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

IN THE MATTER OF:

[redacted]

Appellant
_____/

Docket No. 15-003051 MSB
Case No. [redacted]

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 [redacted]. Appellant appeared on her own behalf. [redacted], Interpreter Network, appeared as an interpreter for Appellant. [redacted], Appellant's son, appeared as a witness and also assisted with interpretation. [redacted] Appeals Review Officer, represented the Department. [redacted], Departmental Specialist, appeared as a witness for the Department.

ISSUE

Did the Department properly reject claims 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. Appellant requested a hearing after Medicaid made numerous claim adjustments which resulted in Medicaid taking money back from previously paid claims (bills) submitted by medical providers on Appellant's behalf. This resulted in the providers then re-sending the same bills to Appellant and seeking payment. (Exhibit A, pp 4-8; Exhibit 1; Testimony)

2. If an individual is eligible for Medicare, but not enrolled in Medicare, Medicaid claims will be denied. (Exhibit A, p 4; Testimony)

3. At the time Medicaid initially paid Appellant's claims, the Medicaid processing system (CHAMPS) showed that Appellant was not eligible for Medicare. However, CHAMPS was later updated to reflect that Appellant enrolled in

Medicare Part A effective [redacted] and Medicare Part B effective [redacted]. (Exhibit A, pp 4-6; Testimony)

4. Between [redacted] and [redacted], Appellant's Medicaid claims for Part B covered services that had previously been paid were adjusted resulting in Medicaid taking payments back. (Exhibit A, pp 4-8, Testimony)

5. If an individual is eligible for Medicare Part A, then that individual is also automatically eligible to enroll in Medicare Part B. Medicare Part B services cover practitioner's services, outpatient hospital services, medical equipment and supplies, and other health care services. (Exhibit A, pp 4; 9-11; Testimony)

6. On [redacted], Appellant's hearing request was received by the Michigan Administrative Hearing System. With the request for hearing, Appellant included a copy of the bills she has received since the Medicaid claims adjustment took place. (Exhibit 1)

7. Since Appellant's request for hearing has been received, the Department has been working to resolve the issue for Appellant. Specifically, the Department has arranged for Medicaid to buy Medicare Part B coverage for Appellant back to [redacted]. Once that change is in place, Appellant's medical providers can bill Medicare for Part B covered services from [redacted] forward and then re-bill Medicaid for any Medicare copays and deductibles. (Exhibit A, p 4; Testimony)

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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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.
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> *Medicaid Provider Manual,*
> *Coordination of Benefits Section,*
> *January 1, 2015, pp 1, 6, 8*

The Department's witness testified that Appellant requested a hearing after Medicaid made numerous claim adjustments which resulted in Medicaid taking money back from previously paid claims (bills) submitted by medical providers on Appellant's behalf. The Department's witness indicated that this resulted in the providers then re-sending the same bills to Appellant and seeking payment. The Department's witness testified that if an individual is eligible for Medicare, but not enrolled in Medicare, Medicaid claims will be denied. The Department's witness indicated that at the time Medicaid initially paid Appellant's claims, the Medicaid processing system (CHAMPS) showed that Appellant was not eligible for Medicare. However, CHAMPS was later updated to reflect that Appellant enrolled in Medicare Part A effective January 1, 2008 and Medicare Part B effective November 1, 2013. As such, the Department's witness indicated that for the period of time between [redacted] and [redacted], Appellant's Medicaid claims that had previously been paid for Part B covered services were adjusted resulting in Medicaid taking payments back. The Department's witness indicated, however, that since Appellant's request for hearing has been received, the Department has been working to resolve the issue for Appellant. Specifically, the Department has arranged for Medicaid to buy Medicare Part B coverage for Appellant back to [redacted]. Once that change is in place, Appellant's medical providers can bill Medicare for Part B covered services from [redacted] forward and then re-bill Medicaid for any Medicare copays and deductibles.

Appellant testified that she has been dealing with this situation for a long time and would like it resolved as soon as possible. Appellant indicated that her medical providers keep sending her bills and calling her regarding the balances owed.

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 adjusted claims based on the available information.

However, the Department is working with Appellant to resolve this issue and it appears that Appellant will eventually be able to seek payment for the adjusted claims once her retroactive Medicare coverage is in effect.

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 claims 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 Nick Lyon, Director
Michigan Department of
Health and Human Services

cc: [redacted]

RJM/[redacted]

Date Signed: [redacted]

Date Mailed: [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.