15-016630STATE OF MICHIGAN
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
FOR THE DEPARTMENT OF HEALTH AND HUMAN SERVICES
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IN THE MATTER OF:

[redacted],

Docket No. 15-016630 MSB
Case No. [redacted]

Appellant.
_____/

DECISION AND ORDER

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

After due notice, a telephone hearing was held on [redacted]. [redacted], Appeals Specialist with [redacted], non-attorney representative, appeared and testified on Appellant's behalf. [redacted] Appeals Review Officer, represented the Michigan Department of Health and Human Services (DHHS or Department). [redacted], Analyst, testified as a witness for the Department.

ISSUE

Did the Department properly deny a request for an exception to the twelve-month billing limitation for medical services?

FINDINGS OF FACT

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

1. Sometime in [redacted], or [redacted], for an unknown reason that is not at issue in this appeal, Appellant's MA closed. At that time, the Department re-opened Appellant's MA and assigned her an incorrect ID # ending in [redacted] and an incorrect case number due to an administrative error.

2. In [redacted], Appellant filed an application for MA. Appellant's representative checked the department's data base system at that time, searching by Appellant's social security number and date of birth. The State of Michigan data base system indicated that Appellant did not have Medicaid coverage. (Exhibit I.3).

3. On [redacted] the Department issued a notice of health care coverage

determination informing Appellant that she "is eligible for MA for [redacted] ongoing". The [redacted] notice contains the incorrect ID #. (Exhibit A.11).

4. On [redacted] Appellant was issued a new Medicaid ID card with an incorrect ID #. (Exhibit A.6).

5. In [redacted], Appellant was issued notice with the correct MA ID #. (Department Testimony).

6. Due to the errors, Appellant's social security and ID numbers were "merged and split" (Department Testimony) causing the data base to indicate that Appellant did not have Medicaid coverage. (Department Testimony).

7. The Department failed to timely process Appellant's [redacted] MA application. In response, Appellant filed a hearing request. The Department did not communicate with Appellant's representative until [redacted] and at that time Appellant was informed for the first time by the DHS worker in writing that Appellant actually had a duplicate ID # and that there was in fact active MA coverage showing in Bridges for [redacted] ongoing as of the [redacted] date. (Exhibit I.3).

8. On [redacted] Appellant filed an MSA 1038 for a Medical bill exception to the twelve month billing limitation for medical services for the dates of [redacted]. (Exhibit A.7).

9. On [redacted] the department denied the MSA 1038 for the reason that the exception criteria was not met due to the beneficiary was "issued notice on [redacted] regarding eligibility from [redacted]-ongoing" and that the error was corrected and "eligibility was established more than 12 months after the DOS." (Exhibit I.3; Department Testimony).

10. On [redacted] Appellant filed a hearing request. (Exhibit I.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 requests or claims through Medicaid must be submitted in accordance with the policies, rules, and procedures as stated in the Medicaid Provider Manual (MPM) and, in the pertinent part, the MPM states:

SECTION 12 - BILLING REQUIREMENTS [CHANGE MADE 4/1/15]

All claims must be submitted in accordance with the policies, rules, and procedures as stated in the manual and in compliance with applicable coding guidelines and conventions. **(text added 4/1/15)**

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 MDHHS 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, MDHHS 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 MDHHS staff;
  - MDHHS staff failed to enter (or entered erroneous) authorization, level of care, or restriction in the system;
  - The MDHHS contractor issued an erroneous PA; and
  - Other administrative errors by MDHHS 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 MDHHS office to initiate the following exception process:
>
> - The MDHHS caseworker completes and submits the Request for Exception to the Twelve-Month Billing Limitation for Medical Services form (MSA-1038) to MDHHS.
> - Providers can determine if an MSA-1038 has been approved/denied by accessing the MSA-1038 status tool or by contacting the MDHHS 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 MDHHS 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 MDHHS website for additional CHAMPS-related information. Questions regarding claims submitted under this exception should be directed to MDHHS Provider Inquiry. (Refer to the Directory Appendix for contact and website information.)
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> *MPM, October 1, 2015 version,*
> *General Information for Providers Chapter, pages 37-38*

Unrefuted evidence here is that the Department erred in assigning Appellant an incorrect ID #, and an incorrect case number. Also unrefuted is that the department data base did not show MA eligibility. The department argues that this administrative error was corrected in [redacted] and thus, the correction took place within the 12 month DOS billing period which was the basis for the exception denial. Appellant argues, that evidence shows that it was not corrected as of [redacted], and in fact, there is no

evidence that it was corrected until Appellant was informed in [redacted] by the DHS case worker, in writing.

After a careful review of the credible and substantial evidence, this ALJ finds that the error by the department falls under the administrative error criteria allowing for the exception request to be granted for the reasons set forth below.

First, evidence shows that the department issued, in error, an incorrect ID # and incorrect case number in [redacted], or earlier. However, the department contends that the error was corrected and Appellant was informed of the same by way of the [redacted] notice titled "Health Care Coverage Determination Notice" found on Exhibit A.11. However, an examination of this notice shows that while it does indicate eligibility for [redacted]-onging", it contains Appellant's incorrect ID number.

Appellant argues that the error was not corrected in [redacted]. Appellant argues that as late as [redacted], the State of Michigan data base system did not show that Appellant had Medicaid. In response, the Department argued that the incorrect ID and incorrect case number were nominal errors as Appellant's status could have been searched by other methods, including social security number, date of birth. However, Appellant's representative testified that he did in fact search by social security number and date of birth in [redacted] and the data based showed no MA eligibility. In response, the Department argued that he knows that what must have happened is that the DHS worker "merged and split" the social security number and ID numbers which is the reason that no eligibility was shown.

The Department's reasoning is at best circular. If the initial error caused another error that resulted in the system showing no eligibility at a later date, then the department or administrative error is continuing. And in fact, despite the Department's hearing summary statement that the ID was correctly changed "later" (Exhibit A.6), testimony by the Department was that it did not issue corrected notice to Appellant until sometime in [redacted]. Moreover, any action taken by an employee of the Department, whether DHS or Central Office, is an action by the Department. The Department cannot prevail by arguing that an employee in a different division made an error by merging and splitting numbers.

The MPM exception process is set up to allow for exceptions where "the MDHHS staff failed to enter (or entered erroneous) authorization, level of care, or restriction in the system"…and "other administrative errors by MDHHS or its contractors that can be documented." The facts here are that the MDHHS entered an erroneous ID # and erroneous case number into the system. The facts further show that as of [redacted], this was not corrected.

Appellant has met his burden of proof by a preponderance of evidence. The Department failed to rebut the error with credible and substantial evidence, and thus, the action cannot be upheld.

It is noted that the Department the DHS case worker who has personal knowledge of this case was not present at the administrative hearing for administrative hearing for testimony and/or cross-examination.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, finds that, the Department improperly denied an Appellant's request for an exception to the twelve-month billing limitation for medical services.

IT IS THEREFORE ORDERED THAT:

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

Janice G Spodarek
Administrative Law Judge
for Nick Lyon, Director
Michigan Department of Health and Human Services

Date Signed: [redacted]

Date Mailed: [redacted]

JS/cg

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.