**STATE OF MICHIGAN**
**MICHIGAN ADMINISTRATIVE HEARINGS SYSTEM**
**FOR THE DEPARTMENT OF COMMUNITY HEALTH**
P.O. Box 30763, Lansing, MI 48909
(517) 335-2484; Fax: (517) 373-4147

IN THE MATTER OF:

**Docket No.** 14-013754 MSB

[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 Appellant's request for a hearing.

After due notice, a hearing was held on [redacted], Appellant's authorized hearing representative appeared and testified on the Appellant's behalf. [redacted], Appeals Review Officer, represented the Department. [redacted], Medicaid Analyst with the Michigan Department of Community Health (MDCH, Department) Customer Service Division appeared as a witness for the Department.

## ISSUE

Did the Department properly deny payment for Appellant's medical bill for eye doctor services received on [redacted] at [redacted], while Appellant was eligible but not enrolled in Medicare?

## 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 is a [redacted]-year old Medicaid beneficiary, born [redacted] (Exhibit A, p. 6 and testimony).

2. On [redacted] Appellant became eligible for full Medicaid, she was also eligible but not enrolled in Medicare. (Exhibit A, pp. 2, 3, 5, 8, 15 and testimony).

3. On [redacted], Appellant incurred expenses for eye doctor services received at [redacted]. (Exhibit A, pp. 2, 4, 7, 10, 12, 14 and testimony).

4. On [redacted], the Department received a Beneficiary Complaint form from the Appellant dated [redacted], asking that the Department pay a hospital bill for eye doctor services received at [redacted] in [redacted] on [redacted] Appellant stated she had full Medicaid on the date of service and that Medicaid should have paid the bill. (Exhibit A, pp. 6-7).

5. On [redacted] the Department sent the Appellant a letter stating because she was eligible for Medicare effective [redacted], but did not enroll until [redacted], Medicaid could not pay the provider because Medicaid could only cover the services after other sources of payment were exhausted including Medicare. See *Medicaid Provider Manual*, *Coordination of Benefits*, *Section 2.6.A. – Medicare Eligibility*, July 1, 2014, p. 6. (Exhibit A, pp. 15, 16).

6. On [redacted], Michigan Administrative Hearing System (MAHS) received the Appellant's request for hearing. (Exhibit A, p. 21).

## 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 witness [redacted] established that the policy setting forth the Coordination of Benefits where a beneficiary is eligible for Medicare is found in the Medicaid Provider Manual. The *Medicaid Provider Manual*, *Coordination of Benefits*, *Section 2.6.A. – Medicare Eligibility*, July 1, 2014, p. 6, which states:

> **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 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.

[redacted] stated because Appellant was eligible for Medicare effective [redacted], but had failed to enroll in Medicare, Medicaid could not be billed for the eye doctor services received at [redacted] on [redacted] referred to information from Medicare.gov which indicates that there is an initial enrollment period for people who will be turning [redacted] and they are able to apply [redacted] months prior to the first day of their birthday month that they will turn [redacted] presumed that this also applied to the [redacted]-year residency requirement, but not being a Medicare specialist he could not say for certain one way or the other. [redacted] suggested that the Appellant should contact Medicare and request enrollment for [redacted]. If Medicare enrollment were established for [redacted], then both Medicare and Medicaid could be billed for the [redacted] services.

Appellant's representative testified that when she first called Social Security in [redacted] she was told by an unnamed worker that due to the residency requirement she could not apply for Medicare until [redacted], after the Appellant met the [redacted]-year residency requirement. Appellant's representative also claimed that the worker who she met in person to apply for Medicare told her the first day the Appellant could apply was [redacted] Appellant's representative gave the name and contact number for the worker at Social Security, a [redacted], but when called by the undersigned administrative law judge, the worker was unavailable to testify at the hearing. Appellant's representative also said she was told by a Medicare worker that she could not get retroactive eligibility for Medicare for [redacted].

The Appellant bears the burden of proving by a preponderance of the evidence that she was not eligible for Medicare for [redacted] such that the policy quoted above from the Medicaid Provider Manual would not preclude Medicaid payment for the medical bill at issue. Appellant has failed to meet her burden of proof. Her representative's statements concerning what the Social Security workers allegedly told her are unreliable hearsay and cannot be used to establish the Appellant's claim. Therefore, since the Appellant received eye doctor services received at [redacted] on [redacted] when it appears she was eligible for Medicare but not enrolled, Medicaid cannot pay anything for the services until Medicare coverage is established and Medicare coverage is exhausted for those services. See The *Medicaid Provider Manual*, *Coordination of Benefits*, *Section 2.6.A. – Medicare Eligibility*, July 1, 2014, p. 6.

Based on the above findings of fact and conclusions of law, Appellant has failed to prove, by a preponderance of the evidence that the Department erred in denying payment for the eye doctor services received at [redacted] on [redacted]. As such, the Department's actions must be upheld.

## DECISION AND ORDER

The Department properly denied payment for Appellant's medical bill for inpatient services from [redacted] through [redacted], while Appellant was enrolled in the Adult Benefit Waiver (ABW) Program.

**IT IS THEREFORE ORDERED** that:

The Department's decision is AFFIRMED.

William D Bond

William D. Bond
Administrative Law Judge
for Nick Lyon, Director
Michigan Department of Community Health

Date Signed : [redacted]

Date Mailed: [redacted]

WDB/db

cc: [redacted]

***** 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.