**STATE OF MICHIGAN**
**STATE OFFICE OF ADMINISTRATIVE HEARINGS AND RULES**
**FOR THE DEPARTMENT OF COMMUNITY HEALTH**
P.O. Box 30763, Lansing, MI 48909
(877) 833-0870; Fax: (517) 334-9505

IN THE MATTER OF:

[redacted]

Appellant
_____/

Docket No. 2009-22565 MSB
Case No. [redacted]

## DECISION AND ORDER

This matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9 and MCL 400.37 upon the Appellant's request for a hearing.

After due notice, a hearing was held on [redacted] Appellant's legal guardian, appeared and testified on behalf of Appellant. [redacted], Appeals Review Officer, represented the Department. [redacted], testified as a witness for the Department.

## ISSUE

Did the Department properly deny payment of Appellant's medical bill?

## FINDINGS OF FACT

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

1. Appellant is a [redacted] Medicaid Beneficiary.

2. On [redacted] and [redacted], Appellant was admitted to the Emergency Room (ER) of [redacted] and provided with services. (Exhibit 1, pp. 2, 8 & 9)

3. During the time that Appellant received ER services, he had a Medicaid spend-down (deductible) case, and the two providers at the ER hospital were not aware that he met his spend-down amount and had active Medicaid Coverage during the month the services were provided. (Exhibit 1, p. 2)

4. Appellant's was billed for a total amount o [redacted]) for ER services provided in [redacted]. (Exhibit 1, p. 2)

5. On [redacted], the Department (DCH) sent Appellant and his legal guardian letters, stating that it investigated the problem regarding the unpaid medical bills for services rendered in [redacted], and discovered that the providers were not aware that Appellant had subsequently met his Medicaid spend-down amount and had Medicaid coverage for the time period in question. (Exhibit 1, pp. 8 & 9)

6. On [redacted] the State Office of Administrative Hearings and Rules received Appellant's hearing request, protesting the fact that he is being held responsible for unpaid medical bills in the total amount of [redacted].

## CONCLUSIONS OF LAW

The Medical Assistance Program 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.

> Providers cannot bill beneficiaries for services except in the following situations:
>
> - A co-payment for chiropractic, dental, hearing aid, pharmacy, podiatric, or vision services is required. However, a provider cannot refuse to render service if the beneficiary is unable to pay the required co-payment on the date of service.
> - A monthly patient-pay amount for inpatient hospital or nursing facility services. The local DHS determines the patient-pay amount. Non-covered services can be purchased by offsetting the nursing facility beneficiary's patient-pay amount. (Refer to the Nursing Facility Chapter for more 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 DHS 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 DHS 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 has been told prior to rendering the service that it was not covered by Medicaid. If the beneficiary is not informed of Medicaid non-coverage 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 non-authorized or non-covered 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, customized seating systems) that began, but were not completed, during a

period of eligibility. (Refer to the provider-specific chapters of this manual for more 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 or for 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.

*Medicaid Provider Manual, General Information for Providers Section, July 1, 2005, Pages 17-18*

All claims must be submitted in accordance with the policies, rules, and procedures as stated in the manual.

Each claim received by MDCH receives a unique identifier called a Claim Reference Number (CRN). This is a ten-digit number found in the Remittance Advice (RA) that indicates the date the claim was entered into the MDCH Claims Processing (CP) System. The CRN is used when determining active review of a claim. (Refer to the Billing & Reimbursement Chapters for more information.) A claim must be initially received and acknowledged (i.e., assigned a CRN) by MDCH within

twelve months from the date of service (DOS). DOS has several meanings:

- For inpatient hospitals, nursing facilities, and MHPs, it is the "From" or "Through" date indicated on the claim.
- For all other providers, it is the date the service was actually rendered or delivered.

**Claims over one year old** must have continuous active review to be considered for Medicaid reimbursement. Claim replacement can be resubmitted within 12 months of the latest RA date or other activity.

Active review means the claim was received and acknowledged by MDCH within twelve months from the DOS. In addition, claims with DOS over one year old must be billed within 120 days from the date of the last rejection. For most claims, MDCH reviews the claims history file for verification of active review.

Only the following types of claims require documentation of previous activity in the Remarks section of the claim:

- Claim replacements;
- Claims previously billed under a different provider ID 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.

There are occasions when providers are not able to bill within the established time frames (e.g., awaiting notification of retroactive beneficiary eligibility). In these situations, the provider should submit a claim to Medicaid, knowing the claim will be rejected. This gives the provider a CRN to document continuous active review.

Exceptions may be made to the billing limitation policy in the following circumstances.

- Department administrative error occurred, including:
  - The provider received erroneous written instructions from MDCH staff;
  - MDCH staff failed to enter (or entered erroneous) authorization, level of care, or restriction on the system;

- MDCH contractor issued an erroneous PA; and
- Other administrative errors by MDCH or its contractors that can be documented.

Retroactive provider enrollment is not considered an exception to the billing limitation.

- Medicaid beneficiary eligibility/authorization was established retroactively:
  - Beneficiary eligibility/authorization was established more than twelve months after the DOS; and
  - The provider submitted the initial invoice within twelve months of the establishment of beneficiary eligibility/authorization.
- Judicial Action/Mandate: A court or MDCH administrative law judge ordered payment of the claim.
- Medicare processing was delayed: The claim was submitted to Medicare within 120 days of the DOS and Medicare submitted the claim to Medicaid within 120 days of the subsequent resolution. (Refer to the Coordination of Benefits Chapter in this manual for further information.)

Providers who have claims meeting either of the first two exception criteria must contact their local DHS office to initiate the following exception process:

- The DHS caseworker completes and submits the Request for Exception to the Twelve-Month Billing Limitation for Medical Services form (MSA-1038) to MDCH.
- DHS informs the provider when the MSA-1038 has been approved by MDCH.
- Once informed of the approval, the provider prepares claims related to the exception, indicating “MSA-1038 approval on file” in the comment section.
- The provider submits claims to MDCH through the normal submission process.

Refer to the Billing & Reimbursement chapters of this manual for additional information on claim submission. Questions regarding claims submitted under this exception should be directed to MDCH Provider Inquiry. (Refer to the Directory Appendix for contact information.)

*Medicaid Provider Manual, General Information for Providers Section, July 1, 2005, Pages 19-21*

Appellant is being held responsible for [redacted] in unpaid medical bills for ER services provided to him in [redacted]. The Department has denied a Medicaid reimbursement for these medical bills on the basis that this claim exceeds Medicaid's 1-year billing limitation.

Appellant's legal guardian testified that she was not aware of the bills until she received Appellant's credit report over a year after the services were provided. She testified further that Appellant is on a fixed income and does not have the money to pay these bills.

It is the responsibility of the clients to ensure that a provider is aware of their Medicaid eligibility. In this case, the providers of the ER services were not informed of Appellant's Medicaid eligibility in a timely manner. The Department did not receive a claim from Appellant or the providers within 1 year of the date of services, and there is no evidence that would support an exception to the Department's 1-year billing limitation. Medicaid policy will not allow a Medicaid reimbursement for the bills in question because they were not submitted timely. Therefore, the Department's denial of a Medicaid reimbursement for the medical bills in question must be upheld.

## DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the Department properly denied Appellant's request for a Medicaid reimbursement.

**IT IS THEREFORE ORDERED** that:

The Department's decision is AFFIRMED.

Marya Nelson-Davis
Administrative Law Judge
for Janet Olszewski, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 7/16/2009

***** NOTICE *****

The State Office of Administrative Hearings and Rules may order a rehearing on either its own motion or at the request of a party within 30 days of the mailing date of this Decision and Order. The State Office of Administrative Hearings and Rules will not order a rehearing on the Department's motion where the final decision or rehearing cannot be implemented within 90 days of the filing of the original request. The Appellant may appeal the Decision and Order to Circuit Court within 30 days of the receipt of the Decision and Order or, if a timely request for rehearing was made, within 30 days of the receipt of the rehearing decision.