

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

IN THE MATTER OF:

██████████

Appellant

Docket No. 2014-19679 MSB  
Case No. ██████████

**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 ██████████. Appellant appeared on her own behalf. ██████████, Appeals Review Officer, represented the Department. ██████████, Departmental Specialist, appeared as a witness for the Department.

**ISSUE**

Did the Department properly reject a claim for Medicaid-covered services rendered to Appellant?

**FINDINGS OF FACT**

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

1. In ██████████ and ██████████, Appellant had Medicaid coverage through the Plan First! Program. (Exhibit A, pp 5-6; Testimony)
2. Appellant was also enrolled in Medicare Part A (Hospital Coverage) effective November 1, 2007, and was eligible to be enrolled in Medicare Part B (Medical Insurance) on the same date, but Appellant refused the Medicare Part B coverage. (Exhibit A, p 7; Testimony)
3. Appellant received medical services on ██████████ and ██████████. (Exhibit A, pp 3-4, Testimony)
4. The cost of Appellant's medical services can not be covered by Medicaid when those services would have been covered through Medicare Part B, if Appellant had enrolled. (Exhibit A, pp 8-9, 14; Testimony)
5. On ██████████, the Department notified Appellant that Medicaid could not pay for the medical bills she incurred on ██████████ and ██████████ because those bills would have been covered by Medicare Part B

had Appellant chosen to enroll in Medicare Part B. (Exhibit A, p 13; Testimony)

6. On ██████████, Appellant's hearing request was received by the Michigan Administrative Hearing System. The hearing request was returned to Appellant so that she could sign the request. The signed hearing request was then received on ██████████. (Exhibit 1)

## **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 coordination of benefits states:

### **SECTION 1 – INTRODUCTION**

This chapter applies to all providers.

Federal regulations require that all identifiable financial resources be utilized prior to expenditure of Medicaid funds for most health care services provided to Medicaid beneficiaries. Medicaid is considered the payer of last resort. If a beneficiary with Medicare or Other Insurance coverage is enrolled in a Medicaid Health Plan (MHP), or is receiving services under a Prepaid Inpatient Health Plan (PIHP) or Community Mental Health Services Program/Coordination Agency (CMHSP/CA), that entity is responsible for the Medicaid payment liability.

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### **2.6. MEDICARE**

#### **2.6.A. MEDICARE ELIGIBILITY**

Many beneficiaries are eligible for both Medicare and Medicaid benefits. If a provider accepts the individual as a Medicare beneficiary, that provider must also accept the individual as a Medicaid beneficiary.

If a Medicaid beneficiary is eligible for Medicare (65 years old or older) but has not applied for Medicare coverage, Medicaid does not make any reimbursement for services until Medicare coverage is obtained. The beneficiary must apply for Medicare coverage at a Social Security Office. Once they have obtained Medicare coverage, services may be billed to

Medicaid as long as all program policies (such as time limit for claim submission) have been met.

Medicaid beneficiaries may apply for Medicare at any time and are not limited to open enrollment periods. Beneficiaries may be eligible for Medicare if they are:

- 65 years of age or older.
- A disabled adult (entitled to SSI or RSDI due to a disability).
- A disabled minor child.

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*Medicaid Provider Manual,  
Coordination of Benefits Section,  
October 1, 2013, pp 1, 6*

With regard to providers billing Medicaid beneficiaries, the Medicaid Provider Manual provides, in pertinent part:

### **11.1 GENERAL INFORMATION**

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

\* \* \* \*

- The beneficiary refuses Medicare Part A or B.

\* \* \* \*

*Medicaid Provider Manual  
General Information for Providers Section  
October 1, 2013, p 31*

The Department's witness testified that, per policy, the cost of Appellant's medical services cannot be covered by Medicaid when those services would have been covered through Medicare Part B, if Appellant had enrolled. Here, the Department witness indicated that in ██████████ and ██████████, Appellant had Medicaid coverage through the Plan First! Program, but she was also eligible for Medicare Part A and B. The Department's witness testified that Appellant refused Medicare Part B coverage, so the cost of Appellant's medical services cannot be covered by Medicaid.

[REDACTED]  
Docket No. 2014-19679 MSB  
Decision and Order

Appellant testified that the outstanding bills arose from one procedure, which was preapproved, so she could not understand why only part of the procedure was covered. Appellant indicated that if she had known the anesthesia for the procedure was not covered, she never would have had the procedure done. Appellant did admit that she never signed up for Medicare Part B when she was eligible because the monthly premium was too high.

In response, the Department's witness indicated that a prior authorization request only reviews the service being sought, not eligibility for the service. Here, the Department's witness indicated that Medicaid could not cover the bills because Medicare would have covered the bills if Appellant chose to enroll in Medicare Part B.

The Medicaid Provider Manual policy is clear that Medicaid is a payor of last resort and if a Medicaid beneficiary is eligible for Medicare but has not applied for, or refused Medicare coverage, Medicaid does not make reimbursement for services until Medicare coverage is obtained. Accordingly, this ALJ must uphold the Department's rejection of the [REDACTED] and [REDACTED] claims based on the available information.

**DECISION AND ORDER**

The Administrative Law Judge, based on the above findings of fact and conclusions of law, finds that the Department properly rejected the claim for Medicaid-covered services rendered to Appellant.

**IT IS THEREFORE ORDERED THAT:**

The Department's decision is AFFIRMED.



Robert J. Meade  
Administrative Law Judge  
for James K. Haveman, Director  
Michigan Department of Community Health

cc: [REDACTED]

[REDACTED]  
Date Signed: March 14, 2014

Date Mailed: March 14, 2014

**\*\*\* 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.