

ISSUE

Did the Department properly respond to Petitioner's Beneficiary Complaint Form (BCF) regarding medical bills from 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. In REDACTED of 2022, Petitioner underwent surgery and was hospitalized from REDACTED 2022 through REDACTED 2022. (Testimony).
2. Petitioner had Medicaid coverage through the Healthy Michigan Plan for July through October 2022. (Exhibit A, p 2; Testimony).
3. At some point after the surgery, Petitioner began to receive medical bills relating to the surgery. (Testimony). Petitioner contacted the hospital where the surgery was performed and was informed that they were aware he had Medicaid and that Medicaid was the only insurance on file for him. (*Id.*)
4. Petitioner did not hear anything else until over two years later when he started receiving notices from collection agencies regarding certain bills relating to his 2022 surgery. (Testimony).
5. On March 7, 2024, Petitioner filed a BCF with the Department regarding medical bills from Flint Clinical Pathologists for service dates of REDACTED, 2022, REDACTED 2022, and REDACTED 2022. (Exhibit A, pp 2, 5; Testimony).
6. On August 26, 2024, the Department sent Petitioner a written response to his BCF which indicated that because the provider never billed Medicaid for these dates of service, it was presumed that they did not accept him as a Medicaid beneficiary. And because more than one year had passed since the services were provided, the provider could no longer bill Medicaid and Petitioner would have to resolve the bills with the provider. (Exhibit A, p 5; Testimony).
7. On January 21, 2025, Petitioner filed a request for hearing with the Michigan Office of Administrative Hearings and Rules (MOAHR) . (Exhibit A, pp 9-13).
8. With the request for hearing, Petitioner submitted additional bills from the time, including a bill from Kellam & Associates for a service date of REDACTED 2022; a bill from Chest and Sleep Medicine Consultants for a service date of REDACTED 2022, and a bill from Diagnostic Radiology Associates of Flint for a service date of REDACTED 2022. (Exhibit A, pp 2, 9-13; Testimony).

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 identified in the Medicaid Provider Manual (MPM). Moreover, with respect to a providers billing beneficiaries, 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 their 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 they were 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 them 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 their **miHealth** card is not accepted and that they are 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.

SECTION 11 – BILLING REQUIREMENTS

11.3 TIMELY FILING BILLING LIMITATION

Each claim received by MDHHS receives a unique identifier called a Transaction Control Number (TCN). This is an 18-digit number found in the Remittance Advice (RA) that

indicates the date the claim was entered into the Community Health Automated Medicaid Processing System (CHAMPS). The TCN is used when determining active review of a claim. (Refer to the Billing & Reimbursement Chapters for additional information.)

A claim must be initially received and acknowledged (i.e., assigned a TCN) by MDHHS within 12 months from the date of service (DOS).* DOS has several meanings:

- For claims using the institutional format and MHPs, it is the "To" or "Through" date indicated on the claim.
- For all other providers, it is the date the service was actually rendered or delivered.

All claims must be resolved within one year from the date of service unless an exception exists as noted below. It will no longer be necessary to maintain continuous activity through multiple claim submissions. Claim replacements requesting additional payment must meet exception criteria to be considered beyond one year from DOS.

Only the following types of claims require documentation of previous activity in the Remarks section of the claim (e.g. previous TCNs):

- Claim replacements;
- Claims previously billed under a different provider NPI number;
- Claims previously billed under a different beneficiary ID number; and
- Claims previously billed using a different DOS "statement covers period" for nursing facilities and

inpatient hospitals.

*Medicaid Provider Manual
General Information for Providers Chapter
July 1, 2024, pp 31-32, 37-38*

Here, as discussed above, Petitioner requested a hearing with respect to bills he has received from medical providers relating to a surgery he underwent in 2022. In requesting a hearing, Petitioner bears the burden of proving by a preponderance of the evidence that the Department erred. The Department's Specialist testified that because the providers here

never billed Medicaid, the Department determined that they did not accept Petitioner as a Medicaid beneficiary.

The Department's Specialist noted that unfortunately when services are provided in a hospital, some of the providers bill separately from the hospital and they do not always pull insurance information for the patient from the hospital. The Department's Specialist also noted that there is no Department policy requiring providers to obtain insurance information from a hospital under these circumstances, so Petitioner would have to resolve these bills with the providers. The Department's Specialist also indicated that one of the reasons Medicaid gives providers up to a year to bill for a claim is so that situations like this can usually be avoided.

The Department's Specialist did indicate that it was determined from past billing history that provider Diagnostic Radiology Associates of Flint did accept Petitioner as a Medicaid beneficiary so the Department is in the process of contacting Diagnostic Radiology Associates of Flint to inform them that they should not have billed Petitioner and should pull the charges back from collections and write them off.

Finally, the Department's Specialist indicated that the charge from Kellam & Associates from REDACTED2022, was before Petitioner became eligible for Medicaid, so Petitioner will have to resolve that bill with the provider. Likewise, the Department's Specialist indicated that the REDACTED 2022, bill from Flint Clinical Pathologists was also prior to Petitioner's effective Medicaid coverage, so Petitioner will have to resolve that bill with the provider.

Petitioner testified that he was not seeking reimbursement for the REDACTED 2022, bill or the REDACTED 2022, bill because he knows he did not have Medicaid on those dates. Petitioner explained that those bills were on the same page as other bills he does dispute, so that's why they were included.

Petitioner testified that he underwent surgery and was hospitalized from REDACTED, 2022, through REDACTED, 2022. Petitioner indicated that at some point after the surgery, he began to receive medical bills relating to the surgery, but when he contacted the hospital he was informed that they were aware he had Medicaid and that Medicaid was the only insurance on file for him. Petitioner testified that he did not hear anything else until over two years later when he started receiving notices from collection agencies regarding certain bills relating to his 2022 surgery. Petitioner testified that he is still getting bills for the 2022 surgery and received one last week for \$5000.

Given the record and applicable policies in this case, Petitioner has proven by a preponderance of the evidence that the Department erred in responding to his BCF.

The above policy indicates:

Providers cannot bill beneficiaries for services except in the following situations:

- 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.

First, it should be noted that Petitioner is not disputing the bills from before he became eligible for Medicaid. As such, the bill from Flint Clinical Pathologists for service date REDACTED 2022, and the bill from Kellam & Associates for service date REDACTED 2022, are not part of this appeal.

Here, the Department presumes that these providers did not accept Petitioner as a Medicaid patient because they never billed Medicaid for the services. And, while that may usually be a reasonable presumption, the Department did not point to any policy supporting that presumption. The only policy the Department pointed to was policy that all claims must be submitted within one year of the service being provided, and that policy in no way supports the presumption.

As indicated above, policy clearly puts the burden on the provider to choose not to accept the beneficiary as a Medicaid beneficiary and make the beneficiary aware of this fact prior to the services being rendered. The providers here certainly never informed Petitioner that they were choosing not to accept him as a Medicaid beneficiary, so, if they were Medicaid enrolled providers, they should not have billed him for these services.

Petitioner's Medicaid insurance information was on file at the hospital where the surgery was performed, so the providers had easy access to this information. The alternative would require the Medicaid beneficiary to figure out, while lying in a hospital bed before or after surgery, which of the providers coming to treat him would bill separately from the hospital and then inform those providers that he was a Medicaid beneficiary. Policy does not put this burden on beneficiaries, nor would it make sense to put such a burden on beneficiaries.

With that said, normally in this situation, the beneficiary would receive a bill within one year of the service and the provider would still be able to bill Medicaid. Here, when Petitioner started receiving bills relating to the surgery, he contacted the hospital where the surgery was performed and believed that the matter had been resolved, not realizing that some of the providers billed separately from the hospital.

Accordingly, the Department acted improperly in responding to Petitioner's BCF, and its actions must be reversed. The Department should determine if any of the providers were Medicaid enrolled providers at the time the services were provided. If the providers were enrolled in Medicaid, then they would have been responsible for notifying Petitioner that they were not accepting him as a Medicaid beneficiary and, if they did not, would have improperly billed Petitioner. If the providers were not Medicaid enrolled providers at the time the services were rendered, then Petitioner will have to resolve the bills with the providers.

DECISION AND ORDER

The Administrative Law Judge, based on the above Findings of Fact and Conclusions of Law, decides that the Department improperly responded to Petitioner's Beneficiary Complaint.

IT IS, THEREFORE, ORDERED that:

- The Department's decision is **REVERSED**.

Within 10 days of this Order, the Department shall begin taking steps to comply with this Order.