STATE OF MICHIGAN
STATE OFFICE OF ADMINISTRATIVE HEARINGS AND RULES
FOR THE DEPARTMENT OF COMMUNITY HEALTH
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IN THE MATTER OF:

Docket No. 2009-35668 MSB
Case No. [redacted]

[redacted]

Appellant
_____/

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], appeared on behalf of the Appellant. Appellant was present during the hearing. [redacted], represented the Department. [redacted], appeared as a witness for the Department.

ISSUE

Did the Department properly deny claims for Medicaid-covered services rendered to Appellant prior to [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 has been enrolled in various forms of Michigan Medicaid from [redacted] to present. (Exhibit 1 Page 2).
2. Appellant was enrolled in Medicare Part A in [redacted]. (Exhibit 1 Page 4).
3. Appellant was eligible for Medicare Part B on the [redacted] date he was enrolled in Medicare A, but did not enroll in Medicare Part B.
4. Appellant was enrolled in Medicare Part B in [redacted]. (Exhibit 1 Page 2).
5. Appellant received Medicare Part B-covered outpatient medical services between [redacted]. Medicaid denied payment of provider claims for that time period. The Appellant received provider bills for services within that time

period. (Exhibit 1 Pages 2, 3, 4).

6. The Department received Appellant's request for hearing on [redacted]. (Exhibit 1 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.

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:
>
> *****
>
> - **The beneficiary refuses Medicare Part A or B.**
>
> *****
>
> *Medicaid Provider Manual, General Information for Providers, July 1, 2009, Page 17*

> **2.6. MEDICARE**
>
> **2.6.A. MEDICARE ELIGIBILITY**
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> 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:
>
> - 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.F. MEDICAID LIABILITY [CHANGES MADE 7/1/05]**
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> **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 shouldinstruct the beneficiary to pursue Medicare through the SSA.
>
> (Bold emphasis made by ALJ)
>
> *Medicaid Provider Manual, Coordination of Benefits Section, October 1, 2009, Pages 6 and 9*

In investigating Appellant's case the Department's witness researched Social Security Administration/Medicare status and obtained information on the Appellant's Medicare Part A and B enrollment. (Exhibit 1 Page 2).

The Department's witness testified that Appellant was enrolled in Medicare Part A in [redacted]. The Department's witness explained that at the time a person is enrolled in Medicare Part A he is eligible to be enrolled in Part B. The Department's witness further explained that at the time a person is enrolled in Medicare Part A, if he is not enrolled in Medicare Part B the Department's policy prohibits use of Medicaid to pay for Medicare Part B-covered claims. The Department's witness testified that from [redacted] through to [redacted] Appellant was enrolled in Medicaid and Medicare Part A, but because he was eligible for but did not enroll in Medicare Part B and pay Part B premiums, the Department was required to follow the policy above and reject any claims for Part B services. (Exhibit 1 Pages 2, 4-9).

The Appellant's wife/representative testified that the Appellant was never told he had to enroll in Medicare Part B and pay the premiums in order to have Medicaid cover his outpatient medical bills. The Appellant said that the social security benefits information letter was evidence that he was not able to enroll in Medicare Part B until [redacted]. (Exhibit 1 Page 3).

The Department responded that an individual is eligible to enroll in Part B when eligible for Part A and the social security information letter only indicated when Appellant enrolled in Part B, not whether he would be able to enroll. This Administrative Law Judge granted

Appellant an opportunity to provide evidence that Appellant was not eligible to enroll until [redacted], and indicated that the evidentiary record would close on [redacted], even if the evidence was not received by that time. On [redacted], this Administrative Law Judge received a fax indicating the Appellant had contacted the social security office and were told it would be "4 to 6 wks to let us know anything."

The Department policy is clear that if a person is eligible for Medicare B but does not enroll in Medicare B, the Medicaid program will reject any claims for Medicare Part B-covered services. To Appellant's belief that he was not aware of the policy, it is a Medicaid beneficiary's responsibility to be informed about the program and to pursue all financial resources available before utilizing Medicaid. In the paragraph immediately following the signature line of the DHS Assistance Application FIA-1171, notice is given about Medicaid paying only what Medicare does not. All applicants, including Appellant, are required to fill out the application.

The Appellant did not prove by a preponderance of evidence that he was not eligible for Medicare Part B or that the Department improperly denied payment for claims between [redacted]. The jurisdiction of this Administrative Law Judge does not extend to equity and policy must be strictly applied with no exception.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the Department properly rejected the claim for Medicaid-covered services rendered to Appellant.

IT IS THEREFORE ORDERED that:

The Department's decision is AFFIRMED.

Lisa K. Gigliotti
Administrative Law Judge
for Janet Olszewski, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 12/1/2009

***** 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.