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Date Mailed: June 22, 2020
MOAHR Docket No.: 20-002549
Agency No.: [redacted]
Petitioner: [redacted]

ADMINISTRATIVE LAW JUDGE: Corey Arendt

DECISION AND ORDER

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

After due notice, a hearing was held on June 17, 2020. Petitioner appeared on her own behalf and offered testimony. Theresa Root, Appeals Review Officer, represented Respondent, Michigan Department of Health and Human Services (MDHHS or Department). Edward Kincaid, Department Analyst, appeared as a witness for the Department.

Exhibits:

Petitioner	1. Additional medical bills
Department	A. Hearing Summary

ISSUE

Did the Department properly handle Petitioner's complaint regarding 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 is a Medicaid and Medicare beneficiary. (Testimony.)

2. Prior to April 14, 2020, Petitioner submitted medical bills to the Department for payment consideration. (Testimony.)

3. The medical bills provided were for service dates in November 2018 ([redacted] in [redacted] Tennessee) and for bills from August 2019 through approximately April 14, 2020. (Exhibit A; Testimony.)

4. In November 2018, Petitioner received inpatient treatment at [redacted], Tennessee. At all times relevant to this proceeding, [redacted] has not been a Michigan Medicaid enrolled provider. (Testimony.)

5. In November 2018, Petitioner had full Medicaid. (Testimony.)

6. In August 2019, Petitioner went from full Medicaid to Medicaid with a spenddown. (Testimony.)

7. At all times relevant to this proceeding and as it applies to the bills provided for the time period of August 2019 through April 14, 2020, Petitioner had an unmet spenddown. (Testimony.)

8. On April 29, 2020, the Michigan Office of Administrative Hearings and Rules, received from Petitioner, a request for hearing concerning the unpaid medical bills. (Exhibit A, p 8.)

9. After April 29, 2020, Petitioner submitted additional medical bills from the time period of April 29, 2020 through June 2, 2020. (Exhibit 1; Testimony.)

10. At all times relevant to this proceeding and as it applies to the bills provided for the time period of April 29, 2020 through June 2, 2020, Petitioner has had an unmet spenddown. (Testimony.)

11. Medicare has paid on some of the bills in question. (Testimony.)

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, which providers in pertinent part, the following:

SECTION 11 - BILLING BENEFICIARIES

11.1 GENERAL INFORMATION

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

- A Medicaid copayment is required. (Refer to the Beneficiary Copayment Requirements subsection of this chapter for additional information about copayments.)

- A monthly patient-pay amount for inpatient hospital or nursing facility services. The local MDHHS office determines the patient-pay amount. Noncovered services can be purchased by offsetting the nursing facility beneficiary's patient-pay amount. (Refer to the Nursing Facility Chapter for additional 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 MDHHS 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 MDHHS 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 is told prior to rendering the service that it is not covered by Medicaid. If the beneficiary is not informed of Medicaid noncoverage 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.

It is recommended that providers obtain the beneficiary's written acknowledgement of payment responsibility prior to rendering any nonauthorized or noncovered 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, custom-fabricated seating systems) that began, but were not completed, during a period of eligibility. (Refer to the provider-specific chapters of this manual for additional 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.

- 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.

SECTION 12 - BILLING REQUIREMENTS

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.

12.1 BILLING PROVIDER

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.

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 TIMELY FILING BILLING LIMITATION [CHANGE MADE 7/1/18]

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 claims using the institutional format 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.

∗Initial pharmacy claim must be received within 180 days.

This does not apply to state-owned and -operated facilities, as they do not receive a warrant. Note: Nursing Facilities – In cases where a nursing facility may need to submit a claim adjustment due to a change in the beneficiary's patient-pay amount and the claim has not had continuous active review, the adjustment must be submitted within six months from the date MDHHS made the change in the patient-pay amount. The Remarks section must note a reason for the adjustment.

All claims must be resolved within one year from the date of service unless an exception exists as noted below. It will no longer be necessary to maintain continuous activity through multiple claim submissions. Claim replacements requesting additional payment must meet exception criteria to be considered beyond one year from DOS.

Only the following types of claims require documentation of previous activity in the Remarks section of the claim (e.g. previous TCNs):

- 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.

Exceptions may be made to the timely filing 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 or restriction **(revised per bulletin MSA 17-46)** 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 timely filing billing limitation.

- Medicaid beneficiary eligibility/authorization was established retroactively more than 12 months after the DOS.
- Medicaid beneficiary eligibility/authorization was established retroactively less than 12 months after the DOS. Claims will be accepted up to six months after the retroactive eligibility determination date. Providers with claims that meet this retroactive eligibility exception must indicate ‘timely filing’ in the comment section of the claim.
- Judicial Action/Mandate: A court or MAHS administrative law judge ordered payment of the claim. A copy of the judicial action or court order may be required to support this exception.
- Medicare processing was delayed: The claim must reflect that Medicaid was billed within 120 days of the date of payment, rejection or retroactive recovery of funds by Medicare. (Refer to the Coordination of Benefits Chapter in this manual for further information.)
- Provider returning overpayment: A claim replacement should be submitted with a comment that the provider is returning money. The replacement should be completed to reflect the return of money (e.g., including primary payer’s payment or, if returning all the money, zeroing out the money fields).
- Primary insurance taking back payment after timely filing limitation has passed: Must submit a copy of insurance letter or EOB from primary insurance showing date money was taken back from paid

claim. The claim must be submitted within 120 days of the primary insurance letter or remit date.

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 Chapter
October 1, 2018, pp 32-33; 38-40

The Department's Analyst testified that the Department received Petitioner's request to have several medical bills paid. The Department's Analyst indicated that the bills in questions could not be paid as a result of the Provider not being a Michigan Medicaid enrolled Provider (November 2018 billings) or because Petitioner had an unmet spenddown (all other billings).

Petitioner did not directly dispute the Department's conclusions other than to indicate the services were medically necessary and that she could not meet her approved spenddown amount.

Based on the evidence presented, the Department properly denied payment of the bills submitted.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the Department properly handled Petitioner's complaint.

IT IS THEREFORE ORDERED that:

The Department's decision is AFFIRMED.

CA/sb

Corey Arendt
Administrative Law Judge
for Robert Gordon, 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 Office of Administrative Hearings and Rules (MOAHR).

A party may request a rehearing or reconsideration of this Order if the request is received by MOAHR 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. MOAHR will not review any response to a request for rehearing/reconsideration.

A written request may be mailed or faxed to MOAHR. If submitted by fax, the written request must be faxed to (517) 763-0155; Attention: MOAHR Rehearing/Reconsideration Request.

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

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

DHHS -Dept Contact

Carol Gates
Customer Service Division
P.O. Box 30479
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