[redacted]
, MI [redacted]

Date Mailed: February 5, 2020
MOAHR Docket No.: 19-012779
Agency No.: [redacted]
Petitioner: [redacted]

ADMINISTRATIVE LAW JUDGE: Steven Kibit

DECISION AND ORDER

This matter is before the Michigan Office of Administrative Hearings and Rules (MOAHR) and the undersigned Administrative Law Judge pursuant to MCL 400.9 and upon Petitioner's request for hearing.

After due notice, a telephone hearing was held on January 30, 2020. Petitioner appeared and testified on her own behalf. Theresa Root, Appeals Review Officer, represented the Respondent Department of Health and Human Services (DHHS or Department). Edward Kincaid, Specialist, testified as a witness for the Department.

During the hearing, the Department submitted an evidence packet that was admitted into the record as Exhibit A, pages 1-24. Petitioner did not submit any exhibits.

ISSUE

Did the Department improperly fail to pay for medical services provided to Petitioner?[1]

FINDINGS OF FACT

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

1. Prior to January 1, 2019, Petitioner was approved for Medicare coverage. (Testimony of Specialist).

2. She was also approved for Medicaid coverage, but with a deductible/spend-down that had to be met each month before her Medicaid coverage became active for that month. (Testimony of

[1] Petitioner also identified a dispute during the hearing with respect to an alleged failure by the Department to pay Petitioner's Medicare premiums, coinsurances and deductibles, but that dispute is beyond the scope of this case. The undersigned Administrative Law Judge will however forward Petitioner's request to the appropriate local DHHS office for processing regarding that issue.

Specialist).

3. Petitioner did not meet her spend-down during the months of January of 2019, February of 2019, or March of 2019; and her Medicaid coverage therefore did not become active for those months at that time. (Testimony of Specialist).

4. On January 29, 2019, Petitioner received medical services provided by Quest Diagnostics. (Exhibit A, page 11).

5. On February 7, 2019, Petitioner received medical services provided by University Physicians Group. (Exhibit A, page 9).

6. On March 6, 2019, Petitioner received medical services provided by Harper University Hospital. (Exhibit A, page 10).

7. Each of those three providers subsequently billed Medicare for the services that were provided and received partial payment. (Testimony of Petitioner; Testimony of Specialist).

8. The remaining balances were then billed to Petitioner. (Exhibit A, pages 9-11).

9. Specifically, Quest Diagnostics billed Petitioner for $[redacted]; University Physicians Group billed Petitioner for $[redacted]; and Harper University Hospital billed Petitioner for $[redacted]. (Exhibit A, pages 9-11).

10. The Department did not receive any claims submitted by Quest Diagnostics, University Physicians Group or Harper University Hospital at that time. (Testimony of Specialist).

11. In December of 2019, Petitioner was retroactively approved for full Medicaid coverage as of January 1, 2019. (Exhibit A, pages 5, 8).

12. On December 10, 2019, the Michigan Office Administrative Hearings and Rules (MOAHR) received the request for hearing filed in this matter. (Exhibit A, pages 16-24).

13. In that request, Petitioner stated in part that she was appealing the medical bills that she had received. (Exhibit A, page 16).

14. She also attached three medical bills, with one bill from each of Quest Diagnostics, University Physicians Group and Harper University Hospital. (Exhibit A, pages 18-20).

15. Following the receipt of the request for hearing, the Specialist for the Department spoke with representatives from Quest Diagnostics, University Physicians Group, and Harper University Hospital. (Testimony of

Specialist).

16. During those conversations, he advised them that Petitioner has now been approved for Medicaid coverage during the three dates of service at issue and that the providers can therefore bill Medicaid. (Testimony of Specialist).

17. Quest Diagnostics indicated that it would bill the Department, but it has not yet done so. (Testimony of Specialist).

18. University Physicians Group indicated that it would bill the Department, it has since done so, and it has received payment. (Testimony of Specialist).

19. Harper University Hospital indicated that it has referred Petitioner's bill to a collection agency; it no longer has oversight of the account, and that it would not contact the collection agency or pull back the bill. (Testimony of Specialist).

20. It did advise the Specialist that he could contact the collection agency directly, but, when he did so, he was told that Petitioner's account was paid off and she had a zero balance. (Testimony of Specialist).

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 33-34

Moreover, regarding the coordination of Medicaid benefits with other programs, including Medicare, the Medicaid Provider Manual (MPM) states in the pertinent parts:

SECTION 1 – INTRODUCTION

This chapter applies to all providers.

Federal regulations require that all identifiable financial resources be utilized prior to expenditure of Medicaid funds for most health care services provided to Medicaid beneficiaries. Medicaid is considered the payer of last resort. If a beneficiary with Medicare or Other Insurance coverage is enrolled in a Medicaid Health Plan (MHP), or is receiving services under a Prepaid Inpatient Health Plan (PIHP) or Community Mental Health Services Program/Coordination Agency (CMHSP/CA), that entity is responsible for the Medicaid payment liability.

* * *

2.6. MEDICARE

2.6.A. MEDICARE ELIGIBILITY

> Many beneficiaries are eligible for both Medicare and Medicaid benefits. If a provider accepts the individual as a Medicare beneficiary, that provider must also accept the individual as a Medicaid beneficiary.
>
> If a Medicaid beneficiary is eligible for Medicare (65 years old or older) but has not applied for Medicare coverage, Medicaid does not make any reimbursement for services until Medicare coverage is obtained. The beneficiary must apply for Medicare coverage at a Social Security Office. Once they have obtained Medicare coverage, services may be billed to Medicaid as long as all program policies (such as time limit for claim submission) have been met.
>
> Medicaid beneficiaries may apply for Medicare at any time and are not limited to open enrollment periods. Beneficiaries may be eligible for Medicare if they are:
>
> - 65 years of age or older.
> - A disabled adult (entitled to SSI or RSDI due to a disability).
> - A disabled minor child.
>
> *MPM, January 1, 2019 version*
> *Coordination of Benefits Chapter, pages 1, 9*

Here, as discussed above, Petitioner requested a hearing with respect to medical bills she has received with respect to services provided to her. Petitioner also attached three specific medical bills that she has received as part of that request and, while she later testified that she has received other bills, the record does not reflect any such bills.

In requesting a hearing, Petitioner bears the burden of proving by a preponderance of the evidence that the Department erred.

Given the record and applicable policies in this case, Petitioner has failed to meet her burden of proof and the Department's actions must be affirmed.

It is undisputed that Petitioner did not have active Medicaid coverage on the three dates when the services at issue in this case were provided and that no claims for payment were submitted to the Department with respect to those services at that time, with federal regulations and state policy expressly prohibiting any payment by Medicaid without a claim.

Moreover, while Petitioner was subsequently approved for retroactive coverage for a time period including the dates of service, the Department continued to act properly. The Department's Specialist has advised the three providers that Petitioner has now been approved for Medicaid coverage for the dates of service at issue and that the providers can therefore bill Medicaid, with one provider subsequently billing the Department and receiving payment while the other two providers have not yet billed the Department.

While the Specialist has directly advised the providers that they can now bill Medicaid for the services provided to Petitioner, the Department cannot force the providers to bill the Department and Petitioner's true dispute 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 Medicare beneficiary, as the providers clearly did in this case, that provider must also accept the individual as a Medicaid beneficiary and it can only bill Petitioner in certain circumstances.

Accordingly, any remaining dispute between Petitioner and her providers over a bill does not involve any action by the Department and is beyond the scope of the undersigned Administrative Law Judge's jurisdiction; and, whatever other avenues of relief Petitioner could pursue, this matter is limited to reviewing the Department's actions and, for the reasons discussed above, 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.

IT IS, THEREFORE, ORDERED that:

The Department's actions are **AFFIRMED**.

Steven Kibit

SK/sb

Steven Kibit
Administrative Law Judge
for Robert Gordon, 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 Office of Administrative Hearings and Rules (MOAHR).

A party may request a rehearing or reconsideration of this Order if the request is received by MOAHR 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. MOAHR will not review any response to a request for rehearing/reconsideration.

A written request may be mailed or faxed to MOAHR. If submitted by fax, the written request must be faxed to (517) 763-0155; Attention: MOAHR Rehearing/Reconsideration Request.

If submitted by mail, the written request must be addressed as follows:

Michigan Office of Administrative Hearings and Rules
Reconsideration/Rehearing Request
P.O. Box 30763
Lansing, Michigan 48909-8139

DHHS -Dept Contact

Carol Gates
Customer Service Division
P.O. Box 30479
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DHHS Department Rep.

M. Carrier
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