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],

Docket No. 15-009619 MSB
Case No. [redacted]

Appellant
_____/

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], Appeals Review Officer, represented the Department of Health and Human Services (Department). [redacted], Departmental Analyst, appeared as a witness for the Department.

State's Exhibits A pages 1-19 were admitted as evidence.

ISSUE

Did the Department properly reject a claim 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. In [redacted] and [redacted], Appellant had Medicaid coverage through the Plan First! Program. (Exhibit A, pp 5-6; Testimony)

2. Appellant was also enrolled in Medicare Part A (Hospital Coverage) effective November 1, 2007, and was eligible to be enrolled in Medicare Part B (Medical Insurance) on the same date, but Appellant refused the Medicare Part B coverage. (Exhibit A, p 7; Testimony)

3. Appellant received medical services on [redacted] and [redacted]. (Exhibit A, pp 3-4, Testimony)

4. The cost of Appellant's medical services can not be covered by Medicaid when those services would have been covered through Medicare Part B, if Appellant had enrolled. (Exhibit A, pp 8-9, 14; Testimony)

5. On [redacted], the Department notified Appellant that Medicaid could not pay for the medical bills she incurred on [redacted] and [redacted] because those bills would have been covered by Medicare Part B had Appellant chosen to enroll in Medicare Part B. (Exhibit A, p 13; Testimony)

6. On [redacted], Appellant's hearing request was received by the Michigan Administrative Hearing System. The hearing request was returned to Appellant so that she could sign the request. The signed hearing request was then received on [redacted]. (Exhibit 1)

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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> ***
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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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Medicaid Provider Manual,
Coordination of Benefits Section,
October 1, 2013, pp 1, 6

With regard to providers billing Medicaid beneficiaries, the Medicaid Provider Manual provides, in pertinent part:

11.1 GENERAL INFORMATION

Providers cannot bill beneficiaries for services except in the following situations:

* * * *

- The beneficiary refuses Medicare Part A or B.

* * * *

Medicaid Provider Manual
General Information for Providers Section
October 1, 2013, p 31

Appellant requested an administrative hearing regarding medical bills she received from Ananda Medical Clinic and Med-Share, Inc. for service dates [redacted]. She is requesting that Medicaid pay for the services. With the exception of [redacted], Appellant had full Medicaid coverage approved for each service date 9enrolled in [redacted] Health Plan in [redacted] and had Fee for Service or Straight Medicaid for all other dates). In [redacted] Appellant's Medical Assistance Eligibility was a Medicaid Deductible. A Medicaid Deductible is a process which allows clients with excess income to have Medicaid benefits approved if they

incur medical expenses that total an amount equal to or more than their deductible amount and they report those expenses to the Department county office in a timely manner. Once the deductible amount is met, Medicaid eligibility is approved for a period determined by the Department county office. In [redacted] Medicaid eligibility was approved as of [redacted], when it was determined that she met the monthly spend-down.

On [redacted], Appellant submitted a Beneficiary Complaint Form regarding the medical bills. On [redacted], the Department Problem Resolution Unit sent Appellant a response letter indicating that [redacted] Clinic had agreed to bill Medicaid directly for the [redacted] service dates. [redacted] has not billed Medicaid for those dates after Medicaid coverage was added. The letter also explained that Medicaid cannot make payment for service date [redacted] because there is no Medicaid eligibility established for that date. For all other service dates, it was indicated that payment was not made by Medicaid due to [redacted] not being enrolled in Medicare Part B. Medicare Part B covers practitioner's services, outpatient hospital services, medical equipment and supplies, and other health care services. Federal regulations require that all identifiable resources available for payment, including Medicare, be billed prior to billing Medicaid. Since Appellant was eligible for Medicare Part A as of [redacted] she was also eligible for Medicare Part B had she chosen to pursue it then. On [redacted] Appellant was enrolled in Medicare Part b as of [redacted].

Upon receiving the hearing request, the Department determined that Medicare Part B coverage has been added for Appellant back to [redacted] and the Medicaid system now reflects this change. It was updated on [redacted]. As soon as possible, medical providers should first bill Medicare Part B and then Medicaid/[redacted] Health Plan for any copays or deductibles pertaining to the [redacted] and [redacted] service dates. Appellant will need to contact the medical providers and inform them that she has been enrolled in Medicare Part B retroactively. Regarding the [redacted] and [redacted] service dates during which time Appellant was enrolled in Molina Healthcare, she should contact [redacted] to report that she has been enrolled in Medicare Part B for those months so that their system can be updated accordingly. If for some reason the March and [redacted] bills are not resolved because of an issue with [redacted] Healthcare, Appellant has appeal rights through the health plan.

The Department's witness testified that, per policy, the cost of Appellant's medical services cannot be covered by Medicaid when those services would have been covered through Medicare Part B, if Appellant had enrolled. Here, the Department witness indicated that in October and [redacted], Appellant had Medicaid coverage through the Plan First! Program, but she was also eligible for Medicare Part A and B. The Department's witness testified that Appellant refused Medicare Part B coverage, so the cost of Appellant's medical services cannot be covered by Medicaid.

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 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 rejected the claim for Medicaid-covered services rendered to Appellant.

IT IS THEREFORE ORDERED THAT:

The Department's decision is AFFIRMED.

Landis Y. Lain
Administrative Law Judge
for Nick Lyons, Director
Michigan Department of Health and Human Services

cc: [redacted]

LYL[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.