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[redacted], MI [redacted]

Date Mailed: September 4, 2020
MOAHR Docket No.: 20-005131
Agency No.: [redacted]
Petitioner: [redacted]

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 Petitioner's request for a hearing.

After due notice, a telephone hearing was held on September 2, 2020. Petitioner appeared and testified on her own behalf. Allison Pool, Appeals Review Officer, represented the Respondent Michigan Department of Health and Human Services (MDHHS or Department). Edward Kincaid, Departmental Specialist, testified as a witness for the Department. No exhibits were admitted during the hearing.

ISSUE

Did the Department improperly fail to pay for medical services provided to Petitioner in January 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 January 2, 2020, Petitioner received medical services at Ascension Providence Hospital, Southfield Campus. (Testimony of Petitioner).

2. At that time, she did not have Medicaid coverage. (Testimony of Petitioner; Testimony of Department's witness).

3. No claim for payment was submitted to the Department by that medical provider. (Testimony of Department's witness).

4. Petitioner was billed by the hospital. (Testimony of Petitioner).

5. Petitioner subsequently applied for Medicaid coverage. (Testimony of Petitioner; Testimony of Department's witness).[1]

6. Petitioner was then approved for Medicaid coverage beginning February 1, 2020. (Testimony of Petitioner).

7. On August 12, 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.

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.)

[1] Petitioner was also in the process of appealing an earlier termination of her Medicaid coverage at that time, but that request for hearing was later dismissed due to lack of jurisdiction after it was determined that Petitioner's request for hearing was untimely. *See* Docket Nos. 18-013862, 19-000385.

- 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, 2020 version*
> *General Information for Providers Chapter, pages 38-39*

Here, the facts in this case are undisputed and, as discussed above, they demonstrate that Petitioner did not have Medicaid coverage at the time she received the medical services in January of 2020 and that, while she subsequently applied for Medicaid coverage, coverage was only approved beginning February 1, 2020. It is also undisputed that no claims have been submitted to the Department for payment from the provider and that Petitioner has been billed.

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 date 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 those services, with federal regulations and state policy expressly prohibiting any payment by Medicaid without a claim.

Moreover, even if claims for payment for the services provided in January of 2020 had been submitted, they would have been denied given that Petitioner did not have Medicaid coverage at that time. Petitioner did regain Medicaid coverage in February of 2020, but she would still have to be covered on the actual date of service in order to the Department to reimburse for the services, with Petitioner's belief that her coverage effective February 1, 2020 encompassed all bills for the prior three months based on a misunderstanding of policy. While retroactive Medicaid coverage may be available back to the first day of the third calendar month prior to the most recent application for Medicaid, eligibility must still be made for each of the three retroactive months, *see* Bridges Administrative Manual (BAM) 115, pages 12-13, and there was no such finding in this case as the Department only and expressly made Petitioner eligible as of February 1, 2020.[2]

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[2] Petitioner testified that her understanding of policy was based on what she was told by the Department, but that testimony is unsupported and, regardless, it would not change the decision in this case given the clear policies and undisputed facts. To the extent Petitioner disputes that effective date of her Medicaid eligibility, she may request a hearing with respect to that decision, though any such request may be untimely at this point.

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 January of 2020.

IT IS, THEREFORE, ORDERED that:

The Department's decision is **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
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DHHS Department Rep.

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