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. 2010-51292 MSB

[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]. [redacted], appeared on behalf of the Appellant. Appellant [redacted] was not 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 in [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 was enrolled in Michigan Medicaid from [redacted] through [redacted]. (Exhibit 1, Page 2).

2. Appellant was [redacted] years of age and eligible for Medicare in [redacted] but Appellant did not enroll in Medicare at any time in [redacted]. (Exhibit 1, Pages 2, 8).

3. Appellant enrolled in Medicare Part B beginning [redacted], and Medicare Part A on [redacted]. (Exhibit 1, Pages 2, 8).

4. The Department paid the Appellant's Medicare Part A and B buy-in premiums from the date of enrollment in [redacted]. (Exhibit 2).

5. Appellant received Medicare Part A-covered inpatient medical services in [redacted] and [redacted]. Medicaid denied payment of provider claims for that time period. (Exhibits 2, 3, 4, 5).

6. The Department received Appellant's request for hearing on [redacted], filed by the [redacted] company on behalf of Appellant. (Exhibit 1, Pages 5-6).

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 Department's Medicaid policy regarding when a beneficiary can be billed for medical services is as follows:

> **10. BILLING BENEFICIARIES**
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> Providers cannot bill beneficiaries for services except in the following situations:
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> *****
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> - **The beneficiary refuses Medicare Part A or B.**
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> *****
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> *Medicaid Provider Manual, General Information for Providers, Section 10*
> *October 1, 2010, Page 21*

> **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. <u>The beneficiary must apply for Medicare coverage at a Social Security Office</u>.

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.

2.6.B. MEDICARE PART A

Since Medicare Part A pays for care in an inpatient hospital, nursing facility (NF), services provided by a home health agency (HHA) or in other institutional settings, Medicaid's reimbursement for services under Medicare Part A may vary.

If MDCH is paying a beneficiary's Medicare Part B premium and the beneficiary does not have free Medicare Part A, MDCH also pays the beneficiary's Medicare Part A premium.

MDCH monitors beneficiary files to identify all beneficiaries who currently have Medicare Part B coverage only, and have Part B buy-in. Once these beneficiaries are identified, MDCH automatically processes Part A buy-in.

When a beneficiary has incurred Medicare Part A charges and is eligible for, but does not have, Medicare Part A buy-in, the claim is rejected. Providers must wait for the beneficiary to obtain Medicare coverage, then bill Medicare for services rendered. After Medicare's payment is received, Medicaid should be billed for any co-insurance and/or deductible amounts. For Medicare Part A and Part B/Medicaid claims, Medicaid's liability never exceeds that of the beneficiary.

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2.6.F. MEDICAID LIABILITY

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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.
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> *****
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> (Underline emphasis made by ALJ)
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> *Medicaid Provider Manual, Coordination of Benefits Section, July 1, 2010, Pages 6 and 8*

In investigating Appellant's case the Department's witness researched and obtained information on the Appellant's Medicaid, and Medicare Part A and B enrollment. (Exhibit 1, Pages 2, 7, 8).

The Department's witness testified that Appellant was eligible for but did not enroll in Medicare Part A and Part B in [redacted]. The Department's witness explained that if a person is eligible for Medicare Part A and Medicare Part B but does not enroll, the Department's policy prohibits use of Medicaid to pay for claims that would be covered by Medicare Part A and Part B. The Department's witness testified because Appellant was eligible for but did not enroll in Medicare Part A and Part B, the Department was required to follow the policy above and reject any claims for Part A and Part B services. (Exhibit 1, Pages 2, 10-18).

The Appellant's representative argued that the Appellant did not know she had to enroll in Medicare in order to be eligible for Medicaid, and that the premiums for Medicare would be almost 50% of the Appellant's income.

The Department responded that Medicaid in Michigan has a program whereby Medicaid pays the premium cost for the Appellant's Medicare part A and B premiums, and therefore Appellant would not have had to pay any of her income for Medicare premiums in [redacted] or currently. The Department explained that because the Appellant did not enroll in Medicare the Medicaid premium payments did not get activated.

The Appellant's representative argued that the Appellant was never sent notice from the Social Security Administration about her Medicare Part A and Part B eligibility. The Appellant's representative also argued that the Appellant said she had not received anything from the Department informing her that she had to enroll in Medicare.

The Department's witness stated that the Michigan Department of Community Health automatically sent the Appellant a computer-generated letter informing her that she must enroll in Medicare Part A the year she turned [redacted] a second follow-up letter, and similar letters on other occasions. The Department's witness explained that the Appellant's case that would not have been any different. The Department's representative submitted into evidence policy from both the Department of Community Health and Department of Human Services showing that letters notifying individuals they must enroll in Medicare are

automatically sent to Michigan Medicaid beneficiaries. (Exhibit 1, Page 17; Exhibit 2). In fact, and the Appellant did receive at least one such letter in [redacted]. (Exhibit 2).

The Department policy is clear that if a person is eligible for Medicare Part B but does not enroll in Medicare Part A and Part B, the Medicaid program will reject any claims for Medicare Part A and B-covered services. To Appellant's representative's belief that Appellant 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 and sign the application.

The Appellant was required under Department policy to enroll in Medicare when she turned eligible to receive Medicare. The Appellant did not enroll in Medicare and therefore Department policy prohibits Medicaid dollars to pay for Medicaid covered services.

The Appellant did not prove by a preponderance of evidence that she was not eligible for Medicare Part A or Part B, or that the Department improperly denied payment for claims in [redacted] and [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 [redacted] claims 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: ___10/28/2010___

***** 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.