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

IN THE MATTER OF:

Docket No. 15-014459 MSB

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 a non-attorney representative with appeared and testified on Appellant's behalf. Appeals Review Officer, represented the Michigan Department of Health and Human Services (DHHS or Department). Analyst, testified as a witness for the Department.

ISSUE

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

FINDINGS OF FACT

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

1. Between through Appellant was hospitalized at (Exhibit A, page 18).

2. On those dates of service, Appellant's Medicaid coverage was inactive. (Testimony of Appellant's representative; Testimony of Department's analyst).

3. In Appellant was retroactively approved for full Medicaid coverage for all of (Exhibit A, pages 12-13).

4. On the Department sent Appellant written notice of that approval. (Exhibit 1, page 10; Exhibit A, page 12).

5. In [redacted], the medical provider billed Medicaid for Appellant's entire inpatient hospitalization, including dates of service in [redacted]. (Exhibit A, page 16; Testimony of Appellant's representative; Testimony of Department's analyst).

6. The claim was subsequently denied on the basis that Appellant did not have Medicaid eligibility on all of the dates of services encompassed by the claim and because some additional, required documentation was not submitted. (Exhibit A, page 17; Testimony of Department's analyst).

7. In [redacted] Appellant was retroactively approved for full Medicaid coverage for all of [redacted] and [redacted] (Exhibit A, page 14).

8. On [redacted] the Department sent Appellant written notice of that approval. (Exhibit 1, page 12).

9. The Department also approved a request for an exception to the t[redacted]-month billing limitation for medical services provided in [redacted] and [redacted] (Exhibit A, page 15).

10. The medical provider then billed Medicaid multiple times for Appellant's entire inpatient hospitalization, including dates of service in [redacted] and [redacted] but the claims were all denied. (Exhibit A, pages 18-19).

11. In [redacted] the medical provider billed Medicaid for only the dates of services in [redacted] and the claim was paid. (Exhibit A, page 20).

12. In [redacted] Appellant, through his representative's organization, requested that his Medicaid worker submit another exception request on his behalf, this time for services provided in [redacted] (Exhibit 1, pages 1, 4-5).

13. Subsequently, another request for exception to the [redacted]-month billing limitation was submitted on Appellant's behalf. (Exhibit 1, page 12; Exhibit A, page 8).

14. That exception request was for services provided in [redacted] and it asserted that there had been an administrative error because of a delayed eligibility determination and a failure of a previous worker to send in an exception request when Appellant's initial eligibility was determined and the medical bills submitted. (Exhibit 1, page 12; Exhibit A, page 8).

15. On or about [redacted] that exception request was denied. (Exhibit 1, page 12; Exhibit A, page 8).

16. The exception request was denied on the basis that a failure to bill Medicaid timely when eligibility existed on the eligibility database before the [redacted]-month limitation expired is not an appropriate reason for an exception and, in this case, Appellant was sent a notice of eligibility on [redacted] regarding his Medicaid eligibility for [redacted]. (Exhibit 1, pages 13-15).

17. On [redacted], the Michigan Administrative Hearing System (MAHS) received the request for hearing filed in this matter with respect to that denial. (Exhibit 1, pages 25-26; Exhibit A, pages 4-5).

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.)

MPM, October 1, 2015 version,
General Information for Providers Chapter, pages 37-38

Here, the Department denied a request for an exception to the -month billing limitation for medical services provided to Appellant in According to the Department's witness, the request was denied because Appellant was approved for full Medicaid coverage in which was less than months from the dates of service in and there was sufficient time for Medicaid to be billed within the required month period. He also testified that there was no administrative error that would justify an exception.

Appellant has appealed that denial and, in doing so, bears the burden of providing by a preponderance of the evidence that the Department erred in denying the exception request.

Given the record in this case, Appellant has failed to meet that burden of proof and the Department's decision must therefore be affirmed. The above policy identifies the limited grounds upon which an exception to the billing limitation policy may be granted, but none of those grounds apply in this case.

For example, while exceptions may be made where a Department administrative error occurred, Appellant's representative failed to identify any administrative error by Department staff or its contractors. The representative does assert that the Medicaid worker erred by not requesting an exception for the services in at the same time she requested an exception for the services in and but the timing of the exception request made no difference in the decision to deny it and the Department's decision on the request for an exception for would have been the same if it was made earlier. Similarly, while Appellant's representative appears to argue that the Department erred in completely denying the claim submitted in for Appellant's entire inpatient hospitalization, which including dates of

service in and that it should have instead separated the months identified in the claim and approved payment for services provided in , as Medicaid coverage had already been approved for that month. However, she offers no basis in policy for the Department doing so rather than acting on the entire claim that was submitted.

The above policy also provides that an exception to the billing limitation policy may also been approved where a Medicaid beneficiary eligibility/authorization was established retroactively; the beneficiary eligibility/authorization was established more than months after the date(s) of service; and the provider submitted the initial invoice within months of the establishment of beneficiary eligibility/authorization. However, while Appellant's Medicaid eligibility for was established retroactively, it was not established more than months after the dates of service at issue in this case and therefore did not meet all the criteria for an exception.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, finds that, the Department properly denied a request for an exception to the month billing limitation for medical services provided in .

IT IS THEREFORE ORDERED THAT:

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

Steven Kibit
Administrative Law Judge
for Nick Lyon, Director
Michigan Department of Health and Human Services

Date Signed:
Date Mailed:
SK/db
cc:

***** 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.