

**STATE OF MICHIGAN
MICHIGAN ADMINISTRATIVE HEARINGS SYSTEM
FOR THE DEPARTMENT OF COMMUNITY HEALTH**

P.O. Box 30763, Lansing, MI 48909
(877) 833-0870; Fax: (517) 373-4147

IN THE MATTER OF:

Docket No. 2013-27342 PEME
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]. [REDACTED], guardian, appeared on behalf of the Appellant. [REDACTED], Appeals Review Officer, represented the Department. His witness was [REDACTED], Medicaid analyst.

ISSUE

Did the Department properly deny Appellant's request for a Pre-Eligibility Medical Expense offset (PEME)?

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 [REDACTED]-year old Medicaid beneficiary. (Appellant's Exhibit #1)
2. The Appellant was admitted to [REDACTED] Nursing Home on [REDACTED]. (Appellant's Exhibit 1)
3. The Appellant's date of application for Medicaid was [REDACTED]. (Appellant's Exhibit 1 – throughout)
4. The Appellant incurred residential expense at the nursing facility during the month of [REDACTED] (See Appellant's Exhibit 1 and Department's Exhibit A, p. 2)
5. The Appellant sought PPA reduction offset in the amount of \$ [REDACTED] for expenses already incurred, billed and paid for the time period before Medicaid approval. (See Testimony)

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6. The request was denied on ██████████. The Department denied the Appellant's request for PPA offset – because the bills had already been paid by the Appellant. (Department's Exhibit A, pp. 2, 3 and 8)
7. The Appellant was notified of the negative action on ██████████. (Department's Exhibit A, pp. 2 and 7)
8. The instant request for hearing was received by the Michigan Administrative Hearing System, for the Department of Community Health on ██████████.

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

Medicaid eligibility is a responsibility of the Department of Human Services through a contract with the Department of Community Health. The Department of Human Services is also responsible for determining a beneficiary's patient pay amount at the time of long-term care Medicaid eligibility. The Code of Federal Regulations requires a nursing facility to collect the total patient pay amount. [42 CFR 435.725]

Accordingly, the NF is [presumably] well motivated and required under the Medicaid Provider Manual (MPM) to check and verify the Medicaid status of all residents and to instruct the payor on payment practices.

It is axiomatic that it is the “[p]roviders responsibility to determine eligibility/enrollment status of patients at the time of treatment... Providers are advised to check the eligibility response for changes of enrollment status prior to billing... Split billing is not permitted....It is the provider's responsibility to determine eligibility/enrollment status of beneficiaries at the time services are provided...” See *generally*, MPM §4 and §8 Billing and Reimbursement for Institutional Providers, April 1, 2013, pages 11 through 40

However, there are reasonable policies established throughout the Act¹ – and PEME is no exception. See BEM 164

PEME is defined as an “unpaid medical expense incurred in the three months prior to application for Medicaid...” in this case September, October and November of 2012.

¹ 42 CFR 435.217 and 236; Deficit Reduction Act 2005; the Social Security Act 1903 (x), PL 109-171

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Citing Medicaid policy the Department's witness explained that medical bills cannot be subject to offset if already paid – the offset applies only to unpaid medical bills. BEM 164

The Appellant's argument sounded in equity as she claimed an attempt to spend the Appellant's limited income wisely. She said that they applied "late" for Medicaid, on [REDACTED], and still owed for the entire month. She testified that she thought paying the bills was the "correct thing" to do. She said the NF is now demanding payment – and there is no money to make payment.

The ALJ's jurisdiction does not extend to the provision of an equitable remedy such as suggested by the Appellant. However, the Appellant's guardian was urged to contact her DHS caseworker – in a note from the Department's witness regarding long term care or rehabilitation services on her Notice of Denial – as the DCH witness has no contact with the Department of Human Services in these matters.

The Appellant has failed to preponderate her burden of proof that the Department erred in denying her request for application of a PPA offset.

DECISION AND ORDER

The Department properly denied the Appellant's request for PEME.

IT IS THEREFORE ORDERED that:

The Department's decision is AFFIRMED.

ls/

Dale Malewska
Administrative Law Judge
for James K. Haveman, Director
Michigan Department of Community Health

[REDACTED]
cc: [REDACTED]

Date Signed: 7/1/2013

Date Mailed: 7/1/2013

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***** NOTICE *****

The Michigan Administrative Hearings 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 Hearings 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.