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. 2009-4807 MSB
Case No. [redacted]
Load 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]. The Appellant appeared without representation. He had no witnesses. [redacted] represented the Department. Her witness was [redacted].

ISSUE

Did the Department properly deny the Appellant's claim for payment of Medical bills?

FINDINGS OF FACT

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

1) The Appellant is a disabled, spend-down, Medicaid/Medicare beneficiary. (Appellant's Exhibit #1)

2) Between the months of [redacted] the Appellant received medical services at his local hospital and from various providers. (See Appellant's Exhibit #2 – throughout)

3) The Department of Human Services (DHS) denied his bills owing to its determination that he did not meet his deductible. (Appellant's Exhibit #2, pp. 14-17)

4) The Appellant sought guidance from his DHS caseworker between [redacted], relative to his unpaid medical bills, with negative results. He provided written documentation of his attempts to contact his case worker, [redacted] (Appellant's #1, p. 2 and Appellant's Exhibit 2, pp. 2-4)

5) The Department of Community Health, problem resolution unit, determined that the Appellant's medical billings were the Appellant's responsibility as he was Medicare eligible and had opted out of Part B coverage – as of [redacted] (Department's Exhibit A, p, 2)

6) In a blank form document (DCH 1144) the Department maintained that the Appellant was advised that Medicaid is the payor of last resort and that Part B enrollment was encouraged. (Department's Exhibit A, p. 3 [Sub A])

7) The Appellant said he never received the MDCH automated letter advising him of his Part B premium. There was no proof of service or addressing to prove posting and receipt. (*See* Testimony of [redacted] and Department's Exhibit A, p. 3 [Sub A])

8) The Appellant explained his proposition that as a "disabled person" the DHS erred in leading him in the wrong direction. (*See* Testimony of Appellant)

9) The Appellant said he would enroll in Part B at the next open enrollment period. (*See* Closing remarks of the Appellant)

10) The relevant CIMS document printed [redacted] shows 2F then 20 Medicaid status beginning [redacted]. There was no Medicaid status dating back to [redacted] (Appellant's Exhibit #1)

11) The instant request for hearing was received by SOAHR on [redacted] (Appellant's 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.

All claims must be submitted in accordance with the policies, rules, and procedures as stated in the Medicaid Provider Manual.

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.

It is recommended that providers obtain the beneficiary's written acknowledgement of payment responsibility prior to rendering any nonauthorized or noncovered service the beneficiary elects to receive.

. . . .

Medicaid Provider Manual, (MPM), General Information
for Providers Section, January 1, 2009, Page 17

[ ] MEDICARE PART B

Medicare Part B covers practitioner's services, outpatient hospital services, medical equipment and supplies, and other health care services. When a beneficiary is eligible for and enrolled in Medicare Part B, Medicare usually pays for a percentage of the approved Medicare Part B allowable charges and Medicaid pays the applicable deductible and/or co-insurance up to Medicaid's maximum allowable amount. Coverage for outpatient therapeutic psychiatric coverage varies.

Beneficiaries are encouraged to enroll in Medicare Part B as soon as they are eligible to do so. A beneficiary's representative can apply for Medicare Part B benefits on behalf of the beneficiary. After the beneficiary's death, DHS is responsible for making the application to the Social Security Administration (SSA) to cover medical services provided prior to the death.

MPM, Coordination of Benefits, January 1, 2009, page 7

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The Department provided evidence that the Appellant was eligible for Medicare and opted out of Part B [redacted] making him responsible for payment of his Part B services.

However, a year later the Appellant began the process of questioning his case worker for explanations about why he was being dunned for medical bills - items he thought covered (in whole or part) under his deductible (Medicaid) status.

The Appellant documented his attempts to contact his case worker over the [redacted] while his medical bills aged to second billing, but it was not enough to preponderate his burden of proof.

The Appellant's Medicaid application clearly alerts him of his duty to report changes in his coverages – a status he actively changed on [redacted] Whether that was a correct decision or not – he should have reported it in his application:

PLEASE KEEP THIS PAGE.
INFORMATION ABOUT MEDICAID
Rules may have changed since this was printed. Check with your local FIA office.

Medicaid helps people pay for medical care. A person may have Medicare, Health Insurance, and Medicaid. Medicaid may help with expenses **not paid by Medicare or Health Insurance.**

Further in the application it requires the recipient to inform the agency within ten days if there are changes in Medicare coverage:

PLEASE KEEP THIS PAGE.
ACKNOWLEDGMENTS
State of Michigan Family Independence Agency

This is your copy of your rights and responsibilities as an applicant for or recipient of assistance benefits. By signing the application you acknowledge that you understand your rights and responsibilities.

2. Reporting Changes. I understand that the agency needs to know of any changes in income or assets of all persons listed on the application form. I will report any change in my living arrangement, such as address change, persons coming to live with me or leaving home, getting married, and so on. I will tell the agency of a change **within ten days** of the change. I understand that if I intentionally do **not** do this, I can be prosecuted for fraud or perjury. If I begin employment, I must report this within 10 days of my start date.
The types of changes that must be reported **within ten days** of the date I first know about them are:

• Employment starts or stops
• Change of employer
• Change in rate of pay
• Hours of work change by more than 5 hours per week if it will last more than one month.
• Unearned income starts or stops (examples: Social Security, pension, unemployment and retirement)
• Unearned income changes by more than $50 since the last reported change
Exception: For Medicaid only (except for Healthy Kids), you must report a change of more than $25.
• Health or hospital insurance premiums or **coverage change**
• Child care need or provider changes
• Change of address and shelter costs
• Child support expenses paid
• Change of persons in the home

My specialist will notify me if my reporting requirements change. If I have any doubt about whether to report a change, I will ask my Family Independence Agency specialist.
(Emphasis supplied) DHS Assistance Application FIA 1171

The lack of a timely response from the Appellant's case worker and the lack of a proof of service for the Part B letter are noteworthy gaps in the Department's proofs. But, the jurisdiction of the SOAHR does not extend to equitable solutions and policy must be strictly applied.

Based on the information before it, the Department of Community Health [problem resolution unit] correctly denied the Appellant's claim on appeal.

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 Appellant's claim.

IT IS THEREFORE ORDERED that:

The Department's decision is AFFIRMED.

Dale Malewska
Administrative Law Judge
for Janet Olszewski, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 2/11/2009

***** 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.