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

IN THE MATTER OF:

Docket No. 2011-51863 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]. The Appellant appeared without representation. He had no witnesses. [redacted], Appeals Review Manager, represented the Department. Her witness was [redacted], Problem Specialist/MSA.

PRELMINARY MATTER

At hearing the record was left open pending receipt of Appellant's proposed Exhibit 2 – a letter from the Social Security Administration. On receipt it was copied, hand delivered to the Department representative and then admitted into evidence without objection.

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, SSI, Medicare beneficiary. (Appellant's Exhibit #1)

2) Between the months of [redacted] and [redacted] medical bills once covered by Medicaid were rejected and became the responsibility of the Appellant when the Department discovered that the Appellant became eligible for Medicare on [redacted] – but "elected" not to enroll in Medicare Part B until [redacted]. (Department's Exhibit A, p. 2)

3) The Appellant said he was automatically enrolled in Medicare Part B and that this was explained in a letter from the Social Security Administration to him on [redacted]. (See Appellant's Exhibit 2)

4) The Appellant said that in any event he was hospitalized and incapacitated during the time period of decision on his contested Social Security disability case and enrollment requirements for Medicare. (See Testimony of [redacted]).

5) The Appellant was advised of the negative result of his request for help with payment of his now outstanding medical bills in a written communication from the problem resolution unit on [redacted]. His further appeal rights were contained therein. (Appellant's Exhibit 1, page 3)

6) The Department of Community Health, Problem Resolution Unit, determined that the Appellant's medical billings were the Appellant's responsibility as he was covered by Medicare Part A and was eligible for Part B coverage prior to [redacted] – but that he intentionally elected to not enroll until [redacted]. Accordingly, bills prior to that date were not the responsibility of Medicaid. (Department's Exhibit A, page 2)

7) Medicaid is the payor of last resort. (Department's Exhibit A, pages 2 and 8)

8) In a transmittal communication the Appellant advised that he would "pay the retro premiums" if so instructed by the court. (Appellant's Exhibit 1)

9) The instant request for hearing was received by the Michigan Administrative Hearing System for the Department of Community Health 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 Medicaid copayment is required. (Refer to the Beneficiary Copayment Requirements subsection of this chapter and to the provider specific chapters for additional information about copayments. However, a provider cannot refuse to render

service if the beneficiary is unable to pay the required copayment 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. (Note deleted by ALJ)
- 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), §11.1, General Information for Providers Section, October 1, 2011, page 27[1]

[ ] 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 (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.

[ ] 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.

[1] Except for reference to copayments and monthly PPA this section of the MPM is substantially similar to that in effect for the Appellant at the time of the Department's negative action.

> 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, October 1, 2011, page 7

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The Department provided evidence that the Appellant was eligible for Medicare on [redacted] and for unknown reasons opted out of Part B coverage (until [redacted]) making him responsible for payment of his pre-[redacted], Part B services.

A year later the Appellant began the process of questioning why he was being dunned for medical bills - items once covered (in whole or part) under Medicaid, prior to his receipt of Part B coverage.

The Appellant testified that he was pursuing a contested case for disability with the Social Security Administration. He prevailed and thereafter had Medicare effective [redacted] He said he was told Part B enrollment was automatic. The problem, as stated by the Appellant, was that prior to [redacted], he was incapacitated and hospitalized – apparently unable to make decisions.

The Appellant testified credibly about his predicament. His reliance on Appellant's Exhibit #2 was misplaced; as there was no reference to automatic enrollment or Part B instructions different than those voiced by the Department's specialist, [redacted]. It was not enough to preponderate his burden of proof.

The record shows that the Appellant was a Medicaid beneficiary dating back to [redacted]. While cold comfort, at some point in recent history the Appellant was confronted with his Medicaid application which clearly alerts him of his duty to report changes in his coverages – such as receipt of SSI disability and/or Medicare:

> **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 MPM puts significant responsibility on the Provider(s) to verify their patient's correct Medicaid status – on pain of no reimbursement. So, if the Appellant was truly incapacitated while hospitalized – and I have no reason to doubt his credibility on that issue – somebody had to be making decisions for him. It is unknown from the Appellant if he investigated the accuracy of the billing with his healthcare providers.

Furthermore, it was unclear whether the Appellant had brought these bills before the problem resolution unit for Medi*care*. According to the Department records the Appellant received both Medicaid (Low Income family) and Medicare through [redacted]. So, the potential for a crossover error from the submitting provider, while not argued by the Appellant, is possible if not already addressed by the problem resolution unit.

Unfortunately, the ALJ's jurisdiction does not extend to equitable solutions for the Appellant. Federal regulations[2] require utilization of all other sources for payment of healthcare services - before Medicaid. The state 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 Olga Dazzo, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 12/7/2011

***** NOTICE *****

The Michigan Administrative Hearing System 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 Michigan Administrative Hearing System 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.

[2] MPM, §1, Coordination of Benefits, page 1, October 1, 2011, to wit; … Providers must investigate and report the existence of other insurance or liability to Medicaid and must utilize other payment sources to their fullest extent prior to filing a claim with the Michigan Department of Community Health (MDCH). If MDCH finds after a claim is adjudicated that another payer was liable for the service, a claim adjustment will be processed. The provider will then have to bill the identified third party resource for the service. Billing Medicaid prior to exhausting other insurance resources may be considered fraud under the Medicaid False Claim Act if the provider is aware that the beneficiary had other insurance coverage for the services rendered.