STATE OF MICHIGAN
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
FOR THE DEPARTMENT OF HEALTH AND HUMAN SERVICES
P.O. Box 30763, Lansing, MI 48909
(877) 833-0870; Fax: (517) 373-4147

IN THE MATTER OF:

Docket No. 15-016792 MSB

[redacted] [redacted] [redacted]

Appellant
_____/

DECISION AND ORDER

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

After due notice, a hearing was held on [redacted]. Appellant appeared on his own behalf. [redacted] Appeals Review Officer, represented the Department. [redacted], Departmental Analyst, appeared as a witness for the Department.

ISSUE

Did the Department properly deny Appellant's request for reimbursement for a medical bill?

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 or around [redacted], the Appellant requested Medicaid. (Exhibit A, pp 4, 8; Testimony)

2. On [redacted] the Appellant received medical services at [redacted]). (Exhibit A, pp 4, 6; Testimony)

3. On [redacted] the Appellant was approved for Medicaid with a retroactive date of [redacted] (Exhibit A, pp 4, 8, 9; Testimony)

4. On or around [redacted], the Appellant received a medical bill from [redacted] for the services provided on [redacted]. (Exhibit A, p 6)

5. On [redacted], the Appellant sent the Department a beneficiary complaint form regarding the unpaid [redacted] medical bill. (Exhibit A, pp 4, 5; Testimony)

6. On [redacted], the Department sent the Appellant a letter indicating an investigation into the unpaid bill indicated the Appellant was not accepted a s a Medicaid patient and as a result the Appellant must resolve the bill with [redacted]. (Exhibit A, pp 4, 7; Testimony)

7. On [redacted], the Michigan Administrative Hearings System (MAHS) received from the Appellant a request for hearing. (Exhibit A, p 3)

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 Department policy on billing requirements states:

> **SECTION 12.1 – BILLING PROVIDER**
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> Providers must not bill MDHHS for services that have not been completed at the time of the billing. For payment, MDHHS 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.
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> **SECTION 12.3 – BILLING INFORMATION**
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> Each claim received by MDHHS 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 MDHHS 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.)

Medicaid Provider Manual
General Information for Providers, October 1, 2015, pp 36-38.

* * *

The Department's witness testified the Department had not taken any inappropriate and or negative action as the Department was never billed by [redacted] for services performed on [redacted] and consequently they did not deny any claims; and additionally there was no evidence that [redacted] ever accepted the Appellant as a Medicaid patient.

The Appellant did not offer any proof to indicate [redacted] accepted him as a Medicaid patient or any evidence to indicate [redacted] billed the Department within the applicable [redacted] month period for the services rendered on [redacted].

Based upon the facts presented and the aforementioned policy, I find the Appellant failed to meet his burden of proof. There does not appear to be any negative action taken by the Department as there is no evidence [redacted] ever billed the Department for the services rendered on [redacted] and there is no evidence [redacted] ever accepted the Appellant as a Medicaid patient. As a result, I have no choice but to affirm the Department's actions.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, finds that the Department properly denied the Appellant's request for reimbursement for a medical bill.

IT IS THEREFORE ORDERED THAT:

The Department's decision is AFFIRMED.

Corey Arendt
Administrative Law Judge
for Director, Nick Lyon
Michigan Department of Health and Human Services

Date Mailed: [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.