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. 15-006962 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], appeared on Appellant's behalf. [redacted], Appellant's wife, and [redacted] Appellant's son, also testified as witnesses on Appellant's 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.

Following the hearing, the undersigned Administrative Law Judge left the record open for [redacted] weeks at Appellant's representative's request; one week for Appellant's representative to submit a brief and [redacted] weeks for the Department's representative to submit a reply.

On [redacted], MAHS received Appellant's Supplemental Brief. On [redacted], MAHS received an objection to consideration of the supplemental brief and accompanying documents from the Department. According to the Department, the brief and documents should not be considered as they were submitted untimely to MAHS and not submitted to the Department at all.

However, while there appears to be merit to the Department's objection, the undersigned Administrative Law Judge also finds that the objection need not be addressed as, for the reasons discussed below, the Department's decision in this case must be affirmed even if the Appellant's supplemental brief is considered.

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 [redacted] Appellant was eligible for Medicare Parts A and B. (Exhibit A, page 11; Testimony of [redacted].

2. However, he did not enroll in Medicare at that time. (Exhibit A, page 11; Testimony of [redacted]).

3. In the summer of [redacted] Appellant was admitted into a nursing facility. (Testimony of [redacted]).

4. He has remained in that nursing facility since being admitted. (Testimony of [redacted]).

5. In [redacted], Appellant applied for Medicaid coverage, with retroactive coverage going back [redacted] months. (Testimony of [redacted]).

6. After [redacted] being asked to provide additional information, Appellant's application was denied in [redacted]. (Testimony of [redacted].

7. However, he did receive Medicaid coverage for [redacted] only. (Exhibit A, page 8; Testimony of [redacted]

8. Appellant both appealed the denial and reapplied for Medicaid in [redacted], but the appeal and the new application were also denied. (Testimony of [redacted]

9. In [redacted], Appellant filed a [redacted] application for Medicaid, but was again denied. (Testimony of [redacted]r).

10. On [redacted], Appellant enrolled in Medicare Part B. (Exhibit A, page 11; Testimony of [redacted]).

11. However, he remained eligible for, but not enrolled in Medicare Part A. (Exhibit A, page 11; Testimony of [redacted]).

12. Appellant also filed a fourth application for Medicaid around that time, which was subsequently approved with retroactive coverage of [redacted] months. (Testimony of [redacted]

13. Appellant has therefore had full Medicaid coverage since [redacted]. (Exhibit A, page 11; Testimony of [redacted]

14. Appellant and the nursing facility then requested payments through Medicaid for the time periods when Appellant did have Medicaid coverage. (Testimony of [redacted]; Testimony of [redacted].

15. However, those requests/claims were denied on the basis that Medicaid claims are rejected where the Medicaid beneficiary is eligible for, but not enrolled in, Medicare Part A and has incurred expenses that would have been covered by Medicare Part A. (Testimony of [redacted] Testimony of [redacted].

16. Appellant then signed up for Medicare Part A, but his coverage would not begin until [redacted]. (Testimony of [redacted]; Testimony of [redacted].

17. On [redacted], the Michigan Administrative Hearing System (MAHS) received the request for hearing filed in this matter. (Exhibit A, pages 4-5).

18. In that request, Appellant and his representative state they are appealing the determination that Medicaid will not cover his care until Medicare Part A becomes effective. (Exhibit A, pages 4-5).

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.B. MEDICARE PART A

Since Medicare Part A pays for care in an inpatient hospital, nursing facility (NF), services provided by a home health agency (HHA) or in other institutional settings, Medicaid's reimbursement for services under Medicare Part A may vary.

If MDCH is paying a beneficiary's Medicare Part B premium and the beneficiary does not have free Medicare Part A, MDCH also pays the beneficiary's Medicare Part A premium.

MDCH monitors beneficiary files to identify all beneficiaries who currently have Medicare Part B coverage only, and have Part B buy-in. Once these beneficiaries are identified, MDCH automatically processes Part A buy-in.

When a beneficiary has incurred Medicare Part A charges and is eligible for, but does not have, Medicare Part A buy-in, the claim is rejected. Providers must wait for the beneficiary to obtain Medicare coverage, then bill Medicare for services rendered. After Medicare's payment is received, Medicaid should be billed for any coinsurance and/or deductible amounts. For Medicare Part A and Part B/Medicaid claims, Medicaid's liability never exceeds that of the beneficiary.

To expedite the buy-in process, providers may notify MDCH, in writing, when a beneficiary age 65 or older, covered by Medicare Part B only, is admitted to an inpatient hospital. (Refer to the Directory Appendix for MDCH Provider Inquiry contact information.)

The following information is required:

- Beneficiary's name, date of birth, and Medicaid identification (ID) number;
- Health insurance claim number (HICN);
- Inpatient hospital admission date; and
- Hospital name, address, and provider NPI number.

Special points to remember:

- Medicaid does not pay for any portion of the services Medicare would have otherwise covered if a provider's error prevents Medicaid from buying-in Medicare Part A.
- To bill a claim when Medicare Part A coverage for Medicare/Medicaid beneficiaries is exhausted

> prior to an admission or during an inpatient hospital stay, refer to the Billing & Reimbursement for Institutional Providers Chapter of this manual.
>
> - To bill a claim when no Medicare payment has been made because the amount of Medicare coinsurance, plus the amount for lifetime reserve days, is greater than the Medicare diagnosis related group (DRG) amount, refer to the Billing & Reimbursement for Institutional Providers Chapter of this manual.
>
> *MPM, January 1, 2015 version*
> *Coordination of Benefits Chapter, pages 1, 6-7*
> *(Emphasis added)*

Here, the Department's witness testified that the claims for services at issue in this case were denied pursuant to the above policies. Specifically, he testified that the above policies clearly provide that the Department will reject any claim for Medicare Part A services when a Medicaid beneficiary is eligible for, but not enrolled in, Medicare Part A. [redacted] also testified that, while Appellant remained eligible for Medicare Part A at all times relevant to this case, Appellant was not enrolled in Medicare Part A and that the Department therefore ultimately denied all claims for Medicare Part A services submitted.

In response, Appellant's representative first argues that during the long process of getting Appellant Medicaid coverage, including multiple applications and appeals, no one informed Appellant that Appellant's lack of enrollment in Medicare Part A would have an effect on his services, leading him to believe he was fully covered, and that Medicaid should have therefore started paying when Appellant became eligible.

However, as testified to by the Department's witness, given that only Appellant's Medicaid coverage was at issue during those applications and appeals, there was no action taken based on Appellant's lack of Medicare coverage and no need to address it at that time. Additionally, Appellant's representative does not point to any authority or policy in support of his argument, and instead bases it on equity and fairness whereas the undersigned Administrative Law Judge 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 A, the Department does not make reimbursement for Medicare Part A services. That is what occurred in this case and, consequently, the Department's rejection of claims based on the available information must be sustained.

Appellant's representative also argues that, given the particular circumstances here, Medicare would not have made any payments even if Appellant had been enrolled in Medicare Part A and that Medicaid would have therefore been fully responsible regardless. Appellant's representative also argues that, given the lack of Medicare coverage for the services at issue here, Appellant did not incur any Medicare Part A charges and that Medicaid is obligated to pay the nursing facility pursuant to Appellant's undisputed Medicaid coverage.

However, Appellant's argument is contradicted by the plain language of the MPM, which expressly states that, if a Medicaid beneficiary is eligible for Medicare, but has not applied for Medicare coverage, Medicaid does not make any reimbursement for services until Medicare coverage is obtained and that it is only after a beneficiary has obtained Medicare coverage the services may be billed to Medicaid. *See* MPM, Coordination of Benefits Chapter, Section 2.6.A. Medicare Eligibility. Appellant's argument also contradicts the structure envisioned by the MPM as, instead of being the payor of last resort and only expending funds after all other identifiable financial resources are utilized, as required by policy, *see* MPM, Coordination of Benefits Chapter, Section 1 – Introduction, Appellant would compel the Department to speculate as to what other programs or other insurance would have paid had a beneficiary properly sought payment from them first.

At the time of the nursing facility services at issue in this case, Appellant was eligible for, but not enrolled in, Medicare Part A. Accordingly, the Department properly denied any claims for services pursuant to the above policies.

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]

[redacted]
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Decision and Order

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.