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. 15-002504 REM

[redacted]

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 telephone hearing was held on [redacted] the Appellant's Authorized Hearing Representative appeared on the Appellant's behalf. [redacted], Assistant Attorney General, represented the Department. Her witness was [redacted], Eligibility Quality Assurance Section Manager, Medicaid Services Administration, Michigan Department of Community Health.

ISSUE

Did the Department properly deny the Appellant's request for a DHS 1038 to a medical billing dated [redacted]?

FINDINGS OF FACT

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

1. The Appellant (DOB [redacted]) was a Medicaid beneficiary. (Bridges).

2. On [redacted], The Appellant was notified that his Medicaid eligibility was established retroactively for the periods from [redacted] and [redacted] was also sent notice of the Appellant's retroactive Medicaid eligibility. (Exhibit A, pp. 2, 11, 12, 15 and testimony).

3. On [redacted], a record was created and entered on [redacted] Community Health's Automated Medicaid Processing System, showing the Appellant's retroactive Medicaid eligibility for [redacted]. (Exhibit A, pp. 2, 11 and testimony).

4. On [redacted], [redacted] claims from [redacted] for dates of service in [redacted] were denied because Appellant was not eligible for Medicaid at that time. (Exhibit A, pp. 2, 18 and testimony).

5. On [redacted], a number of medical bills from various providers for dates of service during the month of [redacted] were received and paid by Medicaid shortly after the Appellant's Medicaid eligibility for the month of [redacted] was determined on [redacted]. (Exhibit A, pp. 2, 18 and testimony).

6. On [redacted], the Department received from DHS a completed MSA-1038 from DHS requesting a billing exception for the month of [redacted] The request for the billing exception was denied for the reason that the failure to bill Medicaid timely when eligibility and/or LOC periods existed on the eligibility database before the [redacted] month limitation is not an appropriate reason. (Exhibit A, pp. 2, 9-10 and testimony).

7. On [redacted], a medical bill from [redacted] for a date of service of [redacted] was denied because Appellant was not eligible for Medicaid at that time. (Exhibit A, pp. 2, 18 and testimony).

8. On [redacted], medical bills from [redacted] for dates of service [redacted] were denied as the claim was filed past the timely filing limitation. (Exhibit A, pp. 2, 18 and testimony).

9. The Appellant's request for a hearing was received by the Michigan Administrative Hearing System (MAHS) on [redacted]. (Exhibit A, p. 3).

10. On [redacted] Appellant's Request for Hearing was denied for a lack of venue.

11. On [redacted], after the matter was appealed to [redacted], the parties stipulated to remand the matter to MAHS to determine whether the Appellant was entitled to a hearing, and if so, to hold a hearing limited to the Department's denial of a late billing exception. The parties further stipulated to dismiss the appeal in Circuit Court. On [redacted] County Circuit Judge [redacted] issued an Order pursuant to the stipulation of the parties remanding the matter to MAHS based on the terms agreed to by the parties and dismissed the appeal with prejudice.

12. On [redacted], at the start of the hearing it was determined that the Appellant did have a right to a hearing and according to the Circuit Court Order, a hearing was held in the above captioned matter.

13. On [redacted], during the administrative hearing it was determined that the Appellant had failed to submit any documentary evidence to the administrative

law judge, or the opposing party, before the scheduled hearing date. Appellant's assumption that such documentary evidence would be sent to MAHS by the Circuit Court who remanded the matter for a hearing, did not establish good cause for permitting the Appellant to submit documentary evidence by fax during or after the hearing, pursuant to Mich Admin Code R 792.11006, 2015 MR 1, Eff. [redacted]

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.

The General Information for Providers chapter in the Medicaid Provider Manual states in part:

> **SECTION 12 - BILLING REQUIREMENTS**
>
> All claims must be submitted in accordance with the policies, rules, and procedures as stated in the manual.
>
> * * *
>
> **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 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.)

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 [redacted]-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,* §§ 12 & 12.3, July 1, 2014, pp. 33-35, footnotes deleted and emphasis added].

The Bridges Administrative Manual, (BAM) 402 also contains a provision regarding the twelve month billing exception. BAM 402 states in part:

> **ENROLLED PROVIDER BILLING PROCEDURES (FEE-FOR-SERVICE)**
>
> **MA**
>
> Enrolled providers are aware of the covered and excluded services available to MA beneficiaries. Providers must use MA billing procedures to obtain payment for services performed. Billings should be submitted within 12 months from the date of service.
>
> **Twelve Month Billing Exceptions**
>
> Exceptions to the 12 month billing policy can be made if the delay is caused by agency error or as a result of a court or administrative hearing decision. Agency errors are limited to:
>
> - Delayed Bridges coding, including level of care changes.
> - MRT review.
> - Administrative review.
> - Delayed eligibility determination.
>
> Exceptions cannot be granted due to provider delays in billing or failure of a recipient or provider to obtain prior authorization.
>
> Form MSA-1038, Request for Exception to the Twelve Month Billing Limitation for Medical Services, is an internal document and must be completed by local office staff to begin the exception process. The completed MSA-1038 should be sent to: **1038@michigan.gov**.
>
> A family independence manager, district manager, or other office designee must be copied on the email. A copy of the hearing decision is no longer required; however, the hearing registration number must be indicated on the MSA-1038.
>
> MDCH will notify the specialist within 30 days of the decision. If approved DHS will notify providers to bill Medicaid as usual but to enter in the comments section of the claim, "MSA 1038 approval on file". [BAM 402, p. 10 of 22, 1-1-2015, emphasis added).

The Department provided evidence that the Appellant requested an administrative hearing regarding the denial of a DHS 1038 exception to a billing dated [redacted]. The Appellant alleged that an exception was appropriate because DHS failed to notify the Appellant and

his authorized representative of the approval of benefits to [redacted]. The Department further provided evidence that the Appellant was not eligible for Medicaid for the month of [redacted]. Furthermore, there was no Form MSA-1038, Request for Exception to the [redacted] Month Billing Limitation for Medical Services for the month of [redacted]

The Department presented evidence that on [redacted], the Department received from DHS a completed MSA-1038 from DHS requesting a billing exception for the month of [redacted]. The request for the billing exception was denied for the reason that the failure to bill Medicaid timely when eligibility and/or LOC periods existed on the eligibility database before the [redacted] month limitation is not an appropriate reason. The Department also submitted evidence that on [redacted] it denied payment of medical bills submitted by [redacted] for dates of service [redacted]. These bills were denied as the claims were filed past the timely filing limitation, i.e. they were submitted past the [redacted] month billing limitation period that runs from the date of service.

The Department has established by a preponderance of the evidence that it properly denied the Appellant's request for a billing exception for the month of [redacted] under the *Medicaid Provider Manual*, *General Information for Providers,* § 12.3 and BAM 402.

Based on the information before it, the Department of Community Health acted properly to deny a billing exception for [redacted], and Medicaid payment of the bills submitted past the billing limitation on [redacted]. Under the policy quoted above from both the Medicaid Provider Manual and BAM, an exception cannot be granted when the retroactive eligibility is established within [redacted] months of the date of service as demonstrated in this case. Therefore, the bills submitted in [redacted] for the dates of service [redacted] were properly denied as having been submitted past the [redacted] month billing limitation. Finally, Appellant was not granted retroactive eligibility for Medicaid for the month [redacted] therefore a billing exception could not have been granted for the Month of [redacted] and since the Appellant was not eligible for Medicaid during [redacted] the Department properly denied Medicaid coverage for the medical bills with dates of service in [redacted]

Appellant did not submit any sworn testimony or exhibits during the hearing to establish that he was entitled to a late billing exception. His only argument was that his Authorized Representative and his provider were not notified of the establishment of his retroactive eligibility for Medicaid. However, there was no actual proof that the Appellant had an Authorized Representative at the time he was granted retroactive eligibility. Furthermore, the Appellant himself was sent actual notice of his retroactive determination of eligibility. Finally, the provider whose bills were denied as having been submitted past the [redacted] month filing limitation, [redacted], also submitted at least [redacted] timely bills on [redacted] within the [redacted] month filing limitation showing that they were aware of the retroactive determination of the Appellant's eligibility for Medicaid. Based upon the preponderance of the evidence submitted in this case, I find the Department acted properly in denying a late billing exception in this case and further that it properly denied payment for the bills submitted past the [redacted] month filing limitation.

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 request for a DHS 1038 to a medical billing dated [redacted]

IT IS THEREFORE ORDERED that:

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

William D Bond

William D. Bond
Administrative Law Judge
for Nick Lyon, 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.