



RICK SNYDER  
GOVERNOR

STATE OF MICHIGAN  
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS  
MICHIGAN ADMINISTRATIVE HEARING SYSTEM  
Christopher Seppanen  
Executive Director

MIKE ZIMMER  
DIRECTOR

[REDACTED]

Date Mailed: [REDACTED]  
MAHS Docket No.: 16-001554  
Agency No.: [REDACTED]  
Petitioner: [REDACTED]

**ADMINISTRATIVE LAW JUDGE: Robert Meade**

**DECISION AND ORDER**

This matter is before the undersigned Administrative Law Judge (ALJ) pursuant to MCL 400.9 and MCL 400.37 upon Appellant's request for a hearing.

After due notice, a hearing was held [REDACTED]. Appellant appeared on his own behalf. [REDACTED], Appeals Review Officer, represented the Department of Health and Human Services (DHHS or Department). [REDACTED], Analyst, appeared as a witness for the Department.

**ISSUE**

Did the Department properly deny payment for medical services provided to the Petitioner due to Petitioner not meeting his Medicaid deductible?

**FINDINGS OF FACT**

The Administrative Law Judge, based upon the competent, material and substantial evidence on the whole record, finds as material fact:

1. Since [REDACTED], Petitioner has had a monthly deductible, or spend down, that he must meet each month to be eligible for Medicaid coverage for the remainder of that month. (Exhibit A, pp 4, 6-7; Testimony)
2. Petitioner undergoes dialysis three days per week. (Exhibit 1; Testimony)
3. On [REDACTED], Petitioner filed a Request for Hearing with the Michigan Administrative Hearing System, in which he indicated that he was having difficulty meeting his deductible each month because his medical providers would not give him bills for services until the end of the month. (Exhibit 1; Testimony)

4. There have been two claims submitted to Medicaid for payment by Petitioner's providers since [REDACTED], both of which were denied payment due to Petitioner not meeting his Medicaid deductible in the month of the service. (Exhibit A, pp 4, 6-7; Testimony)

## **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, General Information for Providers addresses when a beneficiary can be billed by a provider:

### **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 DHS determines the patient-pay amount. Non-covered 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 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 is told prior to rendering the service that it is not covered by Medicaid. If the beneficiary is not informed of Medicaid non-coverage 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 non-authorized or non-covered 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, customized seating systems) that began, but were not completed, during a period of eligibility. (Refer to the provider-specific chapters of this manual for more 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.

*Medicaid Provider Manual  
General Information for Providers Section  
January 1, 2016, Pages 30-32*

Here, there is no question that Petitioner has a monthly deductible, or spend down, that he must meet each month to be eligible for Medicaid coverage for the remainder of that month and that Petitioner failed to meet that deductible for the two bills submitted to Medicaid since [REDACTED]. As such, the Department's denial of payment on those bills was proper.

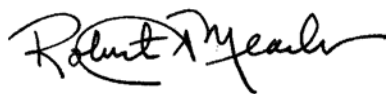
If Petitioner has an issue with the process for meeting his deductible, he should contact his Eligibility Specialist. The Department's witness suggested that Petitioner contact the supervisor of his Eligibility Specialist because he or she might be better versed in assisting Petitioner with his issues.

**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 medical services provided to the Petitioner based on the available information.

**IT IS THEREFORE ORDERED** that:

The Department's decisions are **AFFIRMED**.



RM/cg

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**Robert Meade**  
Administrative Law Judge  
for Nick Lyon, Director  
Department of Health and Human Services

**NOTICE OF APPEAL:** A party may appeal this Order in circuit court within 30 days of the receipt date. A copy of the circuit court appeal must be filed with the Michigan Administrative Hearing System (MAHS).

A party may request a rehearing or reconsideration of this Order if the request is received by MAHS within 30 days of the date the Order was issued. The party requesting a rehearing or reconsideration must provide the specific reasons for the request. MAHS will not review any response to a request for rehearing/reconsideration.

A written request may be mailed or faxed to MAHS. If submitted by fax, the written request must be faxed to (517) 335-6088; Attention: MAHS Rehearing/Reconsideration Request.

If submitted by mail, the written request must be addressed as follows:

Michigan Administrative Hearings  
Reconsideration/Rehearing Request  
P.O. Box 30763  
Lansing, Michigan 48909-8139

**DHHS -Dept Contact**

[REDACTED]

**Petitioner**

[REDACTED]

**DHHS Department Rep.**

[REDACTED]