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: April 25, 2016
MAHS Docket No.: 16-002815
Agency No.: [redacted]
Petitioner: [redacted]

ADMINISTRATIVE LAW JUDGE: Corey Arendt

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]. Petitioner appeared on his own behalf. [redacted], Appeals Review Officer, represented the Department. [redacted], Departmental Analyst, appeared as a witness for the Department.

ISSUE

Did the Department properly reject claims for medical 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. From [redacted] through [redacted], the Petitioner was a Medicaid beneficiary. (Exhibit A, p. 6; Testimony).

2. From [redacted] through [redacted], the Petitioner received services from Pain Rehabilitation Physicians (PRP). The cost of these services amounted to $[redacted]. (Exhibit A, pp. 6-16; Testimony).

3. PRP billed Medicaid for each of the Petitioner's visits from [redacted] through [redacted]. Medicaid denied each of these billings due to Medicare coverage. (Exhibit A, p. 6; Testimony).

4. On [redacted], the Michigan Administrative Hearings System (MAHS) received the Petitioner's request for hearing regarding the unpaid medical bills from PRP. (Exhibit A, pp. 4-5).

CONCLUSIONS OF LAW

The Medical Assistance Program (MA) 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.

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

- A co-payment for chiropractic, dental, hearing aid, pharmacy, podiatric, or vision services is required. However, a provider cannot refuse to render service if the beneficiary is unable to pay the required co-payment on the date of service.
- A monthly patient-pay amount for inpatient hospital or nursing facility services. The local DHHS determines the patient-pay amount. Non-covered services can be purchased by offsetting the nursing facility beneficiary's patient-pay amount. (Refer to the Nursing Facility Chapter for more information.)
- For nursing facility (NF), state-owned and -operated facilities or CMHSP-operated facilities determine a financial liability or ability-to-pay amount separate from the DHHS patient-pay amount. The state-owned and -operated facilities or CMHSP-operated facilities liability may be an individual, spouse, or parental responsibility. This responsibility is determined at initiation of services and is reviewed periodically. The beneficiary or his authorized representative is responsible for the state-owned and -operated facilities or CMHSP ability to pay amount, even if the patient-pay amount is greater.
- The provider has been notified by DHHS that the beneficiary has an obligation to pay for part of, or all of, a service because services were applied to the beneficiary's Medicaid deductible amount.
- If the beneficiary is enrolled in a MHP and the health plan did not authorize a service, and the beneficiary had prior knowledge that he was liable for the service. (It is the provider’s responsibility to determine eligibility/enrollment status of each beneficiary at the time of treatment and to obtain the appropriate authorization for payment. Failure of the provider to obtain authorization does not create a payment liability for the beneficiary.)

- Medicaid does not cover the service. If the beneficiary requests a service not covered by Medicaid, the provider may charge the beneficiary for the service if the beneficiary has been told prior to rendering the service that it was not covered by Medicaid. If the beneficiary is not informed of Medicaid non-coverage until after the services have been rendered; the provider cannot bill the beneficiary.
- **The beneficiary refuses Medicare Part A or B.**
- Beneficiaries may be billed the amount other insurance paid to the policyholder if the beneficiary is the policyholder.
- 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).
- The provider chooses not to accept the beneficiary as a Medicaid beneficiary and the beneficiary had prior knowledge of the situation. The beneficiary is responsible for payment.

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.

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.**

Medicaid Provider Manual,
Coordination of Benefits
October 1, 2015, pp 1, 6, 8.

The Department indicated the billings were denied due to Medicaid coverage. The denial suggests the Petitioner was enrolled with Medicaid during the timer period in question and that the Provider failed to bill Medicare prior to billing Medicaid or the Petitioner was eligible for Medicare but was not enrolled.

The Department indicated they tried to assist the Petitioner in this matter by determining when he had Medicare coverage but was not able to do so as the Medicare cards presented created questions regarding the periods of coverage. The Department indicated they would be more than willing to assist the Petitioner with this issue if he were able to provide them with evidence of his Medicare eligibility during the time period in question.

The Department's Representative indicated the Petitioner could contact the Michigan Medicare/Medicaid Assistance Program at phone number 1-800-803-7174. The Representative indicated they should be able to assist the Petitioner in obtaining the information being requested.

The Medicaid Provider Manual policy is clear that Medicaid is a payer 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 and Medicare billed first. Accordingly, this ALJ must uphold the Department's rejection of the claims based on the available information.

DECISION AND ORDER

The Administrative Law Judge, based on the above Findings of Fact and Conclusions of Law, decides that the Department properly denied the payment of Petitioner's medical bill from PRP.

IT IS, THEREFORE, ORDERED that:

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

CA[redacted]

Corey Arendt
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]

DHHS Department Rep.

[redacted]

Petitioner

[redacted]

Agency Representative

[redacted]