

ISSUE

Did the Department improperly fail to pay for medical services provided to Petitioner on REDACTED, 2023?

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 2023, Petitioner received medical services through Munson Anesthesia. (Exhibit A, page 12; Testimony of Specialist).
2. At that time, he had both private insurance and Medicaid coverage through the Healthy Michigan Program. (Exhibit A, page 12; Testimony of Specialist).
3. Munson Anesthesia subsequently submitted a claim to the Department with respect to those services, but the claim was denied on the basis that the provider failed to bill Petitioner's other insurances prior to billing Medicaid as required. (Exhibit A, page 17; Testimony of Specialist).
4. Munson Anesthesia then billed Petitioner directly for the services. (Exhibit A, pages 9-14; Testimony of Petitioner).
5. Petitioner has not paid the bill he received. (Testimony of Petitioner).
6. He did file a Beneficiary Complaint with the Department with respect to the bill he received. (Exhibit A, page 16; Testimony of Specialist).
7. On June 10, 2025, Petitioner also filed a request for administrative hearing with MOAHR with respect to that bill. (Exhibit A, pages 7-15).
8. On June 17, 2024, the Department sent Petitioner a written response to his Beneficiary Complaint. (Exhibit A, page 16).
9. In part, that response stated:

We have reviewed the bill from **Munson Anesthesia** for date of service **REDACTED**

We determined that you are not responsible for this bill.

According to the Michigan Medicaid Provider Manual, a patient cannot be held responsible for charges if a provider accepted them as a beneficiary of the

Michigan Medicaid Program. (*Chapter: General Information for Providers, Section 10 – Billing Beneficiaries, 10.1 General Information*).

The provider should not send you any more bills for this date of service. If necessary, you may show this letter to the provider, and they can obtain more information by contacting the Provider Helpline about reference number 1-238691556.

Exhibit A, page 16

10. The Department also advised Munson Anesthesia that it may not bill Petitioner. (Testimony of Specialist).
11. Petitioner has not received any further bills since the Department's actions, but he also does not know the current status of the bill he received from Munson Anesthesia. (Testimony of Petitioner).

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 providers billing beneficiaries at the time of the service at issue in this case, the applicable version of the MPM stated 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, October 1, 2023 version
General Information for Providers Chapter, pages 30-31*

Here, as discussed above, Petitioner requested a hearing with respect to a bill he has received from a medical provider.

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

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

The sole action taken by the Department in this case was a denial of a claim submitted by Munson Anesthesia and it is undisputed that the denial was correct given the information the Department had at the time, which reflected that the provider failed to bill Petitioner's other insurance prior to billing Medicaid as required.

Petitioner's true dispute is with his Munson Anesthesia and whether that provider can bill him; and the Department's witness credibly and fully explained during the hearing why the provider cannot bill Petitioner for the services provided on REDACTED 2023. Specifically, in submitting a claim to the Department, the provider accepted Petitioner as a Medicaid beneficiary and, per policy, the provider therefore cannot subsequently bill Petitioner for Medicaid-covered services for which the provider has been denied payment because of improper billing.

The Department has advised the provider to cease billing, and it is not clear if the provider is still seeking payment from Petitioner, with Petitioner not having received any further bills or having contacted the provider since the Department's response to his Beneficiary Complaint. If the provider continues to seek payment, Petitioner will have the Department's response, its exhibit in this case and this Decision and Order to give to the provider to demonstrate why billing is improper, but the Department cannot force the provider to cease billing and any dispute between Petitioner and his provider is outside the undersigned Administrative Law Judge's jurisdiction.

Accordingly, whatever dispute remains between Petitioner and his provider, this matter is limited to reviewing the Department's action and, for the reasons discussed above, the Department's sole action 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 on REDACTED 2023.

IT IS, THEREFORE, ORDERED that:

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