

## ISSUE

Did the Department improperly fail to pay for Petitioner's nursing facility services during the months of February of 2019 to November of 2019?

## 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 of 2019, Petitioner moved into a nursing facility. (Testimony of Petitioner's representative).
2. At that time, Petitioner, with the assistance of the facility, applied for Medicaid coverage. (Testimony of Petitioner's representative).
3. In December of 2019, Petitioner was approved for Medicaid as of December 1, 2019. (Testimony of Petitioner's representative; Testimony of Department's representative).
4. Petitioner did not challenge or request an administrative hearing with respect to the effective start date of her Medicaid coverage. (Testimony of Petitioner's representative).
5. The Department began paying for Petitioner's nursing facility services as of December of 2019. (Testimony of Petitioner's representative; Testimony of Department's representative).
6. The nursing facility subsequently billed Petitioner for the months of February of 2019 through November of 2019. (Exhibit A, page 7; Testimony of Petitioner's representative).
7. No claims for payment for those months were ever submitted to the Department by the facility. (Testimony of Department's representative).
8. On August 5, 2020, the Michigan Office Administrative Hearings and Rules (MOAHR) received the request for hearing filed in this matter with respect to the bills Petitioner was receiving from the nursing facility. (Exhibit A, page 5).

## 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.)
- 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, January 1, 2019 version  
General Information for Providers Chapter, pages 32-33*

Here, the facts in this case are undisputed and, as discussed above, they demonstrate that, while Petitioner was approved for Medicaid as of December 1, 2019, Petitioner did not have Medicaid coverage when receiving nursing facility services between February and November of 2019; no claims have been submitted to the Department for payment for those services; and Petitioner was subsequently billed for those services.

Given the above record, the Department acted properly in this case and its actions must be affirmed. It is undisputed that Petitioner did not have Medicaid coverage on the dates when the services at issue in this case were provided and that no claims for payment have ever been submitted to the Department with respect to the services at issue, with federal regulations and state policy expressly prohibiting any payment by Medicaid without coverage and a claim.

Rather than disputing the above facts, Petitioner's representative instead appears to believe that the Department should have paid for the services provided prior to the effective date of Petitioner's Medicaid coverage, *i.e.* December 1, 2019, because she started working with the nursing facility on getting Petitioner Medicaid coverage as soon as Petitioner was admitted; provided everything the nursing facility asked for; and it was the nursing facility who delayed the process by continually requesting more and different information over the months that Petitioner stayed there. However, to the extent that Petitioner disputes that effective start date of her Medicaid coverage, for whatever reason, she needs to request a hearing with respect to that issue, though the time for doing so may have already passed. Similarly, to the extent Petitioner has a dispute with the nursing facility over its actions or who is responsible for the bills, that dispute is also beyond the scope of this proceeding.

The undersigned Administrative Law Judge only has jurisdiction over the Department and its actions; and, given the record in this case, the Department's actions were proper.

## DECISION AND ORDER

The Administrative Law Judge, based on the above Findings of Fact and Conclusions of Law, decides that the Department did not improperly fail to pay for Petitioner's nursing facility services during the months of February of 2019 to November of 2019.

**IT IS, THEREFORE, ORDERED** that:

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