RICK SNYDER
GOVERNOR

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

MIKE ZIMMER
DIRECTOR

Date Mailed: April 5, 2016
MAHS Docket No.: 16-002012
Agency No.:
Petitioner:

**ADMINISTRATIVE LAW JUDGE:** Landis Y. Lain

## DECISION AND ORDER

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

After due notice, a hearing was held on . Petitioner appeared and testified on her own behalf. , Manager, Appeals Section, represented the Department of Health and Human Services (Department or Respondent). , Department Analyst, appeared and testified on behalf of the Department.

Respondent's Exhibit A pages 1-7 were admitted as evidence.

## ISSUE

Did the Department properly deny Petitioner's complaint regarding a medical bill that her provider submitted to a collection agency?

## FINDINGS OF FACT

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

1. Petitioner is a Medicaid beneficiary.
2. On , Petitioner filed a request for a hearing due to unpaid medical bills she is being held responsible for during the month of . No unpaid bills were attached to the hearing request.
3. In , Petitioner had a primary coverage insurance through and also Medicaid-Healthy Michigan Plan for coverage.

4. Petitioner did contact the beneficiary hotline regarding her unpaid bill and a beneficiary complaint form was sent out to her but never returned.

5. On [redacted], Metro Medical Practice contacted the Department provider help line for claim assistance regarding date of service [redacted].

6. The Department's Problem Resolution Unit contacted the provider regarding the date of service [redacted] for the amount of $[redacted] and the provider stated that there is a zero balance.

7. The Provider stated that they were holding Petitioner responsible for dates of service [redacted] ($[redacted]) and [redacted] ($[redacted]).

8. The Problem Resolution Unit explained to the provider that Medicaid denied the claims due to the beneficiary having primary insurance at [redacted], which must be billed prior to Medicaid. (Respondent's Exhibit A page 2)

9. The Provider indicated that they were having issues with their billing agent.

10. The Problem Resolution Representative stated to the Provider that the beneficiary is not responsible for billing issues. (Respondent's Exhibit A page 3)

11. On [redacted], the Department sent the beneficiary a letter stating that she is not responsible for the bill. (Respondent's Exhibit A page 4)

## 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 claims must be submitted in accordance with the policies, rules, and procedures as stated in the Medicaid Provider Manual.

> 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. Noncovered services can be purchased by offsetting the nursing facility beneficiary's patient-pay amount. (Note deleted by ALJ)
- 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 has been told prior to rendering the service that it was 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.

. . .

Medicaid Provider Manual, (MPM), §11.1, General Information for Providers Section, January 1, 2016, pp 28-29

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MPM, 11.1, page 31, explicitly states that 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. Federal regulations and state policy prohibit payment by Medicaid without a claim. Here, the Provider submitted the medical bills to Medicaid when Petitioner had primary commercial insurance through [redacted] on the relevant dates of service. Medicaid is the payer of last resort. The claim was submitted by the provider in question because the provider was having billing issues at the time services were rendered. Furthermore, because Medicaid providers only have one year to submit claims for services, a claim cannot be submitted at this time. As such, the Petitioner is not responsible for the expenses related to the date of service of [redacted] ($[redacted]) and [redacted] ($[redacted]).

## DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the denial of payment to the Provider for Medicaid covered services was appropriate under the circumstances. Once the provider has accepted a patient as a Medicaid beneficiary, Petitioner no longer has further liability to the provider.

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

LL/[redacted]

Landis Y. Lain
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**

**Petitioner**

**DHHS Department Rep.**