Services sent Appellant written notice that his deductible had been met in [redacted]

[redacted] and that he was retroactively approved for full Medicaid eligibility between [redacted] and [redacted]. (Exhibit A, pages 8, 11).

5. Appellant never met his deductible for [redacted]. (Exhibit A, page 9).

6. On [redacted], the Michigan Department of Human Services sent Appellant written notice that his deductible had been met in [redacted] and that he was retroactively approved for full Medicaid between [redacted] and [redacted]. (Exhibit A, pages 10, 12).

7. [redacted] never rebilled the Department after Appellant's Medicaid became active for [redacted] of the dates of service. (Testimony of [redacted].

8. It did bill Appellant directly for [redacted] (Testimony of Appellant).

9. Appellant did not pay the bill. (Testimony of Appellant).

10. On or about [redacted], Appellant filed a Beneficiary Complaint with the Department in which he indicated that he was getting sued by [redacted] for the unpaid bills. (Testimony of Appellant; Testimony of [redacted]).

11. Appellant did not receive a response to that complaint. (Testimony of Appellant; Testimony of [redacted]

12. In [redacted], Appellant telephoned the Department and advised it that he was now going to court over the unpaid bills. (Testimony of Appellant; Testimony of [redacted]).

13. On [redacted], a Civil Consent Judgment was entered against Appellant for [redacted] in damages, fees, and costs. (Exhibit A, pages 14-15).

14. As part of that consent judgment, Appellant agreed to make installment payments of [redacted] per month. (Exhibit A, pages 14-15).

15. On or about [redacted], Appellant filed a Beneficiary Complaint with the Department regarding the unpaid bills and the judgment against him. (Testimony of [redacted]

16. On or about [redacted], the Department sent Appellant a written response indicating that it could not take any action with respect to the unpaid bills given that a determination of liability had already been made and a civil judgment had already been issued against Appellant. (Testimony of [redacted]).

17. On or about [redacted], Appellant filed another Beneficiary Complaint with the Department regarding the unpaid bills and the judgment against him. (Testimony of [redacted]

18. On or about [redacted], the Department sent Appellant another written response again indicating that it could not take any action given the civil judgment that had already been issued. (Testimony of [redacted].

19. On [redacted], the Michigan Administrative Hearing System (MAHS) received the request for hearing filed in this matter regarding unpaid bills and a civil judgment against Appellant. (Exhibit 1, pages 1-6).

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).

- 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, 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

Here, the Department denied payments for claims submitted regarding services provided to Appellant between [redacted] and [redacted] on the basis that Appellant's Medicaid was inactive on those dates due to an unmet deductible or spend-down. The medical provider subsequently billed Appellant directly and eventually a civil consent judgment was entered against Appellant for [redacted] in damages, fees, and costs. On [redacted], MAHS received the request for hearing filed in this matter regarding the denied claims and the civil judgment entered against Appellant.

At the onset of the hearing, the Department moved for dismissal of this action on the basis that Appellant's request for hearing relates to the civil judgment against him and that neither the Department nor the undersigned Administrative Law Judge can address matters already decided in civil court. However, the Department offered no support for its argument and the undersigned Administrative Law Judge does not find that Appellant is precluded from bringing this action. Appellant does not appear to be asking the tribunal to reverse the civil judgment or to address the issue in that case, *i.e.* any liability between himself and the medical provider. Similarly, the Department was not involved in the civil action and the propriety of its actions was not determined.

Nevertheless, even if the Department was not barred from taking action in this case due to the civil judgment, its actions were proper and must be affirmed for the reasons discussed below.

With respect to the bills arising from services provided on [redacted] and [redacted] credibly testified that Appellant did not have active Medicaid coverage at either the time the services were performed or at the time the claims for payment for the services were submitted, and that the Department therefore denied the claims on the basis that Appellant did not have Medicaid coverage.

Moreover, while Appellant was subsequently approved for retroactive coverage that included those two dates of services, the medical provider never rebilled Medicaid or resubmitted its claims. It was the responsibility of Appellant to inform [redacted] that he had been retroactively approved for Medicaid and to have the provider resubmit the claims for payment, and either he failed to inform [redacted] or the provider simply failed to resubmit the claims. Either way, federal regulations and state policy prohibit payment by Medicaid without a claim and, whatever issues remain between the Appellant and his medical provider regarding the ultimate responsibility between them for the bills, the Department must be affirmed.

With respect to the services provided in [redacted] credibly testified that Appellant did not have active Medicaid at the time, due to his unmet deductible/spend-down, and that Appellant also never subsequently met his deductible for that month either. Moreover, while Appellant and his wife testified regarding their confusion over the spend-down and the lack of information from their eligibility case worker regarding the amount of the spend-down; how it was to be met and when it was met; they failed to present any evidence that the spend-down was ever met for [redacted] or that Appellant was ever approved for Medicaid in that month. Accordingly, Appellant is responsible for the bills arising from the two dates of service 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 claims submitted for services provided to Appellant.

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]

[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.