

**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:

Docket No. 2014-23405 MSB

██████████

██████████

██████████

Appellant.

_____ /

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 ██████████. Appellant appeared and testified on her own behalf. ██████████, Manager of the Appeals Section, represented the Department of Community Health (DCH 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 in ██████████?

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 ██████████, Appellant had fee-for-service Medicaid coverage. (Respondent's Exhibit 1, page 1).
2. Appellant did not have Medicare Part B coverage at that time, though she had previously been enrolled in such coverage between ██████████ and ██████████ and continued to be eligible for it in ██████████. (Respondent's Exhibit 3, page 1; Testimony of ██████████).
3. Appellant received medical services in ██████████. (Testimony of Appellant).
4. Appellant and her medical care provider billed Medicaid for those services, but the requests for payments were denied because Appellant had opted not to enroll in Medicare Part B after ██████████ (Respondent's Exhibit 6, page 1; Respondent's Exhibit 7, pages 1-2; Testimony of ██████████).

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5. Appellant later re-enrolled in Medicare effective [REDACTED]. (Respondent's Exhibit 3, page 1).
6. On [REDACTED], the Michigan Administrative Hearing System (MAHS) received a Request for Hearing in this matter filed by Appellant. (Petitioner's Exhibit 1, pages 1-30).
7. In that request and in her testimony during the hearing, Appellant asserts that she was treated for a broken hand in [REDACTED] and that, while she had both Medicaid and Medicare coverage at the time, neither paid for the medical services she received. (Petitioner's Exhibit 1, page 7; Testimony of Appellant).
8. Appellant also asserted in that she later learned that there had been a mistake regarding her Medicare coverage and that, while she is also pursuing remedies through Medicare, she believes Medicaid should pay for the medical services provided in [REDACTED]. (Petitioner's Exhibit 1, page 7; Testimony of Appellant).

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.C. MEDICARE PART B

Medicare Part B covers practitioner's services, outpatient hospital services, medical equipment and supplies, and other health care services. When a beneficiary is eligible for and enrolled in Medicare Part B, Medicare usually pays for a percentage of the approved Medicare Part B allowable charges and Medicaid pays the applicable deductible and/or coinsurance up to Medicaid's maximum allowable amount. Coverage for outpatient therapeutic psychiatric coverage varies.

Beneficiaries are encouraged to enroll in Medicare Part B as soon as they are eligible to do so. A beneficiary's representative can apply for Medicare Part B benefits on behalf of the beneficiary. After the beneficiary's death, DHS is responsible for making the application to the Social Security Administration (SSA) to cover medical services provided prior to the death.

MPM, January 1, 2014 version
Coordination of Benefits Chapter, pages 1, 6, 8

The above policy of the MPM is clear that Medicaid is a payor of last resort and if a Medicaid beneficiary is eligible for Medicare, but has not applied for Medicare coverage, then Medicaid does not make reimbursement for services until Medicare coverage is obtained.

Here, while Appellant had been enrolled in Medicare Part B through ██████████ and continued to be eligible for it at all times relevant to this action, she was no longer enrolled in Medicare Part B in ██████████. Accordingly, the medical services

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provided in ██████████ could not be covered by Medicaid because Appellant was eligible for Medicare Part B coverage, but had let such coverage lapse by choice.

To the extent Appellant asserts that there was an error made by Medicare with respect to her Medicare coverage, she must pursue relief through Medicare, as she appears to be doing.

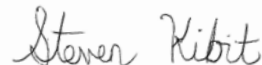
With respect to the disputed issue involving Medicaid in this case, however, the undersigned Administrative Law Judge must uphold the Department's rejection of the ██████████ claims based on the available information.

DECISION AND ORDER

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

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: ██████████

Date Mailed: ██████████

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.