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

RICK SNYDER
GOVERNOR

SHELLY EDGERTON
DIRECTOR

[redacted]

[redacted]
MAHS Docket No.: 15-025851
[redacted]

ADMINISTRATIVE LAW JUDGE: Steven Kibit

DECISION AND ORDER

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

The request for hearing filed on Petitioner's behalf by his son/designated power of attorney in this case was originally comingled with a request for hearing filed by Petitioner's son on his own behalf in another case. During a hearing in that other case, it was determined that there were two separate hearing requests submitted and the undersigned Administrative Law Judge therefore ordered that Petitioner's case would be docketed as a separate matter and scheduled for hearing, with notice provided to the parties in accordance with applicable law and policy.

After due notice, an in-person hearing was held on [redacted]., Petitioner's son and designated power of attorney, appeared and testified on Petitioner's behalf. [redacted], Petitioner's daughter-in-law, also testified as a witness for Petitioner. [redacted], Appeals Review Officer, represented the Respondent Department of Health and Human Services (DHHS or Department). [redacted] Department Analyst, testified as a witness for the Respondent.

ISSUE

Did the Department properly deny Petitioner'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. Petitioner received medical services from a variety of medical providers during the months of [redacted] in the year [redacted] and the month of J[redacted] in the year[redacted] (Exhibit A, pages 5-22).

2. During [redacted], Petitioner did not have Medicaid coverage. (Exhibit A, page 23).

3. During the remaining months, Petitioner had Medicaid coverage, but did not inform his medical providers of his Medicaid coverage. (Exhibit A, page 23; Testimony of Department's witness).

4. None of the medical providers submitted any claims to Medicaid. (Testimony of Petitioner's representative; Testimony of Department's witness).

5. The medical providers did send bills to Petitioner and, when the bills were not paid, some referred Petitioner's debt to collection agencies. (Exhibit A, pages 5-22).

6. The Michigan Administrative Hearing System (MAHS) received the request for hearing filed in this matter on Petitioner's behalf.

7. After receiving copies of the bills submitted by Petitioner's representative, the Department investigated the bills and contacted the providers, who all either indicated that Petitioner's unpaid balance had already been adjusted to zero or that they would bill Medicaid. (Testimony of Department's witness).

8. The Department also attempted to contact the identified collection agencies, but the agencies would not release any information to the Department due to privacy concerns. (Testimony of Department's witness).

9. The Department further contacted Petitioner's representative in an attempt to get his assistance with the collection agencies and sent Petitioner a letter describing its inability to obtain any information from the collection agencies, while also advising him to inform the collection agencies of his Medicaid coverage. (Exhibit A, page 25; Testimony of Department's witness).

10. Petitioner's representative subsequently brought further information regarding the collection agency actions and new bills to the hearing in this matter. (Testimony of Petitioner's representative).

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's witness testified that Petitioner submitted a number of bills and notices of action from collection agencies to the Department, while also requesting that the Department pay the bills. The Department's witness further testified that, in response, it investigated the bills and found that either Petitioner did not have Medicaid on the date of service or the medical providers had never accepted Petitioner as a Medicaid beneficiary at the time the service was provided, and that, even if the providers had accepted Petitioner as a Medicaid beneficiary, no claims or bills were ever submitted to Medicaid by any of the providers. The Department's witness also indicated that, during conversations with the providers, the providers either indicated that Petitioner's unpaid balance had already been adjusted to zero or that they would bill Medicaid

In response, Petitioner's representative and witness did not dispute any of the Department's witness' testimony and they also agreed that no claims or bills had ever been submitted to Medicaid. Petitioner's representative and witness did bring further information regarding the collection agency actions and new bills to the hearing in this matter and requested further assistance from the Department.

However, while the Department may have been able to assist Petitioner through its investigation, this case will not remain open while Petitioner keeps submitting new bills or information as the undersigned Administrative Law Judge is limited to reviewing the Department's past actions. Moreover, given that federal regulations and state policy prohibit payment by Medicaid without a claim and it is undisputed in this case that the providers have never billed Medicaid for services provided during the applicable time periods, the Department's actions were clearly proper. Accordingly, whatever issues remain between the Petitioner and his medical providers regarding the ultimate responsibility between them for the bills, the Department's actions 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 Petitioner's complaint regarding outstanding medical bills.

IT IS THEREFORE ORDERED THAT:

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

Steven Kibit

SK/db

Steven Kibit
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

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]