RICK SNYDER
GOVERNOR

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

SHELLY EDGERTON
DIRECTOR

Date Mailed: January 12, 2017
MAHS Docket No.:
Agency No.:
Petitioner:

ADMINISTRATIVE LAW JUDGE: Steven Kibit

DECISION AND ORDER

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

After due notice, a telephone hearing was held on January 5, 2017. , Petitioner's mother, appeared and testified on Petitioner's behalf. Appeals Review Officer, represented the Respondent (MDHHS or Department). , testified as a witness for Respondent.

ISSUE

Did the Department properly respond to Petitioner's complaint regarding an unpaid medical bill?

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 October 15, 2015, the minor Petitioner received services through . (Testimony of Petitioner's representative).

2. While Petitioner had previously been enrolled in a Medicaid Health Plan, he had full Fee-For-Service Medicaid coverage on the date of service. (Testimony of Department's Analyst).

3. In April of 2016, the Department received a Beneficiary Complaint filed by Petitioner's representative on Petitioner's behalf. (Exhibit A, page 5).

4. In that complaint, Petitioner's representative wrote that, while no one from mentioned a bill prior to the services being performed or Petitioner leaving the office on , someone from subsequently called her and told her that Petitioner was no longer enrolled in his Medicaid Health Plan, which Petitioner's representative was unaware of, and that Petitioner was responsible for the bill. (Exhibit A, page 5).

5. Petitioner's representative then called the Medicaid Health Plan and learned that Petitioner had been dis-enrolled from the plan and placed in full Fee-For-Service Medicaid coverage prior to October 5, 2015. (Exhibit A, page 5; Testimony of Petitioner's representative).

6. Petitioner's representative further noted that, after she advised of the change, it advised her that it did not accept Fee-For-Service Medicaid coverage; she was responsible for payment; and that it would be sending the bill to collections if she did not pay. (Exhibit A, page 5).

7. On October 13, 2016, the Department sent Petitioner's representative written notice that it had investigated the bill with and learned from the provider that Petitioner's account balance was zero. (Exhibit 1, page 2).

8. On November 10, 2016, the Michigan Administrative Hearing System (MAHS) received the request for hearing filed in this matter. (Exhibit 1, pages 1-2).

9. In that request, Petitioner's representative noted that her balance was zero because she paid the bill by credit card in order to protect her credit report and to stop the bill from being sent to collections. (Exhibit 1, page 1).

10. Petitioner's representative also asserted that, while she paid it, she should not be responsible for the bill. (Exhibit 1, page 1).

11. The Department again contacted , who did not refute what Petitioner's representative had described in terms of what happened. (Testimony of Department's Analyst).

12. The Department also informed that, as a matter of Medicaid policy, it was supposed to check eligibility prior to providing services and that it was inappropriate for it to bill Petitioner. (Testimony of Department's Analyst).

13. On December 15, 2016, the Department sent Petitioner's representative written notice that it had investigated her claims. (Exhibit 1, page 7).

14. The notice also stated in part:

> The above listed provider has been advised that you should not have been billed for the above listed date of service and that you should be refunded the payment made directly to the provider. Please allow 90 days before following up with your provider regarding the refund.

Exhibit A, page 7

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.

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, October 1, 2015 version
General Information for Providers Chapter, pages 31-32

Here, the Department's witness testified that Petitioner submitted a Beneficiary Complaint to the Department regarding a bill and that the Department's subsequent investigation determined that Petitioner was improperly billed by the provider because, as described in the above policy, it is the provider's responsibility to determine the eligibility and 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 and the Department's witness testified that the provider was informed that Petitioner should be refunded the payment made to the provider.

In response, Petitioner's representative indicated that she understood the Department's response. However, she also testified that the provider has not repaid her yet. Petitioner's representative further testified that she has not contacted the provider about repayment because the letter from the Department asked that she allow 90 days before following up with the provider regarding the refund and that time period has not passed.

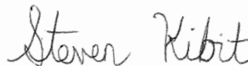
Accordingly, it appears that the matter may be resolved and that the provider will reimburse Petitioner. However, to the extent it is not or the provider fails to repay Petitioner, the Department still acted properly and its actions must be affirmed. Petitioner has Fee-For-Service Medicaid coverage on the date of service in this case, but federal regulations and state policy prohibit payment by Medicaid without a claim and the provider has never billed Medicaid for the services at issue in this case. Moreover, while the Department agrees that Petitioner should not have been billed and should be repaid, and has informed the provider of the applicable policy, it cannot force the provider to repay Petitioner and any remaining dispute Petitioner and the medical provider regarding the responsibility for the bill is between them.

DECISION AND ORDER

The Administrative Law Judge, based on the above Findings of Fact and Conclusions of Law, decides that the Department properly responded to Petitioner's complaint regarding an unpaid medical bill.

IT IS, THEREFORE, ORDERED that:

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



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Steven Kibit
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 Department Rep.