

**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) 373-4147

IN THE MATTER OF:

Docket No. 2014-21309 MSB

██████████

██████████

██████████

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 held on ██████████, ██████████. Appellant appeared and testified on her own behalf. ██████████, Appeals Review Officer, represented the Department of Community Health (Department). Her witness was ██████████, Department Specialist.

ISSUE

Did the Department properly deny Appellant's request for Medicaid coverage for a medical bill from her provider?

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 ██████-year-old Medicaid beneficiary, born ██████████. (Testimony).
2. On D ██████████ Appellant was sent a Notice of Case Action by DHS informing her that her deductible/patient pay amount for the period in ██████████ was ██████████, and that it was met during the period of ██████████ through ██████████. Appellant was further advised, along with the Provider ██████████ that she was responsible for ██████████ for the services she received from the Provider on ██████████ as that was her Medicaid Deductible amount. (Exhibit A, pp. 2, 12-14).
3. On ██████████, ██████████ Appellant received Medicaid eligibility for ██████████ through ██████████. (Exhibit A, pp. 2, 4, 11).

4. On [REDACTED] Appellant submitted a bill to DHS she received from [REDACTED] for services she received on [REDACTED]. (Exhibit A, pp. 2, 4).
5. On [REDACTED] an MSA-1038 Request for Exception to the Twelve-Month Billing Limitation for Medical Services was sent to the DHS Exceptions Units. An exception was denied because eligibility was established before the 12-month limitation period had run, and, therefore, the retroactive determination of eligibility was not an appropriate reason to grant an exception. (Exhibit A, pp. 2, 4, 8, 9, 10).
6. On [REDACTED], Appellant's appeal was received by the Michigan Administrative Hearing System. (Exhibit A, pp. 4-5).

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.

11.1 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 and to the provider specific chapters for additional information about copayments. However, a provider cannot refuse to render service if the beneficiary is unable to pay the required copayment 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. Noncovered services can be purchased by offsetting the nursing facility beneficiary's patient-pay amount. (Note deleted by ALJ).
- 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 noncoverage 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 nonauthorized or noncovered service the beneficiary elects to receive. [*Medicaid Provider Manual, General Information for Providers, §11.1 General Information, October 1, 2013, p. 32*]

12.3 BILLING LIMITATION [CHANGE MADE 10/1/13]

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 "To" or "Through" date indicated on the claim.
- For all other providers, it is the date the service was actually rendered or delivered.

* * *

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 MAHS (**revised 10/1/13**) administrative law judge ordered payment of the claim. [*Medicaid Provider Manual, General Information for Providers, §12.3 Billing Limitation, October 1, 2013, 37, 38, emphasis added, foot note omitted*].

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The Department provided evidence that there had been a request to waive the 12-month billing limitation for the medical bill submitted to DHS on [REDACTED] with a date of service [REDACTED]. The request for the waiver was denied because the Appellant's Medicaid eligibility for the period that included the date of service (DOS), i.e., [REDACTED] through [REDACTED], was retroactively determined on [REDACTED], within the 12-month billing limitation. A bill for the date of service [REDACTED] would still be within the 12-month billing limitation if submitted within approximately nine months after eligibility was determined. Therefore, the retroactive eligibility determination did not meet the criteria for an exception stated above, i.e., Beneficiary eligibility/authorization was established more than 12 months after the DOS.

In addition to the 12-month billing limitation, the bill in question from [REDACTED] in the amount of [REDACTED] was for the Appellant's deductible amount. On [REDACTED], Appellant was sent a Notice of Case Action by DHS informing her that her deductible/patient pay amount for the period in [REDACTED] was [REDACTED], and that it was met during the period of [REDACTED] through [REDACTED]. Appellant was further advised, along with the Provider [REDACTED] that she was responsible for [REDACTED] of the total bill for services for the services she received from the Provider on [REDACTED] as that was her Medicaid Deductible amount.

Appellant testified that she did not understand why she had to pay the [REDACTED]. Appellant stated she believed her Medicaid Deductible amount was [REDACTED]. She indicated the hospital bill in question was obviously more than that so since she met her deductible she should not have to pay anything. She said "her worker" told her she shouldn't have to pay anything for the hospital bill.

According to the policy quoted above from the Medicaid Provider Manual, the 12-month billing limitation would prevent Medicaid from covering the hospital bill submitted on [REDACTED] with a date of service of [REDACTED], since the 12-month billing limitation was exceeded. Furthermore, an exception could not be granted to the 12-month billing limitation where the retroactive eligibility determination did not exceed the 12-month limitation period. In any event, the Appellant and the Provider were both advised that the Appellant was responsible for [REDACTED] of the total bill from the provider for the date of service [REDACTED], because the [REDACTED] was the Appellant's deductible amount that she was personally obligated to pay to the Provider. The amount of the hospital bill would allow the Appellant to meet the eligibility requirement for Medicaid, but it still obligated her to pay her Medicaid deductible amount as her portion of the bill.

Based on the information before it, the Department correctly denied the Appellant's claim on appeal.

DECISION AND ORDER

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

[REDACTED]
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IT IS THEREFORE ORDERED that:

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

William D Bond

William D. Bond
Administrative Law Judge
for James K. Haveman, Director
Michigan Department of Community Health

Date Signed: [REDACTED]

Date Mailed: [REDACTED]

WDB/db

cc: [REDACTED]

***** NOTICE *****

The Michigan Administrative Hearing System 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 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.