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] Case

Docket No. 2012-46398 MSB
No. [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 [redacted] was represented by her mother, [redacted] Department [redacted], appeared as a witness for the Department.

ISSUE

Did the Department properly reject a claim for Medicaid-covered services rendered to Appellant?

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 Medicaid and M edicare Part A and Medicare Part B beneficiary.

2. The Appellant's Medicare Part A effective date i[redacted]. Her Medicare Part B effective date is [redacted]

3. The Appellant's Medicare eligibilitywas established retroactively, following a favorable disability determination from the Social Security Administration.

4. The Appellant was eligible for Medicare Part B coverage retroactively and notified of such by the Social SecurityAdministration, in conjunction with her favorable disability award.

following award of disability benefits.

6. The Appellant received Medicaid covered laboratory services in [redacted] prior to being notified of her favorable social security determination.

7. The Appellant seeks Medicaid coverage for the bill(s) incurred prior to her enrollment in Medicare Part B, [redacted]

8. The cost of the Appellant's laboratory services is not covered by Medicaid.

9. The Appellant requested a formal, administrative hearing [redacted]

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 -

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,
July 1, 2009, Page 17

2.6. MEDICARE

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 (65 years old or older) but has not applied for Medicare coverage, Medicaid does not make any

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

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

Medicaid Provider Manual, Coordination of Benefits Section,
July 1, 2009, Pages 6 and 9

The Department testified that Appellant had Medicaid coverage at the time the laboratory costs were incurred. The bills resultant from that medical care are not covered because subsequent to incurring the costs the Department learned the Appellant was eligible for Medicare Part B coverage and had declined it for that time period. The analyst testified that although it is not mandatory to pursue Medicare Part B coverage, if it is available and refused, Medicaid will not pay for medical costs that would have been covered through the Medicare Part B insurance. The analyst stated that at the time of a retroactive disability award the recipient is notified she is eligible for Medicare Parts A and B. Part B coverage costs money and recipients can opt out of it. Part A coverage is automatic. She explained that because the Appellant was eligible for, but declined Medicare Part B coverage for the time period during which she incurred the laboratory bill, Medicaid will not cover this expense.

The Appellant's mother/hearing representative testified she was never informed she could enroll the Appellant in Part B coverage retroactively and she, in fact, never declined the coverage. She said she provided a copy of the Medicare card with the effective dates for both Part A and Part B coverage. She asserted both that she never declined the coverage and that she was not informed by the Social Security Administration she could enroll retroactively for Part B coverage. She stated she had called the DHS people who informed her daughter had Medicaid coverage at the time of the laboratory expense and they knew of no reason why it would not be covered. Furthermore, she incurred other medical expenses during that time period which were covered. She stated that since the other

The Department analyst countered that the Department mistakenly paid those other bills before the monitoring system learned the Appellant had Medicare Part B eligibility but had declined it.

The Department policy is clear that when a person is eligible for Medicare but does not have Medicare, the Medicaid program will reject any claims for Medicare-covered services. The Appellant does not have evidence supporting a claim she was ineligible for Medicare Part B coverage for the months at issue. While there is testimony making the assertions of ineligibility, an appeal to the Social Security Administration asserting right to buy in for the months at issue was not evidenced either through documentation or testimony and is the next step for the Appellant. The Appellant's dispute rests with the Social Security Administration rather than the Department for Medicare Part B benefit eligibility. While this Administrative Law Judge understands the Appellant's frustration, the jurisdiction of this State Office of Administrative Hearings and Rules for the Department of Community Health 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, finds 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.

Jennifer Isiogu
Administrative Law Judge

cc: [redacted]

Date Mailed _____

**** 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 mailing date of the Decision and Order or, if a timely request for rehearing was made, within 30 days of the mailing date of the rehearing decision.