STATE OF MICHIGAN
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
FOR THE DEPARTMENT OF HEALTH AND HUMAN SERVICES
P.O. Box 30763, Lansing, MI 48909
(877) 833-0870; Fax: (517) 373-4147

IN THE MATTER OF:

[redacted],

Docket No. 15-019119 MSB
Case 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 Appellant's request for a hearing.

After due notice, a hearing was held on [redacted]. Appellant appeared and testified. [redacted], Appeals Review Officer, represented the Department of Health and Human Services (Department). [redacted], Departmental Analyst, appeared as a witness for the Department.

State's Exhibits A pages 1-23 were admitted as evidence.

ISSUE

Did the Department properly deny Appellant's request for payment of hospital or medical expenses?

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 has a Medicaid spend down.

2. On [redacted], Appellant was enrolled in Medicare Part A. There was no evidence that she enrolled in Medicare Part B

3. Appellant met her Medicaid spend down for the month of [redacted].

4. On [redacted], appellant was an inpatient at Providence hospital. At the time she was not approved for Medicaid.

5. On [redacted], Appellant was approved for Medicaid for [redacted].

6. On [redacted], the Department received a Beneficiary Complaint form

(BCF) from Appellant regarding medical bills.

7. The Department contacted Providence Hospital and informed the provider that Appellant has been approved for Medicaid coverage for [redacted] and that they could bill Medicare Part A and then Medicaid for the services.

8. To date there is no evidence that the provider has billed Medicare or Medicaid on behalf of Appellant for the [redacted] inpatient hospital services.

9. Appellant's first re-determination for Medicaid was in [redacted].

10. Regarding bills from Appellant's neurologist, neurology services are covered by Medicare Part B.

11. There is no evidence on the record that Appellant has enrolled in Medicare Part B.

12. Appellant was enrolled in Medicare Part A but opted out of Medicare Part B.

13. On [redacted], the Department sent Appellant a letter stating that Appellant was receiving the bill from Associates in Neurology for dates of service [redacted], because she was eligible for Medicare Part B coverage at the time the services were rendered. Federal regulations require that all identifiable resources available for payment, including Medicare, be billed prior to billing Medicaid. The Medicare Part B benefit was an available financial resource and Appellant opted to not enroll. Refusal of Medicare Part B benefit means that Medicaid is not responsible to make payment. Medicaid can only pay for services after all other sources have been exhausted. Medicaid will not be able to make payment on the Neurologist bills. (State's Exhibit A page 13).

14. On [redacted], Appellant filed a request for a hearing stating that on [redacted], Administrative Law Judge Alice Elkin ordered the Department to pay [redacted] Medical bills and as of [redacted], Medicaid has still refused to pay the bills.

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 policy on coordination of benefits 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.

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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.

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Medicaid Provider Manual,
Coordination of Benefits Section,
October 1, 2013, pp 1, 6

If an LTC applicant requests an offset of their patient pay to cover old medical bills, see Pre-Eligibility Medical Expense (PEME) in glossary and in this item. Assist the applicant by forwarding their unpaid bills to:

Medical Services Administration
Michigan Department of Community Health
P.O. Box 30479
Lansing, MI 48909-9634
Attn: PEME

DCH will determine whether an offset is allowable.

Offsets will be applied to the months following an approval. In general, the allowable expenses are the same as allowed for a group 2 deductible case. In addition, the medical expense(s) must be:

- Expenses incurred in the three months prior to application for Medicaid.
- Unpaid, and an obligation still exists to pay.
- Cannot be from a month where Medicaid eligibility existed.
- Cannot be covered by a third party source (public or private).
- Cannot be from a month in which a divestment penalty has been imposed.
- Cannot have been used previously as a pre-eligibility medical expense to offset a patient pay amount.
- Can include cost of room and board for Medicaid LTC facilities, remedial care, and other medical expenses recognized by Michigan law but not covered under the Michigan state plan.
- **Must be reported prior to the first Medicaid redetermination following the initial eligibility.**
- DCH will terminate offsets if there is a failure to pay the medical provider with the funds.

Bridges Eligibility Manual (BEM)
164 BPB 2014-019 (10-1- 2014) (Emphasis Added)

SECTION 11 - BILLING BENEFICIARIES (Medicaid Provider Manual, General Information for Providers) states in pertinent part:

11.1 GENERAL INFORMATION

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 MDHHS office 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 additional 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 MDHHS 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 MDHHS 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 is told prior to rendering the service that it is not covered by Medicaid. If the beneficiary is not informed of Medicaid non-coverage 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.

Department policy dictates that Appellant was receiving the bill from Associates in Neurology for dates of service [redacted], because she was eligible for Medicare Part B coverage at the time the services were rendered. Federal regulations require that all identifiable resources available for payment, including Medicare, be billed prior to billing Medicaid. The Medicare Part B benefit was an available financial resource and Appellant opted to not enroll. Refusal of Medicare Part B benefit means that Medicaid is not responsible to make payment. Medicaid can only pay for services after all other sources have been exhausted. Medicaid will not be able to make payment on the Neurologist bills.

Medicare Part A is responsible for the hospital bill. After the hospital bills Medicare Part A, they can then bill Medicaid for the remainder of the hospital bill, but the 12 month period has been exhausted

The Appellant's grievance centers on dissatisfaction with the department's current policy. The Appellant's request is not within the scope of authority delegated to this Administrative Law Judge pursuant to a written Delegation of Authority signed by the Michigan Department of Community Health (now Health and Human Services) Director, which states:

> Administrative law judges have no authority to make decisions on constitutional grounds, overrule statutes, overrule promulgated regulation, or overrule or make exceptions to Department policy. (February 22, 2013)

Furthermore, administrative adjudication is an exercise of executive power rather than judicial power, and restricts the granting of equitable remedies. *Michigan Mutual Liability Co v Baker*, *295 Mich 237*; *294 NW168 (1940).*

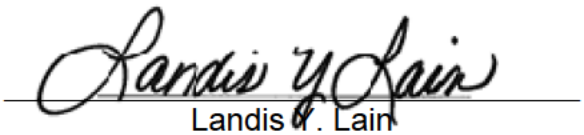
This Administrative Law Judge does not possess equitable powers and, therefore, cannot award benefits or payments as a matter of fairness.

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 payment of Medical Expenses under the circumstances.

IT IS THEREFORE ORDERED THAT:

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



Landis Y. Lain
Administrative Law Judge
for Nick Lyons, Director
Michigan Department of Health and Human Services

cc: [redacted]

LYL[redacted]

Date Signed: December 21, 2015

Date Mailed: December 22, 2015

***** 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.