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Date Mailed: January 13, 2022
MOAHR Docket No.: 21-005664
Agency No.: [redacted]
Petitioner: [redacted]

ADMINISTRATIVE LAW JUDGE: Marya Nelson-Davis

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 telephone hearing was held on January 6, 2022. Petitioner, [redacted], appeared for the hearing and testified. Appeals Review Officer Leigha Burghdoff represented the Michigan Department of Health and Human Services (MDHHS or Department). MDHHS Specialist Edward Kincaid testified as a witness for the Department.

ISSUE

Did the Department properly process and pay for Petitioner's out-of-pocket pharmacy expenses and hospital bills incurred during the period of June 2020 through December 2020?

FINDINGS OF FACT

1. Petitioner has been a Medicaid recipient under the Healthy Michigan Plan category since April 2020.

2. On November 22, 2021, Petitioner filed a Beneficiary Complaint Form, stating that she has paid CVS Pharmacy for prescriptions beginning July 2020, and she provided hospital and Emergency Room Department bills that were not paid by Medicaid.

3. Due to a Department error, Petitioner was disenrolled from the Medicaid health plan, resulting in her Medicaid claims not being approved for payment by Medicaid.

4. As a result of the Department error, an exception to the Medicaid one-year billing limitation for the period of June 1, 2020 through December 31, 2020

was approved by the Department.

5. On November 4, 2021, Petitioner's filed a request for hearing to contest the Department's failure to pay her out-of-pocket pharmacy expenses and hospital bills.

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.)

In this case, there is no dispute that Petitioner was eligible for Medicaid coverage since April 2020, and her out-of-pocket pharmacy expenses and hospital bills that were incurred beginning July 2020 were not paid due to a Department error. An exception to the Medicaid one-year billing limitation has been approved, and the Department is attempting to work with the pharmacy and hospitals or medical centers who billed Petitioner for prescriptions and medical services provided. Petitioner agreed that the Department is attempting to fix its error, and she is giving the Department 90 days to pay her out-of-pocket pharmacy expenses and hospital bills.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, finds that Petitioner's out-of-pocket pharmacy expenses and medical/hospital bills incurred during the period of June 2020 through December 2020 were not properly paid by Medicaid due to a Department error.

IT IS THEREFORE ORDERED that:

The Respondent's decision is **REVERSED.** The Department shall begin the process of issuing a payment for Petitioner's out-of-pocket pharmacy expenses and medical/hospital bills incurred during the period of June 2020 through December 2020, if Petitioner is otherwise eligible for the payments.

MN-D/dh

Marya Nelson-Davis
Administrative Law Judge

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 Lansing, MI 48909
DHHS Department Rep.	M. Carrier Appeals Section PO Box 30807 Lansing, MI 48933
Agency Representative	Leigha Burghdoff P.O. Box 30807 Lansing, MI 48909
Petitioner	[redacted] MI [redacted]