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

IN THE MATTER OF:

[redacted]

Reg. No: 2013-50462
Issue No: 2026
Case No: [redacted]
Hearing Date: August 6, 2013
Montcalm County DHS

ADMINISTRATIVE LAW JUDGE: Landis Y. Lain

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 to protest the denial of claimant's application for MA. After due notice, a telephone hearing was held on August 6, 2013. Claimant appeared and testified. Claimant's [redacted] appeared and testified on claimant's behalf. The department was represented by [redacted], Family Independence Specialist and Assistance Payments Supervisor [redacted].

ISSUE

Did the Department of Human Services (the department) properly determine that claimant's medical bills could not be paid because they were received out of sequence?

FINDINGS OF FACT

The Administrative Law Judge, based upon the competent, material and substantial evidence on the whole record, finds as material fact:

1. Claimant was approved for Medical Assistance with a monthly deductible spend-down of $[redacted]

2. On November 16, 2012 Spectrum Health FAXED a bill for claimant in the amount of $[redacted]

3. On December 20, 2012, claimant submitted bills totaling more than his deductible and Medical Assistance Coverage was approved and entered onto the BRIDGES system with eligibility begin date of November 13, 2012.

4. On February 7, 2013 Spectrum Health again FAXED a hospital bill for 1/16/2013 date of service in the amount of $[redacted]

5. On February 7, 2013 the medical expense was entered into BRIDGES from 1/16/13-1/31/13.

6. On February 14, 2013, Spectrum Health submitted bills for dates of service 11/1/12, 11/3/12, 1/09/13 and 1/10/13

7. On May 30, 2013, claimant filed a request for a hearing to contest the department's failure/refusal to pay bills for January 1-15, 2013 and November 1-15, 2012.

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 or her claim for assistance has been denied. MAC R 400.903(1). Clients have the right to contest a department decision affecting eligibility or benefit levels whenever it is believed that the decision is incorrect. 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 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 Bridges Administrative Manual (BAM), the Bridges Eligibility Manual (BEM) and the Program Reference Manual (PRM).

Michigan provides Medical Assistance Michigan provides MA eligible clients under two general classifications: Group 1 and Group 2 MA. Claimant qualified under the Group 2 classification because she received RSDI income which consists of clients whose eligibility results from the state designating certain types of individuals as medically needy. BEM, Item 105. In order to qualify for Group 2 MA, a medically needy client must have income that is equal to or less than the basic protected monthly income level. Department policy sets forth a method for determining the basis maintenance level by considering:

1. The protected income level,

2. The amount diverted to dependents,

3. Health insurance and premiums, and

4. Remedial services if determining the eligibility for claimants in adult care homes.

If the claimant's income exceeds the protected income level, the excess income must be used to pay medical expenses before Group 2 MA coverage can begin. This process is known as a deductible spend-down.

Claimant's representative argues: that the policy is unfair because it presents a hardship for the claimant who had legitimate expenses that are not being covered. There is no explanation of the "do not alter" policy, which explains the rationale that a client negates coverage for bills which are not submitted in sequence or within the last day of the third month following the month in which the group wants MA coverage.

In the instant case, the department caseworker made the decision based upon this pertinent part of policy:

> This item completes the Group 2 MA income eligibility process.
>
> Income eligibility exists for the calendar month tested when:
>
> - There is no excess income.
> - Allowable medical expenses (defined in **EXHIBIT I**) equal or exceed the excess income.
>
> When **one** of the following equals or exceeds the group's excess income for the month tested, income eligibility exists **for the entire month**:
>
> - Old bills (defined in EXHIBIT IB).
> - Personal care services in clients home, (defined in Exhibit II), Adult Foster Care (AFC), or Home for the Aged (HA) (defined in EXHIBIT ID).
> - **Hospitalization** (defined in EXHIBIT IC). (Emphasis Added)
> - Long-term care (defined in EXHIBIT IC).
>
> When **one** of the above does **not** equal or exceed the group's excess income for the month tested, income eligibility begins either:
>
> - **The exact day of the month** the allowable expenses **exceed** the excess income.
> - **The day after the day of the month** the allowable expenses **equal** the excess income.

In addition to income eligibility, the fiscal group must meet all other financial eligibility factors for the category processed. However, eligibility for MA coverage exists only for qualified fiscal group members. A qualified fiscal group member is an individual who meets all the nonfinancial eligibility factors for the category processed. BEM, Item 545, page 1

Example 7

Expenses Reported After MA Coverage Added

[redacted] has a $[redacted] deductible amount.

10/7/01 - Mr. C. reports the following allowable medical expenses:

10/1/01 Dentist for filling - $[redacted]
10/6/01 Outpatient blood test - $[redacted]

10/14/01 - Authorize full MA coverage effective 10/6/01 with [redacted] liability = $[redacted]

10/28/01 - [redacted] verifies the following additional allowable medical expenses:

10/2/01 Specialist exam - $[redacted]
10/2/01 Prescription - $18.75

Determine that the specialist exam is unpaid. However, [redacted] paid for the prescription.

Coverage cannot be backdated to an earlier date in 10/01. Therefore, you complete a budget on Bridges for 11/01, counting the $[redacted] expense as an old bill. The paid prescription cost cannot be counted.

[redacted] meets his deductible for 11/01, based on the $[redacted] old bill. $[redacted] remains as an unused old bill. BEM, Item 545, page 23.

This Administrative Law Judge finds that policy in BEM Item 545, page 1 clearly states: when "hospitalization" equals or exceeds the group's excess income for the month tested, income eligibility exists **for the entire month. Therefore, Example 7 on page 23 of BEM Item 545 is inconsistent and in direct contravention of the rest of the policy in BEM 545. Claimant did have [redacted] in November 2012 and in January 2013.**

The Department has not established that it was acting in compliance with department policy when it determined that claimant's January 1-15, 2013 and November 1-15, 2012 bills could not be paid because they were received out of sequence. BEM 545 clearly states that the individual must be given the most advantageous use of their old bills (also known as incurred expenses). Department policy clearly dictates that when a person meets the deductible spend down for the month, that they are entitled to receive Medical Assistance coverage for the entire month.

DECISION AND ORDER

The Administrative Law Judge, based upon the above findings of fact and conclusions of law, decides that the department has not appropriately established by the necessary competent, material and substantial evidence on the record that it was acting in compliance with department policy when it determined that claimant's January 2013 and November 2012 bills for medical treatment could not be paid because they were received out of sequence. Department policy clearly states that a person who meets their deductible spend-down qualifies for coverage for the entire month.

Accordingly, the department's actions are **REVERSED**. The Department is ORDERED to reprocess claimant's deductible spend down for the months of January 2013 and November 2012, and include all bills received in a timely manner in its calculation and if claimant is otherwise eligible, to submit the pertinent bills for payment under the Medical Assistance policy.

/s/
Landis Y. Lain
Administrative Law Judge
for Maura D. Corrigan, Director
Department of Human Services

Date Signed: 8/7/13

Date Mailed: 8/8/13

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.

LYL/tb

cc: [redacted]