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:

Docket No. 15-010646 MSB

[redacted] [redacted] [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.

After due notice, a 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, 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. On [redacted] the Appellant received medical services from [redacted] (Exhibit A, pp 6-9; Testimony)

2. As of [redacted] at the time medical services were rendered, the Appellant had a Medicaid spendown that was not met. (Testimony)

3. On [redacted] the Department of Human Services sent the Appellant a notice of case action. The notice indicated the Appellant had met her Medicaid spendown and was now eligible for Medicaid effective [redacted] and continuing until [redacted]. (Exhibit A, p 12; Testimony)

4. On [redacted], the Appellant sent the Department a Beneficiary Complaint regarding unpaid medical bills from the medical services provided to her on [redacted]. (Exhibit A, p 13; Testimony)

5. On [redacted], the Department contacted [redacted] and was informed that at the time services were rendered the Appellant had an unmet spendown; had sent the Appellant a follow up letter; and that they were never informed by the Petitioner that she had met her spendown and was eligible for Medicaid for the time period in which services were rendered. (Exhibit A, p 3, 14; Testimony)

6. On [redacted], the Department sent the Appellant a letter. The letter stated in part:

> The bills you sent to Medicaid were incurred during a time your eligibility shows a Medicaid spendown. A beneficiary must incur medical expenses each month equal to, or in excess of, an amount determined by your local DHS worker to qualify for Medicaid. It has been determined you did meet your spendown for the date of service listed above. It is up to you to inform your providers the spendown has been met so they can submit their claims to Medicaid for payment. The provider listed above stated they were aware of your spendown, but were never informed it had been met. Providers have only one year from the date of service to bill Medicaid. The time limitation has expired. You are responsible for the above date of service. (Exhibit A, p 14)

7. At no point in time between [redacted] and [redacted] did [redacted] bill Medicaid for the services rendered to the Appellant on [redacted]. (Testimony)

8. On [redacted] the Michigan Administrative Hearing System (MAHS) received the request for hearing filed in this matter. (Exhibit A, p 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 must be submitted in accordance with the policies, rules, and procedures as stated in the Medicaid Provider Manual (MPM), which provides, in pertinent parts:

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 36-38
(Internal footnotes omitted)

Here, the Department witness testified that Appellant submitted a Beneficiary Complaint to the Department requesting that the Department pay for medical bills incurred on [redacted] The Department witness also testified that, in response to the complaint, the Department reviewed the complaint and found no evidence that the [redacted] had accepted Appellant as a Medicaid beneficiary at the time the service was provided and that, even if it had, no claims or bills were ever submitted to Medicaid by that provider.

In response, Appellant testified she didn't think she had to contact [redacted] and notify them that she was Medicaid eligible for the date in question as she assumed the Department had sent [redacted] a letter informing them of Medicaid eligibility.

However, even accepting Appellant's testimony as true, federal regulations and state policy prohibit payment by Medicaid without a claim and, in this case, the provider has never billed Medicaid for services provided during the applicable time period. Accordingly, whatever issues remain between the Appellant and her medical provider regarding the ultimate responsibility between them for the bills, the Department's decision must be affirmed.

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**.

Corey A. Arendt
Administrative Law Judge
for Nick Lyon, Director
Michigan Department of Community Health

Date Signed: [redacted]

Date Mailed: [redacted]

CAA/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.