

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. 2014-21303 MSB

██████████

██████████

DECISION AND ORDER

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

After due notice, a hearing was held on ██████████. ██████████ appeared and testified on Appellant's behalf. Appellant also testified on his own behalf. ██████████, Appeals Review Officer, represented the Michigan Department of Community Health (MDCH or Department). ██████████, DCH Department Specialist, appeared as a witness for the Department.

ISSUE

Did the Department properly deny payment for medical services provided to Appellant between ██████████ and ██████████

FINDINGS OF FACT

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

1. Appellant had full ██████████ Medicaid benefits for the time periods of ██████████ through ██████████ and ██████████ through ██████████. (Respondent's Exhibit A, page 5).
2. Appellant was also enrolled in a Medicare ██████████ ██████████ ██████████, for the time period of ██████████ through ██████████. (Respondent's Exhibit A, page 6).
3. On ██████████, the Department received a Beneficiary Complaint, signed by Appellant and his representative on ██████████, in which Appellant and his representative asked the Department to look into unpaid medical bills for the time period of ██████████ through ██████████. (Respondent's Exhibit A, pages 7-8).

Docket No. 2014-21303 MSB
Decision and Order

4. That complaint also indicated that the bills were for services Appellant received while injured in [REDACTED] and that the [REDACTED] refused to pay the bills. (Respondent's Exhibit A, page 7).
5. The complaint further stated that [REDACTED] is a [REDACTED] [REDACTED] and that Appellant thought it had been cancelled when he moved to [REDACTED] in [REDACTED] and re-enrolled in [REDACTED] Medicaid. (Respondent's Exhibit A, pages 7-8).
6. On [REDACTED], the Department issued a letter to Appellant indicating that it had investigated the unpaid bills and

It has been brought to our attention that [REDACTED] [REDACTED] is listed as having a primary insurance other than Medicaid for the above date of service. In order for Medicaid to process a claim for the above listed dates of service the primary needs to be billed first. If you find that this is incorrect, you will need to provide documentation showing the termination date of the prior insurance occurring prior to the date of service. You will need to resolve this bill with the provider.

Respondent's Exhibit A, page 9

7. On [REDACTED], the Michigan Administrative Hearing System (MAHS) received a Request for Hearing filed by Appellant and his representative. (Respondent's Exhibit A, page 3).

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.

Regarding the coordination of benefits through Medicaid, the Michigan Medicaid Provider Manual (MPM) 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.

Coordination of Benefits (COB) is the mechanism used to designate the order in which multiple carriers are responsible for benefit payments and, thus, prevention of duplicate payments. Third party liability (TPL) refers to an insurance plan or carrier (e.g., individual, group, employer-related, self-insured or self-funded plan), commercial carrier (e.g., automobile insurance and workers' compensation), or program (e.g., Medicare) that has liability for all or part of a beneficiary's medical coverage. The terms "third party liability" and "other insurance" are used interchangeably to mean any source, other than Medicaid, that has a financial obligation for health care coverage. Providers must investigate and report the existence of other insurance or liability to Medicaid and must utilize other payment sources to their fullest extent prior to filing a claim with the Michigan Department of Community Health (MDCH). If MDCH finds after a claim is adjudicated that another payer was liable for the service, a claim adjustment will be processed. The provider will then have to bill the identified third party resource for the service.

Billing Medicaid prior to exhausting other insurance resources may be considered fraud under the Medicaid False Claim Act if the provider is aware that the beneficiary had other insurance coverage for the services rendered.

* * *

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.

* * *

2.6.F. MEDICAID LIABILITY

If Medicare has paid 100 percent of the allowable charges and there is no coinsurance involved, then Medicaid has no payment liability.

Neither the beneficiary nor Medicaid is liable for any difference in the amount billed by the provider and Medicare's allowable fee.

If the beneficiary is in a Medicare Risk HMO, MDCH pays fixed copays (except Medicare Part D) on the services up to the lesser of Medicaid's allowable amount minus the Medicare payment for the service or the beneficiary's payment liability, as long as the rules of the HMO are followed.

MDCH reimburses providers for the coinsurance and deductible amounts subject to Medicaid reimbursement limitations on all Medicare approved claims even if Medicaid does not normally cover the service. MDCH payment liability

Docket No. 2014-21303 MSB
Decision and Order

for beneficiaries with Medicare coverage (except Medicare Part D) is the lesser of:

- The beneficiary's liability for coinsurance, copayments, and/or deductibles minus any applicable Medicaid copayment, patient-pay, or deductible amounts.
- The Medicaid fee screen/allowable amount, minus any Medicare or other insurance payments and any applicable Medicaid copayment, patient-pay, or deductible amounts.
- The provider's charge, minus any Medicare or other insurance payments, contractual adjustments, and any applicable Medicaid copayment, patient-pay, or deductible amounts.

For inpatient hospital claims, refer to the Hospital Claim Completion - Inpatient section (Medicare subsection) of the Billing & Reimbursement for Institutional Providers chapter for additional information.

Medicare coverage is not available for a Medicaid beneficiary who is 65 years or older and is an alien who has been in the country less than five consecutive years.

MDCH does not pay for services denied by Medicare or other insurance plans due to noncompliance with Medicare or other insurance plan requirements. If the provider's service would have been covered and payable by Medicare or the other insurance plan but some requirement of the plan was not met, MDCH will deny the claim. The provider and the beneficiary both have equal responsibility for complying with Medicare or the other insurance plan requirements.

Common noncompliance denials include, but are not limited to,:

- Failure to obtain a referral from a participating primary care provider (PCP).
- Failure to be seen by a participating provider.

Docket No. 2014-21303 MSB
Decision and Order

- Failure to be seen in a participating place of service.
- Failure to obtain a second opinion.
- Failure to obtain prior authorization

In instances where MDCH has denied payment or made a post-payment recovery due to noncompliance, it is the provider's responsibility to remediate with the primary payer prior to re-billing with Medicaid.

Note: This also applies to Fee-for-Service pharmacy claims, particularly claims submitted with Other Coverage Code (OCC) "3: Other Coverage Billed – Claim Not Covered."

When the National Council for Prescription Drug Programs (NCPDP) standard does not provide MDCH with a point-of-sale (POS) mechanism to verify full compliance with Medicare or commercial health insurance plan requirements, MDCH will review and recover monies for noncompliance on a post-payment basis (e.g., when the primary payer denies the claim with NCPDP rejection code "75: Prior Authorization Required" and MDCH is unable to verify at the POS whether prior authorization was requested and denied versus prior authorization not requested).

MPM, January 1, 2014 version
Coordination of Benefits Chapter, pages 1, 6, 9-10

The above policy of the MPM makes clear that Medicaid is a payor of last resort and will not make a reimbursement for services if a Medicaid beneficiary also has Medicare coverage and Medicare should pay for the services. Moreover, the above policy also makes clear that the Department does not pay for services denied by Medicare or other insurance plans due to noncompliance with Medicare or other insurance plan requirements.

Here, Appellant was enrolled in both Medicaid and Medicare at all times relevant to this action and the Department refused to make payments for the medical bills submitted by Appellant due to that Medicare coverage and the above policy.

Appellant bears the burden of proving by a preponderance of the evidence that the Department erred in making that decision.

Docket No. 2014-21303 MSB
Decision and Order

Appellant and his representative first testified that [REDACTED] is a [REDACTED] Medicare Plan and that Appellant thought it had been cancelled when he moved to [REDACTED] in [REDACTED] and re-enrolled in [REDACTED] Medicaid. However, it is also undisputed that Appellant remained enrolled in Medicare and, during the hearing, Appellant acknowledged that he had been mistaken. Moreover, while perhaps understandable, Appellant's error does not change the clear policy and the correctness of the Department's decision.

Appellant and his representative also testified that Medicare has already refused to pay for the unpaid bills because it is a plan through the [REDACTED] and Appellant used out-of-state providers. However, as discussed above, "MDCH does not pay for services denied by Medicare or other insurance plans due to noncompliance with Medicare or other insurance plan requirements." MPM, January 1, 2014 version, Coordination of Benefits Chapter, page 10.

To the extent Appellant asserts that there was an error made by his Medicare [REDACTED] with respect to his coverage under that plan, he must pursue relief through Medicare.

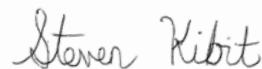
With respect to the disputed issue involving Medicaid in this case, however, the undersigned Administrative Law Judge must uphold the Department's rejection of the unpaid claims based on the available information and applicable policy.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, finds that, based on the available information, the Department properly denied payment for medical services provided to Appellant between [REDACTED] and [REDACTED]

IT IS THEREFORE ORDERED THAT:


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



Steven Kibit
Administrative Law Judge
for James K. Haveman, Director
Michigan Department of Community Health

Date Signed: [REDACTED]

Date Mailed: [REDACTED]


Docket No. 2014-21303 MSB
Decision and Order

SK/db

cc:



***** 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.