STATE OF MICHIGAN
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
FOR THE DEPARTMENT OF HEALTH AND HUMAN SERVICES
P.O. Box 30763, Lansing, MI 48909
(517) 335-3997; Fax: (517) 373-4147

IN THE MATTER OF:

Docket No. 15-002772 MSB

[redacted]

Appellant.
_____/

DECISION AND ORDER

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

After due notice, a telephone hearing was held on [redacted]. Appellant appeared and testified on her own behalf. [redacted] Appeals Review Officer, represented the Michigan Department of Health and Human Services (DHHS or Department). [redacted], Analyst, also testified as a witness for the Department.

ISSUE

Did the Department properly deny claims submitted for services provided 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. Between [redacted] and [redacted], Appellant was covered by both Medicaid and a private insurance policy through [redacted]). (Testimony of Appellant; Testimony of [redacted].

2. During that time period, in [redacted] and [redacted] Appellant received services from [redacted] (Testimony of Appellant; Testimony of [redacted]).

3. [redacted] never billed [redacted] for those services. (Testimony of [redacted]

4. [redacted] did bill Medicaid, but the claims were denied on the basis that Appellant had other commercial insurance that had to be billed prior to Medicaid being billed. (Testimony of [redacted]

5. After Medicaid denied the claims, [redacted] billed Appellant directly. (Testimony of Appellant; Testimony of [redacted].

6. On [redacted], the Michigan Administrative Hearing System (MAHS) received a request for hearing filed by Appellant with respect to those unpaid bills. (Exhibit 1, pages 1-3).

7. While the appeal was pending, [redacted] investigated Appellant's claims and confirmed that Appellant had [redacted] coverage at the time of the services at issue in this case. (Testimony of [redacted]

8. [redacted] then contacted [redacted] and asked it to bill [redacted] first, but [redacted] declined to do so because it was not within [redacted] network of providers. (Testimony of [redacted].

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 Medicaid benefits with other programs, the applicable version of the 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.
>
> * * *

2.1 COMMERCIAL HEALTH INSURANCE, TRADITIONAL INDEMNITY POLICIES, AND MILITARY/VETERAN INSURANCE

If a Medicaid beneficiary is enrolled in a commercial health insurance plan or is covered by a traditional indemnity policy or military/veteran insurance, the rules for coverage by the commercial health insurance, traditional indemnity policy, or military/veteran insurance must be followed. This includes, but is not limited to:

- Prior authorization (PA) requirements.
- Provider qualifications.
- Obtaining services through the insurer's provider network.

Beneficiaries must use the highest level of benefits available to them under their policy. Medicaid is not liable for payment of services denied because coverage rules of the primary health insurance were not followed. For example, Medicaid does not pay the point of service sanction amount for the beneficiary electing to go out of the preferred provider network. Medicaid is, however, liable for Medicaid-covered services that are not part of the primary health insurance coverage.

* * *

MDCH payment liability for beneficiaries with other insurance is the lesser of the beneficiary's liability (including coinsurance, copayments, or deductibles), the provider's charge minus contractual adjustments, or the maximum Medicaid fee screen minus the insurance payments. 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.

Providers may enter into agreements with other insurers to accept payment that is less than their usual and customary fees. Known as "Preferred Provider" or "Participating Provider" Agreements, these arrangements are considered

payment-in-full for services rendered. Neither the beneficiary nor MDCH has any financial liability in these situations.

Providers must secure other insurance adjudication response(s) which must include Claim Adjustment

Reason Codes (CARCs) prior to billing Medicaid. Denials do not need to be obtained in cases where the parameters of the carrier would never cover a specific service (e.g., a dental carrier would never cover a vision service, etc.). In cases where the provider renders a service and the carrier indicates it does not cover that specific service, the provider needs only to bill the carrier once for the service and keep a copy of the denial in the beneficiary's file. When billing on paper, this documentation must be submitted as an attachment to the paper claim. When billing electronically, no attachment is necessary, as all required data must be included in the electronic submission. (Refer to the Billing & Reimbursement Chapters of this manual for additional information.)

If payments are made by another insurance carrier, the amount paid, whether it is paid to the provider or the beneficiary, must be reflected on the claim. It is the provider's responsibility to obtain the payment from the beneficiary if the other insurance pays the beneficiary directly. It is acceptable to bill the beneficiary in this situation. Providers may not bill a Medicaid beneficiary unless the beneficiary is the policyholder of the other insurance. Failure to repay, return, or reimburse Medicaid may be construed as fraud under the Medicaid False Claim Act if the provider has received payment from a third party resource after Medicaid has made a payment. Medicaid's payment must be repaid, returned, or reimbursed to MDCH Third Party Liability Section. (Refer to the Directory Appendix for contact information.)

MPM, April 1, 2015 version
Coordination of Benefits Chapter, pages 1, 3-4
(Emphasis added)

Similarly, with respect to the billing of beneficiaries, the MPM states:

> **SECTION 11 - BILLING BENEFICIARIES**
>
> **11.1 GENERAL INFORMATION**
>
> Providers cannot bill beneficiaries for services except in the following situations:
>
> * * *
>
> - 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).
>
> *MPM, April 1, 2015 version*
> *General Information for Providers Chapter, pages 1, 3-4*

Here, the Department's witness testified that the claims for services at issue in this case were denied pursuant to the above policies. Specifically, the above policies clearly provide that Medicaid is the payor of last resort and Appellant's private insurance must be billed before Medicaid, and that Medicaid is not liable for payment of services denied because coverage rules of the primary health insurance were not followed.

In response, Appellant testified that she tried to cancel her insurance with [redacted] prior to receiving services at [redacted] and was told over-the-phone that she had done so. However, Appellant also acknowledged that the only written documentation she received regarding the termination of her private insurance stated that her [redacted] coverage did not terminate until [redacted]

Appellant bears the burden of proving by a preponderance of the evidence that the Department erred in denying the claims. Moreover the undersigned Administrative Law Judge is limited to reviewing the Department's decision in light of the information it had at the time it made that decision.

In this case, all the information the Department had demonstrated that Appellant possessed coverage through [redacted] at the time of the relevant services and, per the clear policy of the MPM, [redacted] must therefore be billed prior to Medicaid, which is the payor of last resort. No such billing ever occurred. Moreover, even if [redacted] would not have paid for the services if it had been billed first, the Department will still not approve claims and the provider can bill the beneficiary directly when the beneficiary did not follow the rules of the other insurance, such as utilizing network providers. That is what occurred in this case and, consequently, the Department's rejection of claims based on the available information must be sustained.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, finds that, the Department properly denied claims submitted for services provided to Appellant.

IT IS THEREFORE ORDERED THAT:

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

Steven Kibit

Steven Kibit
Administrative Law Judge
for Nick Lyon, Director
Michigan Department of Health and Human Services

Date Signed: [redacted]

Date Mailed: [redacted]

SK/db

cc: [redacted]

***** 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.