**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.** 15-014456 MSB

[redacted] [redacted] [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 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. In [redacted], Appellant received services at Emergency Care Specialists and Advanced Radiology Services. (Exhibit A, pages 10, 12-13, 17).

2. On those dates of service, Appellant had an unmet Medicaid deductible/spend-down. (Exhibit A, page 10; Testimony of Department's analyst).

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

4. The[redacted] providers then billed Appellant directly. (Exhibit A, pages 12-13).

5. On or about [redacted], the Department determined that Appellant had met her deductible for [redacted] and she was retroactively approved for full Medicaid eligibility for that month. (Exhibit A, pages 16; Testimony of Department's analyst).

6. On [redacted], the Michigan Administrative Hearing System (MAHS) received the request for hearing filed in this matter regarding the unpaid bills. (Exhibit A, pages 3-6).

7. On [redacted], Appellant also filed a Beneficiary Complaint with the Department regarding the unpaid bills. (Exhibit A, pages 8-15).

8. The Department investigated that complaint and, in response, decided to approve an exception to the twelve month billing limitation and allow the providers to resubmit any claims for services provided in [redacted]. (Testimony of Department's analyst).

9. The Department also contacted the medical providers directly to inform them of the approved exception, and the providers indicated that they would rebill Medicaid. (Testimony of Department's analyst).

## 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 in [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 Appellant could not or did not pay the bills.

Given that Appellant did not have active Medicaid coverage for those dates of services at either the time the services were performed or at the time the claims for payment were submitted, and the Department properly denied the claims on the basis that Appellant did not have Medicaid coverage.

After the denials, the Appellant was subsequently approved for retroactive coverage that included the dates of services at issue in this case. Moreover, while policy generally requires that claims be submitted within twelve months of the date of service, the Department also granted an exception to that policy in this case and will allow the providers to resubmit the claims now. The providers also indicated that they would do so and the matter appears to be resolved.

While the matter appears to be resolved, the providers had not resubmitted the claims as of the date of hearing. However, the Department also cannot force them to do so and, regardless of whether the providers ever resubmit the claims, the sole issue in this case is the previous denials of claims and, based on the information available at the time, the Department's denials were proper and must be affirmed.

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

Date Signed: [redacted]

Date Mailed: [redacted]

SK/db

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.