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:

Docket No. 2012-53592 MSB

Case No.

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 the Appellant, represented of for the appeared as a witness for the Department.

ISSUE

Did the Department properly deny payment of the Appellant's Advanced Diagnostic Imaging P. C Medicaid 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 the Appellant received services from (Advanced).

2. On the service date the Appellant did not have active Medicaid coverage and did not accept the Appellant as a Medicaid beneficiary.

3. Subsequent to the service date Advanced billed the Appellant for the service and the Appellant took the billing to the Department of Human Services.

4. The Appellant has Medicaid eligibility through a Medicaid Spend down. The Appellant must incur medical expenses and present documentation or billings for those expenses to the Department of Human Services each month before

the Appellant's Medicaid coverage becomes active.

5. On , the Department of Hum an Services sent the Appellant a Notice of Case Action which informed the Appellant that she met her spend down for and had active Medicaid coverage for to

6. Subsequent to the , notice the Appellant did not inform Advanced that she had active Medicaid for and did not submit a Medicaid claim for the services provided to the Appellant.

7. The Appellant submitted her billings to the Department of Human Services to meet her spend down. he Department of Human Services does not submit Medicaid billing to the Department of Community Health Medicaid program unless a 12 mont h billing exception is being requested due to retroactive Medicaid coverage.

8. On staff from the Department of Community Health Problem Resolution Unit contacted staff and were told that had sent the Appellant 16 billing statements fo r the service date and had not submitted claims to the Department. also indicated that the Appellant contacted and informed them she had Medicaid coverage for

9. The Department of Community health Medicaid Provider Manual policy prohibits the Medicaid payment for claims submitted more than twelve months after the date of service.

10. On 2011, 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 C ode of Federal Regulati ons (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 chiropr actic, dental, hearing aid, pharmacy, podiatric, or visi on services is required. However, a provider cannot re fuse 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 recordsfor 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 under stands that a provider is not accepting him as a Medicaidpatient and asks to be private pay, the provider may charge the beneficiary its usual and customary charges for servic es rendered. The beneficiary must be advised prior to servic es being rendered that his **mihealth** card is not accepted and t hat 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 caseshow that the Appellant received services fron Imaging on 10. It is alsonot disputed that In 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. When provided services to the Appellant she did not have active Medicaid and did not accept the Appellant as a Medicaid beneficiary. Subsequently the Appellant the Appellant received a Case Action Notice which indicated that the Appellant met her spend down for and had active Medicaid.

testified on behalf of the Department. indicated that the Department'sclaims billing policy provides that providers must bill within 12 months of the dat e of service. testified that the Appellant'sprovider, , did not submit a claims for the 10 service date either within or after 12 months from the date of service. estified that staff contacted and were told that was never told by the Appellant, after the 0 service date, that she had active Medicaid for so did not submit a claim. testified that it is the Medicaid beneficiary's responsibility to inform a Medicaid

services provider that the beneficiary has active Medicaid. testified that staff indicated that they were informed in 1, by the Appellant that she had active Medicaid for but, at that time, it was too late for to bill Medicaid. testified that the Department did not deny payment because no claims were submitted by If had submitted the claims the Department's policy would not allow for the payment of claims submitted 12 months after the date of service.

The Appellant testified that in when she learned that she was Medicaid eligible for she submitted the bills from to the Department of Human Services and staff told her that they would send the bills to the Medicaid program for payment. The Appellant testified that she did not inform that she had Medicaid for until she contacted to find out why she was being billed. The Appellant testified that she was eligible for Medicaid for and that the Medicaid program should pay

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.
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> 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 page 43-44

The evidence presented shows that on the Appellant received Medicaid covered services from . The Appellant did not have active Medicaid on the services date but acquired Medicaid coverage on The Appellant did not notify until that she had Medicaid coverage for and never submitted a claim to the Medicaid program. Because on the date of services did not accept the Appellant as a Medicaid beneficiary, properly billed the Appellant after the service date. It was the Appellant's responsibility in to inform that Medicaid was approved for Because did not know that the Appellant obtained Medicaid coverage for continued to bill the Appellant and did not submit a claim to the Medicaid program. When the Appellant informed in that she had Medicaid eligibility for it was too late for to submit a claim to the Department.

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 retroactively to which was within the 12 month billing period window. If the Appellant had informed that she had Medicaid coverage could have billed the Medicaid program. Therefore the Department's 12 month billing exception policy does not apply. The Department may not accept and pay any late claims and may bill the Appellant for the services.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that properly billed the Appellant.

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:

Date Mailed: ______________________

***** 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 Communty 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.