

ISSUE

Did the Department improperly fail to pay for medical services provided to Petitioner in REDACTED of 2022?

FINDINGS OF FACT

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

1. During the month of February of 2022, Petitioner had Medicaid coverage through the Department and the Michigan Medicaid program. (Testimony of Petitioner; Testimony of Departmental Specialist).
2. On REDACTED 2022, Petitioner was hospitalized at Sarasota Memorial Hospital in the State of Florida. (Testimony of Petitioner).

3. Petitioner had contacted Sarasota Memorial Hospital before being hospitalized and confirmed it was enrolled in Medicaid. (Testimony of Petitioner).
4. While in the hospital on REDACTED 2022, Petitioner received computerized tomography (CT) scans of his abdomen and pelvis. (Exhibit A, page 11; Testimony of Petitioner).
5. The CT scans were performed by Radiology Associates of Tampa (RA). (Exhibit A, page 11; Testimony of Petitioner).
6. RA is a separate entity from Sarasota Memorial Hospital; it bills separately; and it is not enrolled in the Michigan Medicaid program. (Testimony of Departmental Specialist).
7. The hospital subsequently billed, and was reimbursed by, the Department for services. (Testimony of Petitioner; Testimony of Departmental Specialist).
8. RA did not bill the Department. (Testimony of Departmental Specialist).
9. RA did bill Petitioner directly for the services it provided. (Exhibit A, page 11)-
10. On November 3, 2022, Petitioner filed a Beneficiary Complaint regarding the bills he was receiving. (Exhibit A, pages 10-11).
11. The Department subsequently contacted RA, who advised the Department that it was not enrolled in the Michigan Medicaid program and does not accept it. (Testimony of Departmental Specialist).
12. On January 31, 2023, the Department sent Petitioner a written response to his Beneficiary Complaint. (Exhibit A, page 8).
13. In that response, the Department wrote:

After speaking with the health care provider, we determined that you are responsible for this bill.

Medicaid cannot pay this bill because they are from an out-of-state health care provider that is not enrolled with Michigan Medicaid. Medicaid can only pay for emergency services provided by out-of-state providers who are enrolled in the Michigan Medicaid program.

14. On April 10, 2023, the Michigan Office of Administrative Hearings and Rules (MOAHR) received the request for hearing filed in this matter with respect to the bills Petitioner was receiving. (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).

With respect to out-of-state providers, the applicable version of the MPM stated in part:

7.3 OUT OF STATE/BEYOND BORDERLAND PROVIDERS

Reimbursement for services rendered to beneficiaries is normally limited to Medicaid-enrolled providers. MDHHS reimburses out of state providers who are beyond the borderland area if the service meets one of the following criteria:

- Emergency services as defined by the federal Emergency Medical Treatment and Active Labor Act (EMTALA) and the federal Balanced Budget Act of 1997 and its regulations; or
- Medicare and/or private insurance has paid a portion of the service and the provider is billing MDHHS for the coinsurance and/or deductible amounts; or
- The service is prior authorized by MDHHS. MDHHS will only prior authorize non-emergency services to out of state/beyond borderland providers if the service is not available within the state of Michigan and borderland areas.

Managed Care Plans follow their own Prior Authorization criteria for out of network/out of state services. Providers participating in Medicaid Health Plan and Dental Health Plan networks should refer to the Dental chapter (Healthy Kids

Dental section) and the Medicaid Health Plans chapter of this manual for additional prior authorization information.

Providers must be licensed and/or certified by the appropriate standard-setting authority.

All providers rendering services to Michigan Medicaid beneficiaries must complete the on-line application process described in the Provider Enrollment Section of this Chapter in order to receive reimbursement. Exceptions to this requirement may be made in special circumstances. These circumstances will be addressed through the Prior Authorization process.

Out of state/beyond borderland providers enrolled with the Michigan Medicaid program may submit their claims directly to CHAMPS. Providers should refer to the appropriate Billing and Reimbursement chapter of this manual for billing instructions.

MDHHS is prohibited by federal law from issuing Medicaid payment to any financial institution or entity whose address is outside of the United States.

Out of state/beyond borderland providers have a responsibility to follow Michigan Medicaid policies, including obtaining PA for those services that require PA.

*MPM, January 1, 2022 version
General Information for Providers Chapter, pages 21-22
(Italics added for emphasis)*

Moreover, with respect to providers billing beneficiaries, the applicable version of the MPM states in part:

SECTION 10 - BILLING BENEFICIARIES

10.1 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, January 1, 2022, version
General Information for Providers Chapter, pages 29-30*

Here, Petitioner had Medicaid coverage at the time he received medical services from RA on REDACTED 2022, and he requested a hearing on the basis that the Department has improperly failed to pay for those services.

In requesting a hearing, Petitioner bears the burden of proving by a preponderance of the evidence that Respondent erred. Moreover, the undersigned All 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 his burden of proof and the Department's actions must therefore be affirmed.

As provided in the above policies, the Department can reimburse for emergency services provided by out of state providers. However, the applicable policy also provides that reimbursement is normally limited to Medicaid-enrolled providers and that, if a provider is not enrolled in Medicaid, they do not have to follow Medicaid guidelines about reimbursement.

In this case, RA; the provider in question, is not enrolled in Medicaid; it does not have to follow Medicaid guidelines about reimbursement; and it can therefore bill Petitioner directly.

Moreover, regardless of whether RA could have enrolled in Medicaid and billed the Department, the Department cannot force it to enroll and bill, and no claims were ever submitted to the Department by RA.

Petitioner is understandably confused as to why a provider within a hospital that accepts Medicaid does not accept Medicaid, and why other hospital bills were covered while the CT scans were not. However, the above policies are clear; RA is not bound by Medicaid guidelines about reimbursement, and any dispute between Petitioner and his provider over bills does not involve an action by the Department.

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 2022.

IT IS, THEREFORE, ORDERED that:

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