STATE OF MICHIGAN
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
FOR THE DEPARTMENT OF HEALTH AND HUMAN SERVICES
P.O. Box 30763, Lansing, MI 48909
(517) 373-0722; Fax: (517) 373-4147

IN THE MATTER OF:

MAHS Docket No. 15-020418 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 his own behalf.[1] [redacted] Appeals Review Officer, represented the Michigan Department of Health and Human Services (DHHS or Department). [redacted] Analyst, 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. Beginning in [redacted] Appellant was eligible for Medicare Parts A and B. (Testimony of Appellant; Testimony of Department's Analyst).

2. Since that time, Appellant has been enrolled in Medicare Part A. (Exhibit A, pages 10-11).

3. However, while eligible, Appellant has not been enrolled in Medicare Part B. (Exhibit A, pages 10-11; Testimony of Department's Analyst).

[1] Appellant's request for hearing did identify an Authorized Hearing Representative (AHR) for Appellant. However, the AHR was not present for the hearing and Appellant stated on the record that he wanted to proceed without her.

4. On [redacted] Appellant received services through [redacted] and [redacted] (Exhibit A, pages 12-14; Testimony of Appellant; Testimony of Department's Analyst).

5. On that date of service, Appellant had an unmet Medicaid deductible/spend-down. (Exhibit A, pages 7-8; Testimony of Department's Analyst).

6. [redacted] billed the Department for the services, but its claim was denied because Appellant's Medicaid was inactive due to his unmet deductible. (Exhibit A, page 13; Testimony of Department's Analyst).

7. On or about [redacted] the Department determined that Appellant had met his deductible by [redacted] and he was retroactively approved for full Medicaid eligibility for that date of service. (Exhibit A, pages 7-8; Testimony of Department's Analyst).

8. [redacted] billed the Department for the services, but its claim was denied pursuant to the policy that Medicaid claims are rejected where the Medicaid beneficiary is eligible for, but not enrolled in, Medicare Part B and has incurred expenses that would have been covered by Medicare Part B. (Exhibit A, page 14; Testimony of Department's Analyst).

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

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, including Medicare, the Medicaid Provider Manual (MPM) states in the pertinent parts:

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.

* * *

2.6. 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.

* * *

2.6.F. MEDICAID LIABILITY

If Medicare has paid 100 percent of the allowable charges and there is no coinsurance involved, then Medicaid has no payment liability.

Neither the beneficiary nor Medicaid is liable for any difference in the amount billed by the provider and Medicare's allowable fee.

If the beneficiary is in a Medicare Risk HMO, MDCH pays fixed copays (except Medicare Part D) on the services up to the lesser of Medicaid's allowable amount minus the Medicare payment for the service or the beneficiary's payment liability, as long as the rules of the HMO are followed.

MDCH reimburses providers for the coinsurance and deductible amounts subject to Medicaid reimbursement limitations on all Medicare approved claims even if Medicaid does not normally cover the service. MDCH

payment liability for beneficiaries with Medicare coverage (except Medicare Part D) is the lesser of:

- The beneficiary's liability for coinsurance, copayments, and/or deductibles minus any applicable Medicaid copayment, patient-pay, or deductible amounts.

- The Medicaid fee screen/allowable amount, minus any Medicare or other insurance payments and any applicable Medicaid copayment, patient-pay, or deductible amounts.

- The provider's charge, minus any Medicare or other insurance payments, contractual adjustments, and any applicable Medicaid copayment, patient-pay, or deductible amounts.

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.

Medicare coverage is not available for a Medicaid beneficiary who is 65 years or older and is an alien who has been in the country less than five consecutive years.

MDCH does not pay for services denied by Medicare or other insurance plans due to noncompliance with Medicare or other insurance plan requirements. If the provider’s service would have been covered and payable by Medicare or the other insurance plan but some requirement of the plan was not met, MDCH will deny the claim. The provider and the beneficiary both have equal responsibility for complying with Medicare or the other insurance plan requirements.

Common noncompliance denials include, but are not limited to:

- Failure to obtain a referral from a participating primary care provider (PCP).

- Failure to be seen by a participating provider.

- Failure to be seen in a participating place of service.

- Failure to obtain a second opinion.

- Failure to obtain prior authorization

In instances where MDCH has denied payment or made a post-payment recovery due to noncompliance, it is the provider's responsibility to remediate with the primary payer prior to re-billing with Medicaid.

NOTE: This also applies to Fee-for-Service pharmacy claims, particularly claims submitted with Other Coverage Code (OCC) "3: Other Coverage Billed – Claim Not Covered ." When the National Council for

Prescription Drug Programs (NCPDP) standard does not provide MDCH with a point-of-sale (POS) mechanism to verify full compliance with Medicare or commercial health insurance plan requirements, MDCH will review and recover monies for noncompliance on a post-payment basis (e.g., when the primary payer denies the claim with NCPDP rejection code "75: Prior Authorization Required" and MDCH is unable to verify at the POS whether prior authorization was requested and denied versus prior authorization not requested).

When a Medicaid beneficiary is eligible for, but not enrolled in, Medicare Part B and/or Part D, MDCH rejects any claim for Medicare Part B or Part D services. Providers should instruct the beneficiary to pursue Medicare through the SSA.

If Medicare reimburses for the service, Medicaid does not require PA for the service.

MDCH identifies fee-for-service (FFS) beneficiaries who are retroactively eligible for Medicare. Medicaid payment for services provided to these beneficiaries is adjusted to recoup all monies except the Medicaid liability, and recovered via an automated claim adjustment. FFS providers are notified by MDCH when these adjustments occur. The notification includes beneficiary detail. If a discrepancy in payment exists,

> the provider should contact Provider Inquiry. (Refer to the Directory Appendix for contact information.)
>
> 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 or CA capitation. Refer to the Commercial Health Insurance, Traditional Indemnity Policies, and Military/Veteran Insurance subsection of this chapter for exceptions when a beneficiary has third party resources.
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> **2.6.G. EXCEPTIONS TO THE BILLING LIMITATION**
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> When a delay in payment from Medicare causes a delay in billing Medicaid, an exception may be made if the provider can document that Medicare was billed within 120 days of the date of service and Medicaid was billed within 120 days of the date of payment, rejection or retroactive recovery of funds by Medicare. Medicaid payment is made provided all other requirements (e.g., beneficiary eligibility, medical necessity) are met. A copy of the Medicare claim submitted and Medicare's response must be attached to the Medicaid paper claim to document Medicare's delay. If billing electronically, a note should be added in the Remarks segment that the late billing is due to Medicare's delay in processing the claim. (Refer to the Billing & Reimbursement Chapters of this manual for additional information.)
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> *MPM, August 1, 2015 version*
> *Coordination of Benefits Chapter, pages 1, 6, 8-11*
> *(Emphasis added)*

Here, the Department's Analyst testified that the claims for services at issue in this case were either denied or would be denied pursuant to the above policies. Specifically, he testified that the policies clearly provide that the Department will reject any claim for Medicare Part B services when a Medicaid beneficiary is eligible for, but not enrolled in, Medicare Part B. He also testified that, while Appellant remained eligible for Medicare Part B on the date of service relevant to this case, Appellant was not enrolled in Medicare Part B and that the Department therefore denied all claims for Medicare Part B services submitted. Both the Department's representative and its Analyst also testified that, while it may affect claims, Medicaid eligibility does not require Medicare

enrollment and will not be held up if a beneficiary is not so enrolled.

In response, Appellant testified that he did not know that he had to be enrolled in Medicare Part B or that claims would be denied. He also agreed that he was not enrolled in Medicare Part B at the time, but further argued that either the hospital or the Department should have informed Appellant of the issue prior to the surgery.

The undersigned Administrative Law Judge sympathizes with Appellant's testimony, but he also lacks equitable powers and is bound by the applicable policy. In this case, that clear policy expressly provides that Medicaid is a payor of last resort and if a Medicaid beneficiary is eligible for, but not enrolled in, Medicare Part B, the Department does not make reimbursement for Medicare Part B services. 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 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.