



RICK SNYDER
GOVERNOR

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

SHELLY EDGERTON
DIRECTOR

[REDACTED]

Date Mailed: June 17, 2016
MAHS Docket No.: 16-005982
Agency No.: [REDACTED]
Petitioner: [REDACTED]

ADMINISTRATIVE LAW JUDGE: Landis 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 [REDACTED]. Petitioner [REDACTED] appeared on behalf of the Petitioner; Theresa Root, Appeals Review Officer and [REDACTED], Analyst, appeared to testify and represent the Department.

ISSUE

Did the Department properly determine that it was not responsible for Petitioner's unpaid medical/dental bills?

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 [REDACTED], Petitioner received dental services from a provider who was not enrolled as a Medicaid provider.
3. The Problem Resolution Unit sent Petitioner a letter stating that the reason she was receiving a bill is because the provider she went to is not enrolled with the Medicaid program. Medicaid can only make payment to providers that are enrolled with the Medicaid program.
4. On [REDACTED], the Michigan Administrative Hearings System received a Request for Hearing to contest the Department's determination.

CONCLUSIONS OF LAW

The Medical Assistance Program (MA) 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.

Providers cannot bill beneficiaries for services except in the following situations:

- A co-payment for chiropractic, dental, hearing aid, pharmacy, podiatric, or vision services is required. However, a provider cannot refuse to render service if the beneficiary is unable to pay the required co-payment on the date of service.
- A monthly patient-pay amount for inpatient hospital or nursing facility services. The local DHHS 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 more 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 DHHS 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 DHHS 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 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 or for 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.

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,
(4/01/2016, page 31)*

7.2 NONENROLLED MICHIGAN AND BORDERLAND PROVIDERS

Medicaid pays nonenrolled Michigan and nonenrolled borderland providers for emergency services and for the first claim for non-emergency services that were provided in compliance with Michigan Medicaid coverage policies.

All providers rendering, ordering, prescribing, or referring services to Michigan Medicaid beneficiaries must be enrolled/registered in the Michigan Medicaid program. (Refer to the Directory Appendix for contact information related to the on-line application process.) Exceptions to this requirement may be made in special circumstances. These circumstances will be addressed through the Prior Authorization process. All claims must be submitted in accordance with the policies, rules, and procedures as stated in the manual.

*Medicaid Provider Manual,
General Information for Providers Section,
(4/01/2016, page 14)*

Petitioner testified that the provider did not request her insurance information, but she did note on the paperwork that she had Medicaid. In the instant case, the provider of the services was not enrolled as a Medicaid provider. The Service Provider has not billed Medicaid for services. Medicaid can only make payment to providers that are enrolled in the Medicaid program.

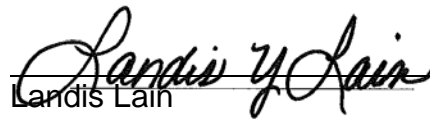
DECISION AND ORDER

The Administrative Law Judge, based on the above Findings of Fact and Conclusions of Law, decides that the Department properly determined that Petitioner's unpaid medical bills were sent to her because she chose to receive services from a provider, ([REDACTED] DDS, PLC) on [REDACTED], who is not a Medicaid Provider. Thus, the provider is not bound by Medicaid rules. The provider has not billed Medicaid for the services. Medicaid cannot pay for services for which it has not been billed.

IT IS, THEREFORE, ORDERED that:

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

LL [REDACTED]



Landis 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

[REDACTED]

DHHS Department Rep.

[REDACTED]

Petitioner

[REDACTED]

Agency Representative

[REDACTED]