STATE OF MICHIGAN
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
FOR THE DEPARTMENT OF COMMUNITY HEALTH
P.O. Box 30763, Lansing, MI 48909
(517) 335-2484; Fax: (517) 373-4147

IN THE MATTER OF:

[redacted]

Docket No. 14-016094 MSB

[redacted]

Appellant.
_____/

DECISION AND ORDER

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

With due notice, a telephone hearing was scheduled for [redacted] on [redacted] However, at that date and time, Appellant requested that the matter be adjourned so that she could submit additional evidence. The Department's representative did not object to any adjournment and the matter was adjourned at Appellant's request.

After due notice, the hearing was held on [redacted] Appellant appeared and testified on her own behalf. [redacted], Appeals Review Officer, represented the Michigan Department of Community Health (DCH or Department). [redacted] Analyst, also testified as a witness for the Department.

ISSUE

Did the Department properly deny Appellant's complaint regarding outstanding medical bills?

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 was a patient with [redacted] office in the years [redacted] and [redacted] (Testimony of Appellant).

2. At the end of [redacted] Appellant has an outstanding debt of [redacted] with that doctor's office. (Testimony of Appellant).

3. Appellant also received medical services from the doctor's office on [redacted]; [redacted]; and [redacted] (Exhibit 2, page 12).

4. At the time of the services in [redacted], Appellant had an unmet Medicaid deductible/spend-down. (Testimony of [redacted]

5. No bills or claims were submitted to the Department with respect to services performed in [redacted] at the time the services were provided. (Testimony of [redacted]).

6. For all three March office visits, the doctor's office billed Appellant a [redacted] copay. (Exhibit 1, page 12).

7. Subsequently, the doctor's office wrote off each [redacted] bill. (Testimony of Appellant).

8. According to Appellant, the bills were written off as a professional courtesy because she previously worked at the doctor's office. (Testimony of Appellant).

9. On [redacted], DHS sent out a Notice of Case Action indicating that Appellant's deductible was met and full Medicaid eligibility was established for the period [redacted] to [redacted]. (Exhibit 1, page 11; Exhibit A, page 5).

10. No bills or claims were submitted to the Department with respect to services performed in [redacted] after Medicaid eligibility was established on [redacted]. (Testimony of [redacted]

11. On or about [redacted], the Department received a Beneficiary Complaint filed by Appellant. (Exhibit A, page 6).

12. In that complaint, Appellant wrote that she received medical services in [redacted] her provider informed her that it tried to bill Medicaid for the services several times, but was denied each time; and the provider has now billed her and submitted the alleged debt to a collections agency. (Exhibit A, page 6).

13. On [redacted] the Department's Problem Resolution Unit sent a written response to Appellant's complaint. (Exhibit A, page 7).

14. In that response, the Department stated in part:

> Thank you for your notice regarding the difficulty you are having with unpaid medical bills. We have investigate the problem with the bill from [redacted] for dates of service [redacted] **&** [redacted].
>
> Regarding your [redacted] services, the provider you went to indicated that they were unaware of your Medicaid eligibility at the time

> the service was provided. The provider was not notified when Medicaid coverage was updated. Because the provider did not accept you as a Medicaid beneficiary at the time the service was provided you will need to resolve the bill with your provider.
>
> Regarding your [redacted] services, as a professional courtesy they have agreed to adjust the balance off.

Exhibit A, page 7

15. On [redacted], the Michigan Administrative Hearing System (MAHS) received the Request for Hearing filed by Appellant in this matter. (Exhibit 1, pages 1-4).

16. In that request, Appellant asserted that the statement that her provider did not know she was on Medicaid is incorrect and that, while some bills were waived, the alleged debt has still been forwarded to a collections agency. (Exhibit 1, pages 1-4).

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 and billing must be completed in accordance with the policies, rules, and procedures as stated in the Medicaid Provider Manual (MPM), which provides, in pertinent parts:

> ### 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.

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, custom-fabricated seating systems) that began, but were not completed, during a period of eligibility. (Refer to the provider-specific chapters of this manual for additional 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.

- 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.

11.2 BENEFICIARY COPAYMENT REQUIREMENTS

Beneficiary copayments may be required for the following Medicaid services:

- Physician office visits (including those provided by podiatrists and nurse practitioners)

* * *

For specific copayment information, refer to the copayment portions of the provider-specific chapters in this manual. A list of current copayments is also available on the MDCH website. (Refer to the Directory Appendix for website information.) Different copayment requirements may apply for beneficiaries enrolled in a Medicaid Health Plan. Contact the appropriate plan for copayment information.

* * *

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

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) 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.)
>
> *MPM, January 1, 2015 version*
> *General Information for Providers Chapter, pages 31-32, 36-38*
> *(Internal footnotes omitted)*

Here, Appellant filed a Beneficiary Complaint with the Department and a Request for Hearing with MAHS in which she asserts that, despite the fact she had Medicaid at the time and the provider accepted her as a Medicaid patient, the Department denied claims for services performed in [redacted] and the provider both billed Appellant and submitted an alleged debt to a collections agency.

Appellant bears the burden of proving by a preponderance of the evidence that the Department erred.

As an initial matter, the undersigned Administrative Law Judge would note that, in light of Appellant's own testimony and documentation, it is not clear that any bills arising from [redacted] services remain in dispute. Appellant testified that she was initially charged copays for [redacted] visits during that month, but that the doctor's office later advised her that the copays were written off as a professional courtesy. Moreover, while Appellant also testified that she was confused at first as to why the billing statement she received from the provider identified an outstanding debt of [redacted] she later confirmed that she had an outstanding debt of [redacted] from services received in [redacted] and that she now knew where the amount billed came from. The billing sheet submitted by Appellant as evidence, while incomplete, also appears to confirm her testimony and demonstrate that no bills from [redacted] remain in dispute.

However, while the exact amount is unclear from her testimony, Appellant also testified that a collections agency is pursuing a debt from her related to the services provided in [redacted] and the mere fact that the provider may have written off some bills does not mean the debt is forgiven or cancelled.

To the extent that Appellant is still being billed, she argues that the billing, as well as the Department's response to her Beneficiary Complaint, is improper as the provider knew that she was a Medicaid beneficiary in [redacted] and it accepted her as a Medicaid patient at that time. As a remedy, Appellant seeks a letter from the Department correcting its previous response, which she plans to show to the Collections Agency.

However, while Appellant asserts that she had full Medicaid eligibility at the time of the services, her own documentation from DHS establishes that her Medicaid eligibility for [redacted] was not established until months later, on [redacted] Moreover, while Appellant also testified that her provider accepted her as a Medicaid beneficiary, the Department's witness credibly testified that no claims or bills have been submitted to the Department with respect to services performed in [redacted]. If Appellant had been accepted as a Medicaid beneficiary and Appellant had notified the provider when her Medicaid coverage was updated, then the provider could have billed the Department after [redacted]. Additionally, as testified to by the Department's witness, given that the Department has not received or denied any claims relating to [redacted], the most it could do in response to the complaint was report its findings to Appellant.

As properly noted in the Department's response to Appellant's Beneficiary Complaint, Appellant's true dispute is with her provider. The policy regarding billing quoted above states that providers may only bill Medicaid beneficiaries in limited situations and it appears that Appellant and her provider dispute whether any of those situations apply here; and, while the Department referenced the provider's position in its letter, the Department itself has not taken any negative actions and the dispute between Appellant

and her provider is therefore outside the scope of this hearing.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, finds that, the Department properly denied Appellant's complaint regarding outstanding medical bills.

IT IS THEREFORE ORDERED THAT:

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

Steven Kibit

Steven Kibit
Administrative Law Judge
for Nick Lyon, Director
Michigan Department of Community Health

Date Signed: [redacted]

Date Mailed: [redacted]

SK/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.