STATE OF MICHIGAN
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
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],

Docket No. 2011-52196 MSB
Case No. [redacted]

Appellant
_____/

DECISION AND ORDER

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

After due notice, a hearing was held [redacted], the Appellant, represented herself. [redacted], Appeals Review Officer, represented the Department of Community Health (MDCH or Department). [redacted], Departmental Specialist for the Medical Services Administration, appeared as a witness for the Department.

ISSUE

Did the Department properly deny payment of the Appellant's University of Michigan physician's medical billings?

FINDINGS OF FACT

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

1. On [redacted], [redacted], and [redacted], the Appellant received services from U of M physicians.

2. Subsequently, U of M Regents submitted claims to the Department for payment. The Department denied the claims because the Appellant was not Medicaid eligible on the [redacted] or [redacted], dates of service.

3. U of M Regents did not resubmit the [redacted] and [redacted], claims after the claims were denied by the Department.

4. On [redacted], the Department of Human Services determined that the Appellant was eligible for Medicaid [redacted] to [redacted].

5. On [redacted], the Department's Problem Resolution Unit received a

Beneficiary Complaint from the Appellant. The Appellant indicated in her complaint that she was on a spend down, met her spend down, and had active Medicaid for the month of [redacted].

6. The U of M Regents sent the Appellant's unpaid medical bills to a collection agency and the Appellant is being billed for the [redacted] services.

7. On [redacted], the Department sent the Appellant a letter in which it informed the Appellant that the Department could not pay the medical bills for services received from U of M Regents for dates of service of [redacted], and [redacted], because the provider had not billed within 12 months of the dates of service.

8. On [redacted], the Michigan Administrative Hearing System received the Appellant's request for an administrative hearing.

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, 2010, pages 21-22*

The undisputed facts in this case show that the Appellant received services from her physician who was affiliated with the U of M Regents (U of M Health System). The Appellant received services on [redacted] and [redacted] In [redacted] the Appellant was on a spend down and had to incur Medical expenses at or above her Department of Human Services determined spend down amount before she had active Medicaid. Subsequent to the provision of services to the Appellant U of M Regents submitted claims to the Department for the [redacted] service dates. The Department denied the claims because the Appellant did not have active Medicaid on the [redacted] dates of service. On [redacted], the Department of Human Services retroactively found the Appellant Medicaid eligible for [redacted]. The U of M Regents failed to resubmit the [redacted] claims. On [redacted], the Department informed the Appellant that it could not pay the U of M Regents claims for [redacted], because the provider had not submitted a claim within 12 months of the [redacted] dates of service.

[redacted], Departmental Specialist, MDCH Medical Service Administration, testified on behalf of the Department. [redacted] indicated that the Department's claims billing policy provides that providers must bill within 12 months of the date of service. [redacted] testified that the Appellant's provider, U of M Regents, did bill within 12 months of the date of services and the claims were denied due to the Appellant's lack of Medicaid eligibility for [redacted]. [redacted] testified that the Department of Human Services found the Appellant Medicaid eligible for [redacted] on [redacted], and it was the provider's responsibility to resubmit the claims before [redacted]. [redacted] indicated that it was the Appellant's responsibility to inform the provider that she had active Medicaid for [redacted].

The Appellant testified that when she learned that she was Medicaid eligible for [redacted] she contacted U of M Regents and was told that they would re-submit the claims to the Department. The Appellant testified that she informed U of M Regents verbally and in writing that she was Medicaid eligible for [redacted] and she was told they would take care of the bills. According to [redacted], U of M Regents did not resubmit the claims.

The Department policy for Medicaid claims is found in the Medicaid Provider Manual, General Information for Providers chapter, section 12.3. This policy provides in pertinent part as follows:

SECTION 12 - BILLING REQUIREMENTS [RE-NUMBERED 10/1/11]
All claims must be submitted in accordance with the policies, rules, and procedures as stated in the manual.

12.1 BILLING PROVIDER [RE-NUMBERED 10/1/11]
Providers must not bill MDCH for services that have not been completed at the time of the billing. For payment, MDCH requires the provider NPI numbers to be reported in any applicable provider loop or field (e.g., billing, rendering, referring, servicing, attending, etc.) on the claim. It is the responsibility of the referring and/or ordering provider to share their NPI with the provider performing the service. Refer to the Billing & Reimbursement Chapters of this manual for additional information and claim completion instructions.

Providers rendering services to the residents of the ICF/MR facility (Mt. Pleasant Regional Center) may not bill Medicaid directly. All covered services (e.g., laboratory, x-rays, medical surgical supplies including incontinent supplies, hospital emergency rooms, clinics, optometrists, dentists, physicians, and pharmacy) are included in the per diem rate.

12.2 CHARGES [RE-NUMBERED 10/1/11]
Providers cannot charge Medicaid a higher rate for a service rendered to a beneficiary than the lowest charge that would be made to others for the same or similar service. This includes advertised discounts, special promotions, or other programs to initiate reduced prices made available to the general public or a similar portion of the population. In cases where a beneficiary has private insurance and the provider is participating with the other insurance, refer to the Coordination of Benefits Chapter of this manual for additional information.

12.3 BILLING LIMITATION [RE-NUMBERED 10/1/11]
Each claim received by MDCH 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 MDCH within 12 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.▽ 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.

Active review means the claim was received and acknowledged by MDCH within 12 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 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.

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 TCN 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.

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 12 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.)

Medicaid Provider Manual,
General Information for Providers Section,
October 1, 2011, pages 32-33
On line pages 43-44

The evidence presented shows that on [redacted] and [redacted], the Appellant's physician provided services to the Appellant. Subsequently, the U of M Regents submitted claims to the Department. Those claims were submitted within 12 months from the date of services but were denied because the Appellant did not have active Medicaid. On [redacted], the Department of Human Services determined that the Appellant was Medicaid eligible for the month of [redacted]. U of M Regent did not resubmit the claims for [redacted]. The Department policy provides that all claims must be submitted within 12 months of the date of service. The policy allows claims to remain

active if the claims are resubmitted within 120 days of the last rejection. The evidence shows that U of M Regent did not resubmit the claims after the initial [redacted] submission. Therefore, the Department properly denied the U of M Regents [redacted] claims because they were not submitted within 12 months of the August 2009 dates of services.

Department policy provides exceptions to the 12 months billing limitation. Exceptions may be made to the 12 months billing limitation if the:

> Medicaid beneficiary eligibility/authorization was established retroactively:
> - Beneficiary eligibility/authorization was established more than 12 months after the DOS; and
> - The provider submitted the initial invoice within twelve months of the establishment of beneficiary eligibility/authorization.
>
> *Medicaid Provider Manual,*
> *General Information for Providers Section,*
> *October 1, 2011, page 33*
> On line page 44

The facts show that the Appellant's Medicaid eligibility was established on [redacted] retroactively to [redacted] to [redacted]; however U of M Regents did not bill within 12 months of the eligibility authorization date or [redacted]. In fact, U of M Regents did not resubmit the claims after the Department's initial denial in [redacted] and September [redacted] Therefore, the Department correctly denied the U of M Regents claims because the claims exceeded the 12 months billing limitation and no billing exception is applicable.

[redacted] testified further that the Appellant was responsible for notification to the provider after the Appellant became aware of her retroactive eligibility. The Appellant testified that she notified the provider orally and in writing that she had retroactive Medicaid eligibility for [redacted] but U of M Regents did not act on the information. Even if this information is correct the fact remains that the provider did not resubmit the claims in issue after the initial denial and the Department properly applied its policy when it denied the claims.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the Department properly denied Medicaid payments for the [redacted] services provided to the Appellant by the University of Michigan Regents.

IT IS THEREFORE ORDERED that:

The Department's decision is AFFIRMED.

Martin D. Snider
Administrative Law Judge
for Olga Dazzo, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 11/8/2011

***** NOTICE *****

The Michigan Administrative Hearing System for the Department of Community Health 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 Michigan Administrative Hearing System for the Department of Community Health 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 mailing date of the Decision and Order or, if a timely request for rehearing was made, within 30 days of the mailing date of the rehearing decision.