

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) 373-4147

IN THE MATTER OF:

Docket No. 2014-35631 MSB

██████████

██████████

██████████

Appellant.

_____ /

DECISION AND ORDER

This matter is before the undersigned Administrative Law Judge (ALJ) pursuant to MCL 400.9 and MCL 400.37, and upon Appellant's request for a hearing.

After due notice, a hearing was held on ██████████. Appellant appeared and testified on her own behalf. ██████████, Appeals Review Officer, represented the Michigan Department of Community Health ("DCH" or "Department"). ██████████, Analyst, appeared as a witness for the Department.

ISSUE

Did the Department properly deny Appellant's requests for reimbursement for medical bills incurred in ██████████ and ██████████

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 received medical services on ██████████ ██████████ ██████████, ██████████, and ██████████. (Respondent's Exhibit A, pages 14-17).
2. At the time the services were rendered, Appellant had active Medicaid coverage and was enrolled in Medicare Part A. (Respondent's Exhibit A, pages 8-10).
3. Appellant was also eligible to be enrolled in Medicare Part B at that time, but had refused such coverage because the monthly premium was too expensive. (Respondent's Exhibit A, pages 10-11; Testimony of Appellant).

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4. At the time she refused the coverage, no one advised Appellant that declining Medicare Part B could affect Medicaid paying for her medical bills. (Testimony of Appellant).
5. Appellant's medical providers submitted claims to Medicaid regarding the services performed and were initially reimbursed. (Testimony of ██████████).
6. However, the Department later changed its mind and recovered the payments. (Testimony of ██████████).
7. The medical providers then billed Appellant for the services. (Testimony of Appellant).
8. In response, Appellant filed a Beneficiary Complaint with the Department regarding the unpaid bill for medical services provided on ██████████. (Testimony of Appellant; Testimony of ██████████).
9. On ██████████ the Department sent Appellant a written response to the Beneficiary Complaint. (Testimony of Appellant).
10. In that response, the Department stated that it had investigated Appellant's complaint regarding the unpaid bill and had determined that Medicaid was not responsible for the bill because Appellant was eligible for Medicare Part B at the time the services were rendered and, while she had refused such coverage, Medicaid can only make payment for services after all other sources have been exhausted. (Testimony of Appellant).
11. On ██████████, the Department received another Beneficiary Complaint regarding the unpaid bills for medical services provided on ██████████ and ██████████. (Respondent's Exhibit A, page 13).
12. On ██████████, the Department sent Appellant a written notice in response to her second Beneficiary Complaint. (Respondent's Exhibit A, page 19).
13. In that response, the Department again stated that it had investigated the problem she was having with her unpaid bills for services rendered on ██████████, ██████████ and ██████████, and had determined that Medicaid was not responsible for the bills. (Respondent's Exhibit A, page 19).
14. Once again, the Department also stated that it was not responsible for the bills because Appellant was eligible for Medicare Part B at the time the services were rendered and, while she had refused such coverage, Medicaid can only make payment for services after all other sources have been exhausted. (Respondent's Exhibit A, page 19).

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15. On [REDACTED], the Michigan Administrative Hearing System (MAHS) received Appellant's request for hearing in this matter regarding the unpaid bills and the Department's response to her first Beneficiary Complaint. (Respondent's Exhibit A, page 3).
16. That appeal was docketed as Docket No. 2014-35631 MSB and scheduled for hearing. (Respondent's Exhibit A, page 2).
17. Subsequently, MAHS received an additional request for hearing filed by Appellant in response to the second response she received from the Department. (Respondent's Exhibit A, pages 5-6).
18. The second request for hearing was initially docketed as a separate case, Docket No. 2014-35767 MSB, and scheduled for hearing. (Respondent's Exhibit A, page 4).
19. However, all of the unpaid bills were discussed during the hearing in this case and it was confirmed on the record that the issue raised in the second request for hearing was duplicative of the issue raised in this matter.
20. Subsequently, Docket No. 2014-35767 MSB was dismissed.

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.

Regarding the coordination of Medicaid benefits with other programs, the applicable version of the Medicaid Provider Manual (MPM) states:

SECTION 1 – INTRODUCTION

This chapter applies to all providers.

Federal regulations require that all identifiable financial resources be utilized prior to expenditure of Medicaid funds for most health care services provided to Medicaid beneficiaries. Medicaid is considered the payer of last resort. If a beneficiary with Medicare or Other Insurance coverage is enrolled in a Medicaid Health Plan (MHP), or is receiving services under a Prepaid Inpatient Health Plan (PIHP) or Community Mental Health Services Program/Coordination

Agency (CMHSP/CA), that entity is responsible for the Medicaid payment liability.

* * *

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 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.

* * *

2.6.C. 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 coinsurance up to Medicaid's maximum allowable amount. Coverage for outpatient therapeutic psychiatric coverage varies.

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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, October 1, 2013 version
Coordination of Benefits Chapter, pages 1, 6, 8

Moreover, with regard to providers billing Medicaid beneficiaries, the MPM provides, in pertinent part:

11.1 GENERAL INFORMATION

Providers cannot bill beneficiaries for services except in the following situations:

* * *

- The beneficiary refuses Medicare Part A or B.

MPM, October 1, 2013 version
General Information for Providers Chapter, page 32

Here, the Department's witness testified that, per the above policy, the cost of Appellant's medical services cannot be covered by Medicaid when those services would have been covered through Medicare Part B if Appellant had been enrolled in that program. The Department's witness also testified that, in September and [REDACTED], Appellant had Medicaid coverage, but she was also eligible for Medicare Part A and B. The Department's witness further testified that Appellant refused Medicare Part B coverage, so the cost of Appellant's medical services cannot be covered by Medicaid.

In response, Appellant acknowledged that she never signed up for Medicare Part B when she was eligible because the monthly premium was too high. However, she also testified that no one ever told her that declining Medicare Part B could affect Medicaid paying for her medical bills and that, if she had known the services would not be covered, she would have delayed them until they were covered.

The undersigned Administrative Law Judge sympathizes with Appellant's situation, but he also lacks equitable powers and is bound by the applicable policy. In this case, that clear policy expressly provides that Medicaid is a payor of last resort and if a Medicaid beneficiary is eligible for Medicare, but has refused Medicare coverage, Medicaid does not make reimbursement for services until Medicare coverage is obtained. That is what

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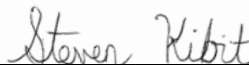
occurred in this case and, consequently, the Department's rejection of the claims based on the available information must be sustained.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, finds that, based on the available information, the Department properly denied Appellant's requests for reimbursement for medical bills incurred in [REDACTED]

IT IS THEREFORE ORDERED THAT:

The Department's decision is **AFFIRMED**.



Steven Kibit
Administrative Law Judge
for James K. Haveman, Director
Michigan Department of Community Health

Date Signed: [REDACTED]

Date Mailed: [REDACTED]

SK/db

cc: [REDACTED]

***** 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.