RICK SNYDER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
Christopher Seppanen
Executive Director

MIKE ZIMMER
DIRECTOR

[redacted]

Date Mailed: April 19, 2016
MAHS Docket No.: 16-002335
Agency No.: [redacted]
Petitioner: [redacted]

ADMINISTRATIVE LAW JUDGE: Landis Lain

DECISION AND ORDER

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

After due notice, a hearing was held on [redacted]. Petitioner appeared on behalf of the Petitioner. [redacted], [redacted] Language Translator, appeared to translate for Petitioner. [redacted], Appeals Review Officer and [redacted], Department Analyst, appeared to testify on behalf of the Department of Health and human Services (Department or Respondent or State), represented the Department.

State's Exhibit A pages 1-12 were admitted as evidence.

ISSUE

Did the Department properly deny Petitioner's complaint regarding a medical bill that her provider submitted to a collection agency?

FINDINGS OF FACT

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

1. Petitioner is a Medicaid beneficiary.

2. In [redacted], a Health Care Coverage Determination Notice was sent to petitioner informing her of medical coverage effective [redacted]. (State's Exhibit A page 9)

3. On [redacted], the Department's Problem Resolution Unit received a Beneficiary Complaint Form along with a collection letter from [redacted], Inc., from Petitioner.

4. On [redacted], the Problem Resolution Unit sent Petitioner a notice stating that they needed additional information and informing Petitioner to notify the provider of her Medicaid Coverage, and to ask the Provider to bill Medicaid for the services provided. (State's Exhibit A page 8)

5. On [redacted], Petitioner filed a request for a hearing due to unpaid medical bills she is being held responsible for during the month of [redacted] in the amount of $[redacted]. (State's Exhibit A page 3)

6. On [redacted], Medical Services Administration received the Request for Hearing regarding the outstanding bill from Bronson Battle Creek Health system that is being held by a collections agency, Medicredit, Inc.

CONCLUSIONS OF LAW

The Medical Assistance Program (MA) 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.

Providers cannot bill beneficiaries for services except in the following situations:

- A co-payment for chiropractic, dental, hearing aid, pharmacy, podiatric, or vision services is required. However, a provider cannot refuse to render service if the beneficiary is unable to pay the required co-payment on the date of service.
- A monthly patient-pay amount for inpatient hospital or nursing facility services. The local DHHS determines the patient-pay amount. Non-covered services can be purchased by offsetting the nursing facility beneficiary's patient-pay amount. (Refer to the Nursing Facility Chapter for more information.)
- For nursing facility (NF), state-owned and -operated facilities or CMHSP-operated facilities determine a financial liability or ability-to-pay amount separate from the DHHS patient-pay amount. The state-owned and -operated facilities or CMHSP-operated facilities liability may be an individual, spouse, or parental responsibility.

This responsibility is determined at initiation of services and is reviewed periodically. The beneficiary or his authorized representative is responsible for the state-owned and -operated facilities or CMHSP ability to pay amount, even if the patient-pay amount is greater.

- The provider has been notified by DHHS that the beneficiary has an obligation to pay for part of, or all of, a service because services were applied to the beneficiary's Medicaid deductible amount.
- If the beneficiary is enrolled in a MHP and the health plan did not authorize a service, and the beneficiary had prior knowledge that he was liable for the service. (It is the provider's responsibility to determine eligibility/enrollment status of each beneficiary at the time of treatment and to obtain the appropriate authorization for payment. Failure of the provider to obtain authorization does not create a payment liability for the beneficiary.)
- Medicaid does not cover the service. If the beneficiary requests a service not covered by Medicaid, the provider may charge the beneficiary for the service if the beneficiary has been told prior to rendering the service that it was not covered by Medicaid. If the beneficiary is not informed of Medicaid non-coverage until after the services have been rendered; the provider cannot bill the beneficiary.
- The beneficiary refuses Medicare Part A or B.
- Beneficiaries may be billed the amount other insurance paid to the policyholder if the beneficiary is the policyholder.
- The beneficiary is the policyholder of the other insurance and the beneficiary did not follow the rules of the other insurance (e.g., utilizing network providers).

- The provider chooses not to accept the beneficiary as a Medicaid beneficiary and the beneficiary had prior knowledge of the situation. The beneficiary is responsible for payment.

Medicaid Provider Manual, (MPM), §11.1, General Information for Providers Section, January 1, 2016, pp 28-29

It is recommended that providers obtain the beneficiary's written acknowledgement of payment responsibility prior to rendering any non-authorized or non-covered service the beneficiary elects to receive.

Some services are rendered over a period of time (e.g., maternity care). Since Medicaid does not normally cover services when a beneficiary is not eligible for Medicaid, the provider is encouraged to advise the beneficiary prior to the onset of services that the beneficiary is responsible for any services rendered during any periods of ineligibility. Exceptions to this policy are services/equipment (e.g., root canal therapy, dentures, customized seating systems) that began, but were not completed, during a period of eligibility. (Refer to the provider-specific chapters of this manual for more information regarding exceptions.)

When a provider accepts a patient as a Medicaid beneficiary, the beneficiary cannot be billed for:

- Medicaid-covered services. Providers must inform the beneficiary before the service is provided if Medicaid does not cover the service.
- Medicaid-covered services for which the provider has been denied payment because of improper billing, failure to obtain PA, or the claim is over one year old and has never been billed to Medicaid, etc.
- The difference between the provider's charge and the Medicaid payment for a service or for missed appointments.
- Copying of medical records for the purpose of supplying them to another health care provider

If a provider is not enrolled in Medicaid, they do not have to follow Medicaid guidelines about reimbursement, even if the beneficiary has Medicare as primary. If a Medicaid-only beneficiary understands that a provider is not accepting him as a Medicaid patient and asks to be private pay, the provider may charge the beneficiary its usual and customary charges for services rendered. The beneficiary must be advised prior to services being rendered that his **mihealth** card is not accepted and that he is responsible for payment. It is recommended that the provider obtain the beneficiary's acknowledgement of payment responsibility in writing for the specific services to be provided.

Medicaid Provider Manual, (MPM), §11.1, General Information for Providers Section, January 1, 2016, pp 28-29

All claims must be submitted in accordance with the policies, rules, and procedures as stated in the manual.

Each claim received by MDHHS receives a unique identifier called a Claim Reference Number (CRN). This is a ten-digit number found in the Remittance Advice (RA) that indicates the date the claim was entered into the MDHHS Claims Processing (CP)

System. The CRN is used when determining active review of a claim. (Refer to the Billing & Reimbursement Chapters for more information.) A claim must be initially received and acknowledged (i.e., assigned a CRN) by MDHHS within twelve months from the date of service (DOS). DOS has several meanings:

- For inpatient hospitals, nursing facilities, and MHPs, it is the "From" 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. 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 twelve 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 ID 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 CRN 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 on the system;
  - 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 twelve 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 MDHHS 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 DHHS office to initiate the following exception process:

- The DHHS caseworker completes and submits the Request for Exception to the Twelve-Month Billing Limitation for Medical Services form (MSA-1038) to MDHHS.
- DHHS informs the provider when the MSA-1038 has been approved by MDHHS.
- 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 submission process.

Refer to the Billing & Reimbursement chapters of this manual for additional information on claim submission. Questions regarding claims submitted under this exception should be directed to MDHHS Provider Inquiry. (Refer to the Directory Appendix for contact information.)

Medicaid Provider Manual, (MPM), §12, Billing Requirements for Providers Section, January 1, 2016

MPM, 11.1, page 31, explicitly states that Medicaid-covered services for which the provider has been denied payment because of improper billing, failure to obtain PA, or

the claim is over one year old and has never been billed to Medicaid. Federal regulations and state policy prohibit payment by Medicaid without a claim.

Here, the Provider did not submit the medical bills to Medicaid. Petitioner had primary commercial insurance through [redacted]. She was diagnosed with breast cancer and could not work so her insurance lapsed. She received Medicaid retroactively to the relevant date of service. Medicaid is the payer of last resort. The evidence on the record indicates that the provider was not informed of Petitioner's Medicaid information at the time of service. Medicaid was approved retroactively to the date of service. Therefore, they did not accept Petitioner as a Medicaid recipient at the time of service. Moreover, the Provider did not bill Medicaid. No claims have been submitted by the provider to Medicaid for services provided to Petitioner. Furthermore, because Medicaid providers only have one year to submit claims for services, a claim cannot be submitted at this time. As such, Medicaid is not responsible for the expenses related to the date of service of [redacted].

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the denial of payment to the Provider for Medicaid covered services was appropriate under the circumstances.

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

LL/[redacted]

Landis Lain
Administrative Law Judge
for Nick Lyon, Director
Department of Health and Human Services

NOTICE OF APPEAL: A party may appeal this Order in circuit court within 30 days of the receipt date. A copy of the circuit court appeal must be filed with the Michigan Administrative Hearing System (MAHS).

A party may request a rehearing or reconsideration of this Order if the request is received by MAHS within 30 days of the date the Order was issued. The party requesting a rehearing or reconsideration must provide the specific reasons for the request. MAHS will not review any response to a request for rehearing/reconsideration.

A written request may be mailed or faxed to MAHS. If submitted by fax, the written request must be faxed to (517) 335-6088; Attention: MAHS Rehearing/Reconsideration Request.

If submitted by mail, the written request must be addressed as follows:

Michigan Administrative Hearings
Reconsideration/Rehearing Request
P.O. Box 30763
Lansing, Michigan 48909-8139

DHHS -Dept Contact [redacted]

Petitioner [redacted]

DHHS Department Rep. [redacted]