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. 14-016346 MSB
Case No. [redacted]

[redacted]

Appellant
_____/

DECISION AND ORDER

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

After due notice, a hearing was held on January 22, 2015. Appellant appeared and testified on her own behalf. [redacted] Appeals Review Officer, represented the Department. Her witness was [redacted] Department Analyst.

ISSUE

Did the Department properly deny the Appellant's complaint regarding a 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 39-year-old Medicaid beneficiary, born [redacted]. (Exhibit A, p 2)

2. On November 13, 2014, Appellant submitted a Beneficiary Complaint to the Department because she received notice from [redacted] that they were attempting to collect an outstanding balance from services rendered on October 13, 2013. (Exhibit A, pp 1-2; Testimony)

3. Appellant had full Medicaid coverage on October 1, 2013, but she was not notified of her approval for Medicaid until August 2014. (Exhibit A, p 8; Testimony)

4. In response to Appellant's complaint, the Department contacted the provider in question, who informed the Department that Appellant never presented her Medicaid information to the provider at the time of service and, therefore, a claim was never submitted to Medicaid. The provider also informed the Department that they had called Appellant and sent her notices regarding her insurance, but never received a response. (Exhibit A, p 3; Testimony)

5. A review of the Medicaid claims database by the Department confirmed that Appellant's provider never submitted a Medicaid claim for the services in question. (Exhibit A, p 5; Testimony)

6. On November 13, 2014, the Department sent Appellant a letter informing her that her provider was unaware of her Medicaid eligibility, providers only have one year to bill Medicaid and, given that the time to bill Medicaid had expired, Appellant would have to resolve the bill with the provider. (Exhibit A, p 4; Testimony)

7. Appellant's appeal was received by the Michigan Administrative Hearing System on December 1, 2014. (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, which providers in pertinent part, the following:

SECTION 11 - BILLING BENEFICIARIES

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. (Refer to the Nursing Facility Chapter for additional 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 is told prior to rendering the service that it is 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.

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SECTION 12 - BILLING REQUIREMENTS

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

12.1 BILLING PROVIDER [CHANGE MADE 7/1/14]

Providers must not bill MDCH for services that have not been completed at the time of the billing. For payment, MDCH requires the provider name and NPI numbers to be reported in any applicable provider loop or field (e.g., attending, billing, ordering, prescribing, referring, rendering, servicing, supervising, etc.) on the claim. It is the responsibility of the attending, ordering, prescribing, referring or supervising provider to share their name, NPI and Michigan Medicaid Program enrollment status 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 residents of the Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) **(revised 7/1/14)** 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

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

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.

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. 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 MAHS 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.

- Providers can determine if an MSA-1038 has been approved/denied by accessing the MSA-1038 status tool or by contacting the DHS caseworker. (Refer to the Directory Appendix, Eligibility Verification, for contact and website information.)

- 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 CHAMPS submission process.

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

Medicaid Provider Manual
General Information for Providers Chapter
October 1, 2014, pp 31-32; 36-38

The Department provided evidence that on November 13, 2014, Appellant submitted a Beneficiary Complaint to the Department because she received notice from [redacted] that they were attempting to collect an outstanding balance from services rendered on October 13, 2013. Appellant had full Medicaid coverage on October 1, 2013, but she was not notified of her approval for Medicaid until August 2014. In response to Appellant's complaint, the Department contacted the provider in question, who informed the Department that Appellant never presented her Medicaid information to the provider at the time of service and, therefore, a claim was never submitted to Medicaid. The provider also informed the Department that they had called Appellant and sent her notices regarding her insurance, but never received a response. A review of the Medicaid claims database by the Department confirmed that Appellant's provider never submitted a Medicaid claim for the services in question. On November 13, 2014, the Department sent Appellant a letter informing her that her provider was unaware of her Medicaid eligibility, providers only have one year to bill Medicaid and, given that the time to bill Medicaid had expired, Appellant would have to resolve the bill with the provider.

Appellant testified that she probably did not provide the ambulance service with her insurance information on the date of service because she was having serious medical issues and was unconscious during the transport to the hospital. Appellant indicated, however, that when the provider called her later regarding her insurance she informed them that she had applied for Medicaid and was awaiting approval. Appellant further indicated that when her Medicaid was finally approved in August 2014, retroactive to October 1, 2013, she called all of her medical providers, including [redacted] and informed them that her Medicaid was now active and that they could submit the bill to Medicaid. Appellant testified that she has no idea why the provider never submitted a bill to Medicaid.

In response, the Department's witness indicated that she sympathized with Appellant's situation, but that there was nothing legally she could do to force providers to submit bills to Medicaid within the one year time limit.

Federal regulations and state policy prohibit payment by Medicaid without a claim. Here, no claim was submitted by the provider in question. Furthermore, because Medicaid providers only have one year to submit claims for services, a claim cannot be submitted at this time. As such, Appellant will have to work out the situation with the provider. However, while doing so, Appellant should point out to the provider that they are only allowed to bill Medicaid beneficiaries for services under very limited circumstances. (See Section 11.1 of the Medicaid Provider Manual, cited above).

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

IT IS THEREFORE ORDERED that:

The Department's decision is AFFIRMED.

Robert J. Meade
Administrative Law Judge
for Nick Lyon, Director
Michigan Department of Community Health

cc: [redacted]

RJM/las

Date Signed: January 23, 2015

Date Mailed: January 23, 2015

***** 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.