STATE OF MICHIGAN
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
FOR THE DEPARTMENT OF HEALTH AND HUMAN SERVICES
P.O. Box 30763, Lansing, MI 48909
(517) 335-2484; Fax: (517) 373-4147

IN THE MATTER OF:

Docket No. 15-006272 MSB

[redacted], [redacted] [redacted]

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 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] Chief Medical Director, also testified as a witness for the Department.

ISSUE

Did the Department properly deny a prior authorization request for genetic testing?

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 is a [redacted] year-old female who had Fee-For-Service Medicaid Coverage between [redacted] and [redacted]. (Exhibit A, pages 11, 20).

2. During that time period, Appellant also had coverage through [redacted] (Testimony of Appellant; Testimony of [redacted]).

3. On [redacted], Appellant received MaterniT21 testing through the [redacted]). (Exhibit A, pages 18, 21).

4. According to Appellant, she was then billed for the testing. (Testimony of Appellant).

5. On or about [redacted], [redacted] submitted a claim to [redacted] for payment for the testing. (Exhibit A, pages 18-19, 21).

6. The amount of the claim was [redacted] and, per [redacted] contract with [redacted], the procedure code used in the billing was CPT Code [redacted]. (Exhibit A, pages 18-19, 21).

7. That same day, [redacted] sent [redacted] a check for [redacted]. (Exhibit A, page 21).

8. On or about [redacted] Sequenom submitted a prior authorization request with respect to the testing to the Department. (Exhibit A, page 7; Testimony of [redacted]).

9. The procedure code for the testing identified in the request was [redacted]. (Exhibit A, page 7; Testimony of [redacted]

10. On [redacted], the Department sent Appellant written notice that the request was denied. (Exhibit A, pages 7-8).

11. With respect to the reason for the denial, the notice stated:

> The policy this denial is based on is Section 2.1 Commercial Health Insurance, Traditional Indemnity Policies, and Military/Veteran Insurance of the Coordination of Benefits chapter of the Medicaid Provider Manual, which indicates:
>
> Medicaid has denied this request per our policy of following the rules of the primary insurance. [redacted] rules state this test must be billed as CPT [redacted] Medicaid does not cover this CPT code.
>
> *Exhibit A, page 7*

12. That same day, the Department also sent a notice of denial to [redacted]. (Exhibit A, page 6).

13. On [redacted], the Michigan Administrative Hearing System (MAHS) received the request for hearing filed by Appellant in this matter. (Exhibit A, pages 3-4).

14. In that request, Appellant stated that she had been told that the services would be covered and that she cannot pay the bills. (Exhibit A, page 3).

15. As of the date of the hearing, Appellant has not received another bill from [redacted]. (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.

All requests or claims through Medicaid must be submitted in accordance with the policies, rules, and procedures as stated in the Medicaid Provider Manual (MPM). Regarding the coordination of Medicaid benefits with other programs, the applicable version of the 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).

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.

* * *

2.1 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.

PA is not necessary for situations of other insurance coverage if all of the following apply:	**PA is required for the following:**
▪ The beneficiary is eligible for the other insurance and the primary insurer rules are followed;	▪ PA is required for cases where the other insurance benefit has been exhausted or the service/item is not a covered benefit.

▪ The provider is billing a standard Healthcare Common Procedure Coding System (HCPCS) code that Medicaid covers, and the primary insurer makes payment or applies the service to the deductible; and ▪ The service/item complies with Michigan Medicaid standards of coverage as described in this manual.	▪ PA is necessary for all other situations, including not otherwise classified (NOC) codes.

Inappropriately recoded claims are rejected by MDCH even if MDCH issued PA.

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.)

Insurance companies should not submit checks directly to Medicaid. Rather, providers must work directly with the insurance company or the beneficiary to obtain the insurance payment. If the insurance company pays the beneficiary directly, it is the provider's responsibility to obtain the payment from the beneficiary; if the policyholder is someone other than the beneficiary, it is the provider's responsibility to obtain the payment from the policyholder.

* * *

3.3 COINSURANCE/DEDUCTIBLE AND/OR COPAYMENT

Medicaid responsibility for payment of coinsurance/deductible and/or copayment amounts is:

Coinsurance, Copayments, and Deductibles	Medicaid pays the appropriate coinsurance amounts, copayment amounts, and deductibles up to the beneficiary's financial obligation

	to pay or the Medicaid allowable amount (less other insurance payments), whichever is less. If the other insurance has negotiated a rate for a service that is lower than the Medicaid allowable amount, that amount must be accepted as payment in full and Medicaid cannot be billed.
Medicaid services not covered by another insurance	If the other insurance does not cover a service that is a Medicaid-covered service, Medicaid reimburses the provider up to the Medicaid allowable amount if all the Medicaid coverage rules are followed.

Beneficiaries are responsible for payment of all copays and deductibles allowed under the MHP/PIHP/CMHSP/CA contract with MDCH. If the beneficiary with other insurance coverage is enrolled in a MHP or receiving services under a PIHP/CMHSP/CA capitation, the MHP/PIHP/CMHSP/CA assumes the Medicaid payment liabilities. Beneficiaries cannot be charged for Medicaid-covered services, except for approved copays or deductibles, whether they are enrolled as a FFS beneficiary, MDCH is paying the HMO premiums to a contracted health plan, or services are provided under PIHP/CMHSP/CA capitation. (Refer to the Medicaid Liability subsection of this chapter for additional information on Medicare claims.)

MPM, April 1, 2015 version
Coordination of Benefits Chapter, pages 1, 3-4, 13-14

Pursuant to the above policy, the Department properly denied the prior authorization request in this case. Per policy, Medicaid is the payor of last resort and Appellant and her medical provider must first seek payment through her primary insurance. Moreover, in doing so, they must comply with the primary insurance's rules for coverage and Medicaid will reject any inappropriately recoded claims. In this case, the provider did seek payment from the primary insurance and, in doing so, complied with the primary insurance's rules by billing for procedure code [redacted]. However, when the provider subsequently sought an authorization through Medicaid, it inappropriately recoded the procedure and the request was therefore properly denied by the Department.

Moreover, while the only action taken in this case by the Department was the denial of the prior authorization request, Appellant testified that she was billed for the services in the past and is concerned about being billed for the procedure again in the future. In response, the Department's witness testified that the bill was fully resolved by the primary insurance at a rate for a service that is lower than the Medicaid allowable amount, in which case the negotiated amount must be accepted as payment in full and Medicaid cannot be billed. It also appears that the Department's witness is correct as Appellant testified that she has not received a bill since the primary insurance issued a payment.

If Appellant is billed again, she can file a Beneficiary Complaint regarding the unpaid bill and, if necessary, another request for an administrative hearing. Whenever beneficiaries contact the Department through its help line and has issues with outstanding bills, a Beneficiary Complaint Form is mailed to them and the beneficiary has the opportunity to describe the issues, state what actions have been taken to resolve the issues, and how the beneficiary would like the issues to be resolved. The completed form is then returned to the Department and assigned to someone in the Problem Resolution Unit. The issues are then investigated, providers contacted, and it is determined whether the billing issues can be resolved. Lastly, a letter is mailed to the beneficiary, stating the Department's decision and what action, if any, was taken. The beneficiary then has the option of filing a hearing request with MAHS if they disagree with the final decision.

However, regardless of what happens in the future, the action taken by the Department at issue in this hearing was proper and must be affirmed.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, finds that, the Department properly denied a prior authorization request for genetic testing.

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.