

ISSUE

Did the Department improperly fail to pay for medical services provided to Petitioner in September of 2020?

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 REDACTED 2020, Petitioner underwent brain surgery and received additional medical services. (Testimony of Petitioner).
2. At that time, she did not have Medicaid coverage. (Testimony of Petitioner; Testimony of Department's witness).
3. Petitioner was billed directly for some or all of those services. (Testimony of Petitioner).
4. On February 22, 2021, the Department sent Petitioner a Health Care Coverage Determination Notice indicating that Petitioner was approved for full Medicaid coverage for the period of September 1, 2020, through November 30, 2020. (Exhibit A, pages 9-12).
5. Petitioner then contacted the Department about having the medical services she received on September 20, 2020, covered, and she was advised to have her providers submit claims to Medicaid. (Testimony of Petitioner).
6. In March and June of 2021, the Department received three claims for services provided on REDACTED 2020, in the amounts of \$103,179.88, \$8,629.20, and \$7,830.00. (Exhibit A, page 28; Testimony of Department's witness).
7. The claims were subsequently approved. (Exhibit A, page 28; Testimony of Department's witness).
8. No claim for services provided in REDACTED of 2020 have been denied. (Exhibit A, page 28; Testimony of Department's witness).
9. On May 11, 2021, 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. (Exhibit A, pages 5-27).

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 applicable version of 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 for additional information about copayments.)
- A monthly patient-pay amount for inpatient hospital or nursing facility services. The local MDHHS office 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.
- 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, July 1, 2020, version
General Information for Providers Chapter, pages 37-38*

Here, Petitioner did not have Medicaid coverage at the time she received the medical services in REDACTED of 2020, but that she was subsequently approved for Medicaid retroactive to September 1, 2020, and she requested a hearing on the basis that the Department has improperly failed to pay for services provided on September 8, 2020.

In requesting a hearing, Petitioner bears the burden of proving by a preponderance of the evidence that Respondent erred. Moreover, the undersigned ALJ is limited to reviewing Respondent's decision in light of the information available at the time the decision was made.

Given the record in this case, the undersigned Administrative Law Judge finds that Petitioner has failed to meet her burden of proof and the Department's actions must therefore be affirmed.

As provided in the Department's exhibit, and uncontradicted by Petitioner, all claims submitted for the services provided to Petitioner on REDACTED 2020, have been approved by the Department. Moreover, while Petitioner testified that she is still receiving some bills, bills that were not included as part of the record, there is simply no evidence of any further claims submitted to the Department for payment, and federal regulations and state policy expressly prohibit any payment by Medicaid without a claim.

The Department cannot force providers to bill the Department and Petitioner's dispute at this time is with her providers and whether they can bill her. In particular, the above policy provides that, if a provider accepts an individual as a Medicaid beneficiary, as Petitioner's providers may or may not have done in this case, it can only bill Petitioner in certain circumstances.

Any dispute between Petitioner and her providers over bills does not involve any action by the Department and is therefore beyond the scope of the undersigned Administrative Law Judge's jurisdiction. Accordingly, whatever other avenues of relief Petitioner could pursue, the Department's actions must be affirmed given the available information and applicable policies.

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 medical services provided to Petitioner in REDACTED of 2020.

IT IS, THEREFORE, ORDERED that:

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