STATE OF MICHIGAN
STATE OFFICE OF ADMINISTRATIVE HEARINGS AND RULES
FOR THE DEPARTMENT OF COMMUNITY HEALTH
P.O. Box 30763, Lansing, MI 48909
(877) 833-0870; Fax: (517) 334-9505

IN THE MATTER OF:

[redacted]

Appellant
_____/

Docket No. 2009- 32226 MSB
Case No. [redacted]

DECISION AND ORDER

This matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9 and MCL 400.37 upon the Appellant's request for a hearing.

After due notice, a hearing was held on [redacted]. [redacted]y, represented the Appellant. [redacted]t) appeared and testified. [redacted], Appeals Review Officer, represented the Michigan Department of Community Health (Department). [redacted] Departmental Specialist, appeared and testified as a witness for the Department.

ISSUE

Did the Department properly deny payment of Appellant's unpaid medical bills for the period [redacted]?

FINDINGS OF FACT

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

1. Appellant is a [redacted] who was eligible for Medicaid and Medicare Part A and B at all times relevant to this matter.

2. Appellant was eligible for Medicaid effective [redacted]. (Exhibit 1)

3. Appellant became eligible for Medicaid Part A effective [redacted]. (Exhibit 1)

4. Appellant did not enroll in Medicare Part B until [redacted], and she was enrolled in Medicare Part D [redacted]. (Exhibit 1)

5. Appellant received medical services from several medical providers during the period of [redacted] (Exhibit 1)

6. Appellant has over [redacted] in unpaid medical bills for the period of [redacted] (Exhibit 1)

7. Appellant submitted her unpaid medical bills to the Department for payment. (Exhibit 1)

8. Appellant's medical bills were not paid by Medicaid on the basis that Appellant was eligible for, but not currently enrolled in Medicare Part B, which was determined to be a potential financial resource for Appellant, effective [redacted], her Medicare Part A entitlement date. (Exhibit 1)

9. On [redacted], the State Office of Administrative Hearings and received Appellant's hearing request, protesting the fact that her medical bills incurred during the period of [redacted] were rejected by Medicaid.

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 DHS Department policy on when a beneficiary can be billed for medical services is as follows:

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 DHS determines the patient-pay amount. Noncovered 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 DHS 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 DHS 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 noncoverage 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.

Medicaid Provider Manual, General Information for Providers, April 1, 2007

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 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:

- Sixty-five years of age or older.
- A disabled adult (entitled to SSI or RSDI due to a disability).
- A disabled minor child.

2.6.E. MEDICAID LIABILITY [CHANGES MADE 7/1/05]

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

(Bold emphasis made by ALJ)

Medicaid Provider Manual, Coordination of Benefits Section, April 1, 2007

In this case, Appellant was enrolled in Medicare Part A effective [redacted], but opted not to enroll in Medicare Part B until [redacted]. There is no dispute that the Department followed the applicable Medicaid policy in denying Medicaid coverage of Appellant's unpaid medical bills for the period of [redacted]. Department policy is clear that if a person is eligible for Medicare, but does not have Medicare, the Medicaid program will reject any claims for Medicare-covered services. Medicaid cannot pay for any medical bills that would have been covered by Medicare Part B, which Appellant was eligible to receive at the time relevant to this matter. Appellant's attorney asserts that the applicable Department policy violates 42 USC 1396a(a)(3), 42 USC 1396a(a)(10)(C), 42 USC 1396a(a)(25)(C), 42 CFR 435.206, 210, & 919, 42 CFR

447.15, and MCLA 400.111b(14). However, Administrative Law Judges have no authority to make decisions on constitutional grounds, overrule statutes, overrule promulgated regulation or overrule or make exceptions to Department policy. (Delegation of Hearing Authority, signed by the Department of Community Health Director, effective August 29, 2006) Accordingly, the Department's decision is upheld.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the Department properly denied payment of Appellant's unpaid medical bills for the period [redacted]?

IT IS THEREFORE ORDERED that:

The Department's decision is AFFIRMED.

Marya A. Nelson-Davis
Administrative Law Judge
for Janet Olszewski, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 10/29/2009

***** NOTICE *****

The State Office of Administrative Hearings and Rules 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 State Office of Administrative Hearings and Rules 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.