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: Docket No. 2010-7038 MSB

[redacted]

Appellant
_____/

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 started on [redacted]. Owing to non-receipt of an exhibit, this matter was rescheduled [without objection] for continued hearing on [redacted]. The Appellant appeared without representation. She had no witnesses. [redacted], appeals review officer, represented the Department. Her witness was [redacted], customer serve representative MSA/MDCH.

ISSUE

Did the Department properly deny reimbursement of Appellant's mail order pharmacy co-payments owing to billing limitation policy?

FINDINGS OF FACT

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

1) At the time of hearing the Appellant is a [redacted] Medicaid beneficiary. (Appellant's Exhibit #1)

2) She is afflicted with Prader-Willi Syndrome (PWS) and requires long term use of the medication Genotropin. (Appellant's Exhibit #1, p. 2)

3) On the DOS the Appellant through her mother had Medicaid full coverage and private pharmacy coverage through Express Scripts until [redacted] and then [redacted] until present. (Department's Exhibit A, p. 4 and Appellant's Exhibit #1)

4) On [redacted], the Department denied the Appellant's request for reimbursement because "the date of [her] receipt/invoice is over one year old." (Department's Exhibit A, p. 5)

5) The Appellant's representative stated that a representative from [redacted] told her that "…they do not bill secondary insurance." (See Testimony and Department's Exhibit A, p. 3)

6) The Department denied 30 of 39 reimbursement claims because the DOS was past the12-month billing limitation. (Department's Exhibit A, p. 4 and See Testimony of Scheidt)

7) The Appellant's representative said, at hearing, that she was able to cure two of the reimbursement issues with a non-mail order pharmacy, but believes she is not responsible for the delayed DOS reimbursement claims. (See Testimony of Appellant and Department's Exhibit A, p. 4)

8) The proofs established, and the ALJ finds as fact, that the Appellant had other insurance on the DOS as established in the Department's evidence. (Department's Exhibit A, pp. 6-13)

9) [redacted] liabilities were not pursued until stale [beyond the 12-month limit for MDCH action]. (See Testimony of Appellant_

10) The instant appeal was received by SOAHR on [redacted]. (Appellant's Exhibit #1)

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.

All claims must be submitted in accordance with the policies, rules, and procedures as stated in the Medicaid Provider Manual (MPM) and as communicated in MSA bulletins:

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> 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.

Coordination of Benefits (COB) is the mechanism used to designate the order in which multiple carriers are responsible for benefit payments and, thus, prevention of duplicate payments. Third party liability (TPL) refers to an insurance plan or carrier (e.g., individual, group, employer-related, self-insured or self-funded plan), commercial carrier (e.g., automobile insurance and workers' compensation), or program (e.g., Medicare) that has liability for all or part of a beneficiary's medical coverage. The terms "third party liability" and "other insurance" are used interchangeably to mean any source, other than Medicaid, that has a financial obligation for health care coverage. Providers must investigate and report the existence of other insurance or liability to Medicaid and must utilize other payment sources to their fullest extent prior to filing a claim with the Michigan Department of Community Health (MDCH). If MDCH finds after a claim is adjudicated that another payer was liable for the service, a claim adjustment will be processed. The provider will then have to bill the identified third party resource for the service. [ ] ….

MPM, Coordination of Benefits, Introduction §1, January 1, 2010, page 1. [1]

SECTION 10 - BILLING REQUIREMENTS

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

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[ ] BILLING LIMITATION

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 additional 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.

[1] This version of the MPM is identical to the edition in place at the time of appeal.

 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. ▽ A claim replacement can be resubmitted within 12 months of the latest RA date or other activity.▽

∗Initial pharmacy claim must be received within 180 days.
▽Pharmacy claims submitted past 180 days require an authorization override by the MDCH PBM.

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

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Medicaid Provider Manual (MPM), §10.3. General Information [ ], January 1, 2010, pages 22, 23

* * *

The Appellant received pharmacy services from the above referenced mail order pharmacies during the times periods listed above. [See Finding of Fact #3].

She arranged for automatic payment as the medication was a long term measure for her PWS child. Accordingly, there was no issue involving late or incomplete payment from the Appellant to the pharmacy. Next, the Department's contractor 4D Pharmacy Management System Inc., sought approval for 39 pharmacy claims for dates service going back to [redacted] The Department witness said those claims were denied for exceeding the 12-month billing limitation.

For unknown reasons the Appellant's co-payments were not addressed by her mail order pharmacies on the DOS. The Appellant testified that she was told by mail order pharmacy representatives prior to hearing that "…there was nothing they could do." Under MPM policy and MSA bulletin - absent that information the Department's contractor cannot be compelled to pay the deductible.

> In Compliance with policy which requires Medicaid to be the payer of last resort, effective June 1, 2005, Michigan Department of Community Health (MDCH) will no longer allow a pharmacy to override the coordination of benefits (COB) edit for a beneficiary whose other insurance carrier has mail order pharmacy coverage. The Other Coverage Codes 3 and 4 will be disallowed for use by a pharmacy for a beneficiary who has a mail order pharmacy benefit. Effective on and after this date, a beneficiary must use the highest level of benefits available under his/her policy. Medicaid is not liable for payment of services denied because the coverage rules of the mail order pharmacy plan were not followed.
>
> MDCH will coordinate benefits with the mail order pharmacy by paying the beneficiary's co-payment through 4D Pharmacy Management Systems, Inc. The beneficiary will place an order for the prescribed medication(s) with the mail order pharmacy, and 4D Pharmacy Management Systems, Inc. will pay the beneficiary's co-payment. The excluded drug categories for Medicaid and Children's Special Health Care Services still apply. Claim(s) for co-payment(s) on medications(s) covered by the mail order pharmacy, but require prior authorization (PA) by MDCH, will be reimbursed without the mail order pharmacy having obtained PA from MDCH as long as the pharmacy is only billing for the co-payment(s).
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> MSA 05-24 Bulletin

The Department witness also testified that providers were copied on MSA Bulletin 05-24 setting forth the coordination of benefits requirements with mail order pharmacies by paying the beneficiary's co-payment through [redacted]

Absent documentation of error from the pharmacy[2] through [redacted] [the contractor] the Department cannot invoke an exception to the policy on billing limitations.

Medicaid is the payer of last resort – absent documentation of error from the mail order pharmacies the Department's decision to deny an exception to its billing limitation policy was proper.

[2] *If* the provider can document error their remedy begins with the Department Human Services and an exception request form MSA 1038.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the Department properly denied an exception to its billing limitation policy.

IT IS THEREFORE ORDERED that:

The Department's decision is AFFIRMED.

Dale Malewska
Administrative Law Judge
for Janet Olszewski, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 2/22/2010

***** 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.