RICK SNYDER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
Christopher Seppanen
Executive Director

MIKE ZIMMER
DIRECTOR

[redacted]

Date Mailed: [redacted]
MAHS Docket No.: 16-002616
Agency No.: [redacted]
Petitioner: [redacted]

ADMINISTRATIVE LAW JUDGE: Robert J. Meade

DECISION AND ORDER

This matter is before the undersigned Administrative Law Judge (ALJ) pursuant to MCL 400.9 and MCL 400.37 upon Petitioner's request for hearing.

After due notice, a telephone hearing was held on [redacted]. Petitioner appeared and testified on his own behalf. [redacted], Appeals Review Officer, represented the Michigan Department of Health and Human Services (DHHS or Department). [redacted], Department Analyst, appeared as a witness for the Department.

ISSUE

Did the Department properly deny claims submitted for services provided to Petitioner?

FINDINGS OF FACT

The Administrative Law Judge, based upon the competent, material and substantial evidence on the whole record, finds as material fact:

1. Petitioner requested an Administrative Hearing regarding medical bills he received from two providers: [redacted], $100 for service date [redacted] and [redacted], $47 for service date [redacted] (Exhibit A, pp 4-6; Testimony).

2. Petitioner was enrolled in Medicaid-Healthy Michigan Plan effective [redacted] and his enrollment into HAP Midwest Health Plan, a Medicaid Health Plan, was effective [redacted]. (Exhibit A, pp 7-8; Testimony).

3. At the time he became eligible for the Healthy Michigan Plan, Petitioner also had commercial primary insurance through [redacted] which was not terminated until [redacted]. Medicaid was not informed that Petitioner's [redacted] insurance was terminated until [redacted]. (Exhibit A, p 9; Testimony).

4. [redacted] does not participate with Medicaid/Healthy Michigan Plan. (Exhibit A; Testimony).

5. Petitioner's request for hearing was received by the Michigan Administrative Hearing System 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.

Regarding the coordination of Medicaid benefits with other programs, the applicable version of the Medicaid Provider Manual (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.
>
> * * *

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.

* * *

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.)

MPM, January 1, 2016 version
Coordination of Benefits Chapter, pages 1, 3-4
(Emphasis added)

Similarly, with respect to the billing of beneficiaries, the MPM states:

> **SECTION 11 - BILLING BENEFICIARIES**
>
> **11.1 GENERAL INFORMATION**
>
> Providers cannot bill beneficiaries for services except in the following situations:
>
> * * *
>
> - The beneficiary is the policyholder of the other insurance and the beneficiary did not follow the rules of the other insurance (e.g., utilizing network providers).
>
> *MPM, July 1, 2016 version*
> *General Information for Providers Chapter, pages 1, 3-4*

Here, the Department's witness testified that the claims for services at issue in this case were denied pursuant to the above policies. Specifically, the above policies clearly provide that Medicaid is the payor of last resort and Petitioner's private insurance must be billed before Medicaid. The Department's witness indicated that Petitioner's private insurance was terminated on [redacted], but Medicaid was not notified of the change until [redacted]. As such, the Department's witness indicated that Medicaid could not be billed for the service date of [redacted]. The Department's witness also indicated that Petitioner's physician, [redacted], does not participate in Medicaid-Healthy Michigan Plan, so because [redacted] referred Petitioner for the blood test he received at [redacted] on [redacted], Medicaid could not cover that service either. The Department's witness did testify that when she contacted [redacted] office, she was informed that Petitioner was not showing a balance due for the [redacted] service.

Petitioner testified that he understood that BCN was now willing to pay $90 out of the $100 bill for [redacted], with him being responsible for a $10 copay, but that he was not aware that the payment had gone through yet. Petitioner indicated that even though his BCN coverage was effective until [redacted], BCN informed him that he could not use the coverage because he was eligible for the Healthy Michigan Plan on [redacted]. Petitioner indicated that his doctor's office had billed BCN numerous times for the dates in question, but they refused to pay. Petitioner testified that he also paid out of pocket for two, seven day prescriptions for Synthroid. Petitioner indicated that he would follow up with [redacted] to see if they would bill BCN again and if BCN would cover the service from [redacted]. Petitioner indicated that his application to be enrolled in a Medicaid Health Plan was delayed longer than usual because when he did not hear anything following the filing of the first application in [redacted], he filed a second application. Petitioner indicated that when he finally

went to the Department's offices, he was informed that neither of his applications were acted upon because he had filed two applications.

Petitioner bears the burden of proving by a preponderance of the evidence that the Department erred in denying the claims. Moreover the undersigned Administrative Law Judge is limited to reviewing the Department's decision in light of the information it had at the time it made that decision.

In this case, all the information the Department had demonstrated that Petitioner possessed coverage through BCN at the time he received services on [redacted] and, per the clear policy of the MPM, BCN must be billed prior to Medicaid, which is the payor of last resort. It appears that now BCN has agreed to cover these services. For the services on [redacted], Petitioner had not yet been enrolled in his Medicaid Health Plan, but the physician who referred him for the blood test, [redacted] did not accept Medicaid. As such, that bill could not be covered by the straight fee-for-service Medicaid Petitioner was eligible for at that time and would not have been covered even if Petitioner had then been enrolled in his managed care plan. 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 Petitioner.

IT IS THEREFORE ORDERED THAT:

The Department's decision is **AFFIRMED**.

RM/cg

Robert J. Meade
Administrative Law Judge
for Nick Lyon, Director
Department of Health and Human Services

NOTICE OF APPEAL: A party may appeal this Order in circuit court within 30 days of the receipt date. A copy of the circuit court appeal must be filed with the Michigan Administrative Hearing System (MAHS).

A party may request a rehearing or reconsideration of this Order if the request is received by MAHS within 30 days of the date the Order was issued. The party requesting a rehearing or reconsideration must provide the specific reasons for the request. MAHS will not review any response to a request for rehearing/reconsideration.

A written request may be mailed or faxed to MAHS. If submitted by fax, the written request must be faxed to (517) 335-6088; Attention: MAHS Rehearing/Reconsideration Request.

If submitted by mail, the written request must be addressed as follows:

Michigan Administrative Hearings
Reconsideration/Rehearing Request
P.O. Box 30763
Lansing, Michigan 48909-8139

DHHS -Dept Contact [redacted]

Petitioner [redacted]

DHHS Department Rep. [redacted]

DHHS Department Rep. [redacted]