STATE OF MICHIGAN
STATE OFFICE OF ADMINISTRATIVE HEARINGS AND RULES

ADMINISTRATIVE HEARINGS FOR THE
DEPARTMENT OF HUMAN SERVICES

IN THE MATTER OF: [redacted],

Claimant

Reg. No: 2009-11290
Issue No: 2026
Case No: [redacted]
Load No: [redacted]
Hearing Date:
April 28, 2010
Iosco County DHS

ADMINISTRATIVE LAW JUDGE: Jay W. Sexton

HEARING DECISION

This matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9 and MCL 400.37 upon claimant's request for a hearing. After due notice, an in-person hearing was held on April 28, 2010, in East Tawas. The claimant personally appeared and testified under oath.

The department was represented by Cindi McGoven (ES).

ISSUE

Did the department correctly deny MA coverage for claimant's September 2007 medical bills due to claimant's failure to verify her medical expenses within 90 days of the service date?

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 department gave claimant written notice (DHS-4400) that her 2007 spend-down/deductible was $473.

(2) The DHS-4400 contains the following instructions:

* * *

> For each month for which you must meet a deductible to qualify for Medicaid, you have until the last day of the third month following the deductible month to submit your incurred medical expenses. However, the sooner you report and provide proof of your medical expenses, the sooner I can determine if you qualify for Medicaid.

(3) In September 2007, claimant was hospitalized for a hysterectomy.

(4) Claimant incurred medical expenses, related to her hysterectomy, totaling approximately $12,000 during September 2007.

(5) On January 28, 2008, the department notified claimant using a DHS-4400 that her spend-down was $360. The January 28, 2008 notice also notified claimant that medical expenses must be reported within 90 days of the date of service.

(6) On January 13, 2009, the department received notice of hospital bills.

(7) This was the first notification that the department received that claimant had incurred medical expenses in 2007.

(8) Claimant did not report her September 2007 medical bills within the 90-day time limit specified in the DHS-4400, dated July 2007 and January 2008.

(9) On November 13, 2008, claimant sent an email to the director of the Iosco County DHS inquiring about payment of her bills and inquiring about payment for her September 2007 bills.

(10) On November 17, 2008, the Iosco director replied to claimant's inquiry and stated in pertinent part:

> We are in receipt of a fax dated [redacted] [redacted]. With this, we received a copy of a medical bill showing $1,897.39 pending and still owing, and a

> receipt for $550, and a billing line detail from [redacted] showing a balance of $1,897.39. These are the first such billing notices or information this office has received regarding your incurred medical expenses since your case was processed and a letter was issued on January 28, 2008. Referenced in the enclosed letter:
>
> 'When your medical expenses total more than your deductible amount, return the form to me immediately so I can decide if you qualify.'
>
> * * *

(11) On January 14, 2009, claimant requested a hearing.

CONCLUSIONS OF LAW

The Medical Assistance (MA) program is established by Title XIX of the Social Security Act and is implemented by Title 42 of the Code of Federal Regulations (CFR). The Department of Human Services (DHS or department) administers the MA program pursuant to MCL 400.10, *et seq.*, and MCL 400.105. Department policies are found in the Program Administrative Manual (PAM), the Program Eligibility Manual (PEM) and the Program Reference Manual (PRM).

Michigan provides Medicaid for eligible persons under two broad classifications: Group I is for those persons who are eligible if they receive FAP/FIP or SSI.

Group II is for those persons whose eligibility results from their level of need. These persons are referred to as medically needy persons. MCL 400.16; PEM 105. Claimant fell under the Group II classification.

The department's policy manuals provide the following policies for determining MA financial eligibility.

MA Group II Income Eligibility Spend-down

> Deductible/spend-down is a process which allows a customer with excess income to be eligible for Group II MA if sufficient allowable medical expenses are incurred.

Active Spend-down

Open an MA case without ongoing Group II MA coverage on CIMS as long as:

- The fiscal group has excess income and
  at least one fiscal group member meets all other member Group II MA eligibility factors. PEM 105.

Such cases are called active spend-down cases. Periods of MA coverage are added each time the group meets its spend-down.

Spend-down Period

Each calendar month is a separate spend-down period. PEM Item 545.

Meeting a Spend-down

Meeting a deductible/spend-down means reporting and verifying allowable medical expenses (defined in Exhibit I) that equal or exceed the spend-down amount for the calendar month tested. PEM Item 545.

To determine whether claimant is eligible for Group II MA, only income available to the fiscal group on a monthly basis must be considered. Certain deductions are allowed. The amount remaining after these deductions is MA budgetable income. MA income is then compared to the medical needs amount to determine whether or not Group II eligibility exists. PEM 545; 42 CFR 435.831, *et seq*.

An MA recipient has until the last day of the spend-down/deductible period to provide necessary verification that the spend-down/deductible has been met. If the required verification is not provided prior to the expiration date, MA cannot be authorized for any part of the spend-down/deductible period. PEM 545.

The preponderance of the evidence in the record establishes that the department correctly notified claimant of the spend-down requirement and the department also correctly notified claimant that she was required to report her medical bills within 90 days of the date of service.

The preponderance of the evidence in the record shows that claimant's September 2007 medical bills were not reported to the department until September 20, 2008. The department did not receive notice of claimant's 2007 hospital bills until January 13, 2009.

Based on claimant's failure to promptly report her medical bills to the department within 90 days of the date of service, the department correctly denied claimant's MA-P eligibility for the September 2008 medical bills.

DECISION AND ORDER

The Administrative Law Judge, based upon the above findings of fact and conclusions of law, decides that the department correctly denied claimant's MA-P coverage of her September 2008 medical bills because claimant failed to provide the department with notification of her medical expenses within 90 days from the date of service.

Accordingly, the department's action is, hereby, AFFIRMED.

SO ORDERED.

/s/_________________________________
Jay W. Sexton
Administrative Law Judge
for Ismael Ahmed, Director
Department of Human Services

Date Signed:_ June 11, 2010______

Date Mailed:_ June 14, 2010______

NOTICE: Administrative Hearings may order a rehearing or reconsideration on either its own motion or at the request of a party within 30 days of the mailing date of this Decision and Order. Administrative Hearings will not order a rehearing or reconsideration on the Department's motion where the final decision cannot be implemented within 90 days of the filing of the original request.

The Claimant 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 date of the rehearing decision.

JWS/tg

cc: