STATE OF MICHIGAN
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
ADMINISTRATIVE HEARINGS FOR THE
DEPARTMENT OF HUMAN SERVICES

IN THE MATTER OF:

[redacted]

Reg. No: 201248432
Issue No: 2026
Case No: [redacted]
Hearing Date: May 30, 2012
Livingston County DHS

ADMINISTRATIVE LAW JUDGE: Corey A. Arendt

HEARING DECISION

This matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9 and MCL 400.37 following Claimant's request for a hearing. After due notice, a telephone hearing was held on May 30, 2012, in Lansing, Michigan. Participants on behalf of Claimant included [redacted]. Participants on behalf of the Department of Human Services (Department) included [redacted].

ISSUES

Whether the department properly processed bills submitted by the Claimant for Medical Assistance (MA) benefits?

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 Claimant had been approved for Medical Assistance (MA) benefits with a deductible during all times relevant to this hearing.

2. On March 26, 2012, the Claimant submitted to the Department separate medical bills.

3. The Department would not apply the bills submitted by the Claimant towards her deductible because the bills were submitted outside three months from the date of service.

4. On April 12, 2012, the Claimant filed a request for hearing to protest the Department's decision to not apply her previously submitted medical bills towards her deductable.

CONCLUSIONS OF LAW

The regulations governing the hearing and appeal process for applicants and recipients of public assistance in Michigan are found in the Michigan Administrative Code, MAC R 400.901-400.951. An opportunity for a hearing shall be granted to an applicant who requests a hearing because his claim for assistance is denied. MAC R 400.903(1)

Clients have the right to contest a department decision affective eligibility for benefit levels whenever it is believed that the decision is incorrect. BAM 600. The department will provide an administrative hearing to review the decision and determine the appropriateness of that decision. BAM 600.

The Medical Assistance (MA) program was established by Title XIX of the Social Security Act and is implemented by Title 42 of the Code of Federal Regulations (CFR). The department administers the MA program pursuant to MCL 400.10, *et seq.*, and MCL 400.105. The goal of the Medicaid program is to ensure that essential health care services are made available to those who otherwise could not afford them. Medicaid is also known as Medical Assistance (MA).

The State of Michigan has set guidelines for income, which determine if a Medicaid group is eligible. Income eligibility exists for the calendar month tested when there is no excess income, or allowable medical expenses equal or exceed the excess income (under the Deductible Guidelines). BEM 545.

Net income (countable income minus allowable income deductions) must be at or below a certain income limit for eligibility to exist. BEM 105. Income eligibility exists when net income does not exceed the Group 2 needs in BEM 544. BEM 166. The protected income level is a set allowance for non-medical need items such as shelter, food and incidental expenses. RFT 240 lists the Group 2 Medicaid protected income levels based on shelter area and fiscal group size. BEM 544. An eligible Medicaid group (Group 2 MA) has income the same as or less than the “protected income level” as set forth in the policy contained in the Reference Table (RFT). An individual or Medicaid group whose income is in excess of the monthly protected income level is ineligible to receive Medicaid.

However, a Medicaid group may become eligible for assistance under the deductible program. The deductible program is a process, which allows a client with excess income to be eligible for Medicaid, if sufficient allowable medical expenses are incurred. Each calendar month is a separate deductible period. The fiscal group’s monthly excess income is called the deductible amount. Meeting a deductible means reporting and verifying allowable medical expenses that equal or exceed the deductible amount for the calendar month. The Medicaid group must report expenses by the last day of the third month following the month it wants medical coverage. BEM 545; 42 CFR 435.831.

Policy allows for the payment of old bills. Old bills are defined as follows:

EXHIBIT IB – OLD BILLS
Medical expenses listed under **Medical Services** in "EXHIBIT I can be used as **old bills** if they meet **all** of the following criteria:

• The expense was incurred in a month prior to the month being tested.
• During the month being tested:
•• The expense is/was still unpaid, **and**
•• Liability for the expense still exists (existed).
• A third party resource is **not** expected to pay the expense.
• The expense was **not** previously used to establish MA income eligibility.
• The expense was one of the following:
•• Incurred on a date the person had no MA coverage.
•• **Not** an MA covered service.
•• Provided by a non-MA enrolled provider.
• A member of the medical group incurred the expense. This includes expenses incurred by a deceased person if both:
•• The person was a medical group member's spouse or unmarried child under 18.
•• The medical group member is liable for the expense.
You must give groups that have excess income the opportunity to verify old bills before you start an active deductible case. Use old bills in chronological order by date of service. BEM 545.

In relation to how old bills are to be treated, policy states as follows:

The individual must be given the most advantageous use of their old bills (also known as incurred expenses). The individual may request coverage for the current month, up to six future months (see eligibility based on old bills in this item), and for any of the prior three months before the current month.
1. Use the budgeting rules in BEM 530. Determine income eligibility in calendar month order, starting with the oldest calendar month.
2. Use BEM 546 to determine the post-eligibility patient-pay amount (PPA) for each L/H month that a client is Group 2 eligible.
3. Determine Medicare Savings Program eligibility separately for Group 2 clients entitled to Medicare Part A (see BEM 165).
4. Request information about **all** medical expenses incurred during and prior to each month with excess income.
5. Notify the group of the outcome of each determination. BEM 545.

The group must report expenses by the last day of the third month following the month in which the group wants MA coverage. BEM 545.

In the case at hand, the Department would not accept the bills submitted by the Claimant because they were submitted after three months from the month following the

date they were incurred. The Department used the date of service as the date that the bills were incurred. The Claimant testified she did not receive the bills from the hospital until February and March of 2012. Although policy does state bills must be turned in by the end of the third month following the month the Clamant wants medical coverage, it does not indicate the month the Claimant wants coverage must be the month the medical service was rendered. In fact, the policy in relation to old bills states that bills can be submitted subsequent to the three months after their service date and be treated as old bills. Therefore, the Administrative Law Judge finds the Department did not properly accept the bills submitted by the Claimant and did not properly give them the most preferential treatment as directed by policy.

DECISION AND ORDER

The Administrative Law Judge, based upon the above findings of fact and conclusions of law, decides that the Department did not properly process the bills that were submitted by the Claimant.

Accordingly, the department's actions are **REVERSED**.

It is HEREBY ORDERED that the Department shall reprocess the bills submitted by the Claimant in the month of March 2012 for the purpose of determining if the Claimant had met her deductible and, in turn issue benefits if benefits should have been issued.

/s/ _____
Corey A. Arendt
Administrative Law Judge
for Maura D. Corrigan, Director
Department of Human Services

Date Signed: June 1, 2012

Date Mailed: June 1, 2012

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 60 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.

CAA/cr

cc: [redacted]