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

IN THE MATTER OF:

Reg. No.: 201329567
Issue No.: 2026
Case No.:
Hearing Date: August 15, 2013
County: Kent

ADMINISTRATIVE LAW JUDGE: C. Adam Purnell

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 August 15, 2013 from Lansing, Michigan. Participants on behalf of Claimant included (Claimant) and (Claimant's spouse). Participants on behalf of the Department of Human Services (Department) included (Eligibility Specialist) and (Assistance Payments Supervisor).

ISSUE

Did the Department properly process Claimant's medical bills toward his Medical Assistance (MA) deductible or "spend down"?

FINDINGS OF FACT

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

1. Claimant, at all relevant times relevant to this hearing, was active for MA Group 2 - Caretaker Relatives (G2C) with a deductible ("spend down") in the amount of $1,468.00.

2. On or about January 10, 2013, Claimant provided the Department with several medical bills, but the bills added together were not enough to meet the deductible amount.

3. On January 25, 2013, the Department received a medical bill with a January 16, 2013 date of service and processed this bill to meet Claimant's deductible.

4. On January 25, 2013, the Department mailed Claimant a Notice of Case Action (DHS-1605) which indicated that Claimant's MA deductible had been met based on the date of service of January 16, 2013.

5. On February 6, 2013, Claimant filed a hearing request to compel the Department to process the medical bills submitted on January 25, 2013.

CONCLUSIONS OF LAW

Department policies are contained in the Bridges Administrative Manual (BAM), the Bridges Eligibility Manual (BEM), and the Reference Tables Manual (RFT).

The client has the right to request a hearing for any action, failure to act or undue delay by the department. BAM 105. The department provides an administrative hearing to review the decision and determine its appropriateness. BAM 600.

The regulations that govern the hearing and appeal process for applicants and recipients of public assistance in Michigan are contained in the Michigan Administrative Code (Mich Admin Code) Rules 400.901 through 400.951. An opportunity for a hearing shall be granted to a recipient who is aggrieved by an agency action resulting in suspension, reduction, discontinuance, or termination of assistance. Mich Admin Code 400.903(1).

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. Department policies for the MA programs are contained in the Bridges Administrative Manual (BAM), the Bridges Eligibility Manual (BEM), the Bridges Reference Manual (BRM), and the Reference Tables Manual (RFT).

The MA program is also referred to as "Medicaid." BEM 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. BEM 105. The Medicaid program is comprised of several sub-programs or categories. BEM 105.

For purposes of MA in general, the terms Group 1 and Group 2 relate to financial eligibility factors. BEM 105. For Group 1, net income (countable income minus allowable income deductions) must be at or below a certain income limit for eligibility to exist. BEM 105. For Group 2, eligibility is possible even when net income exceeds the income limit. BEM 105. This is because incurred medical expenses are used when determining eligibility for FIP-related and SSI-related Group 2 categories. BEM 105.

A deductible case is defined as "an active MA case with no ongoing MA eligibility or coverage." Bridges Program Glossary (BPG) at p 11. The deductible case meets all other eligibility requirements but income exceeds allowable limits. See BPG, p. 11. Periods of coverage are added when the client becomes income eligible by incurring

medical expenses. BPG, p. 11. Deductible is a process which allows a client with excess income to become eligible for Group 2 MA if sufficient allowable medical expenses are incurred. BEM 545. Periods of MA coverage are added each time the group meets its deductible. BEM 545. Each calendar month is a separate deductible period. BEM 545. The first deductible period cannot be earlier than the processing month for applicants and is the month following the month for which MA coverage is authorized for recipients. BEM 545.

According to policy, the fiscal group's monthly excess income is called a deductible amount. BEM 545. Meeting a deductible means reporting and verifying allowable medical expenses that equal or exceed the deductible amount for the calendar month tested. 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. Department policy BAM 130 explains verification and timeliness standards. BEM 545.

The group must report changes in circumstances within 10 days. BEM 545. The Department is instructed to review the group's eligibility when a change that may affect eligibility is reported. BEM 545. Then, the Department may apply changes for the corresponding period as follows if MA coverage has been authorized. BEM 545. But the Department may never reduce MA coverage already authorized on Bridges for the processing month or any past month. BEM 545.

BEM 545 does not permit the Department to alter the MA eligibility begin date if he or she has already authorized coverage on Bridges. BEM 545. However, any expenses the group reports that were incurred from the first of such a month through the day before the MA eligibility begin date might be countable as **old bills**. BEM 545.

BEM 545 provides several examples to instruct Department workers how to proceed when a client reports medical expenses for purpose of an MA deductible. The instant matter is similar to BEM 545 Example 7 listed on pages 23 and 24 which illustrates what occurs when expenses are reported after MA coverage is added. This example provides as follows, “Mr. C. has a $55.00 deductible amount. 10/7/01 - Mr. C. reports the following allowable medical expenses: 10/1/01 Dentist for filling - $37.50; and 10/6/01 Outpatient blood test - $52.00; 10/14/01 - Authorize full MA coverage effective 10/6/01 with Mr. C's liability= $17.50. 10/28/01 - Mr. C. verifies the following additional allowable medical expenses: 10/2/01 Specialist exam - $75.00; 10/2/01 Prescription - $18.75. Determine that the specialist exam is unpaid. However, Mr. C. 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 $75.00 expense as an old bill. The paid prescription cost cannot be counted. Mr. C. meets his deductible for 11/01, based on the $75.00 old bill. $20.00 remains as an unused old bill. Authorize MA coverage for 11/1/01 through 11/30/01 and send Mr. C. a DHS-4598, DHS-114 and DHS-114A.”

The underlying facts in the instant matter are not in dispute. Claimant requested a hearing because the Department refused to process a medical bill he submitted after his deductible case had been processed. During the hearing, Claimant testified that the

Department previously provided him with a Medicaid card that he would present to his medical providers during his appointments. Claimant testified that he presented his Medicaid card to his cardiologist during a January 15, 2013 appointment[1] and the medical office clerk told him “You are all set.” Claimant interpreted this to mean that his treatment was covered and that his cardiologist would not later forward him a bill for services rendered on that date. On January 25, 2013, Claimant sent the Department medical bills for a January 16, 2013 service date. The Department verified these bills and determined that they were allowable medical expenses. The medical bills provided to the Department equaled or exceeded the $1,468.00 deductible amount for the January 2013 calendar month tested. Thus, on January 25, 2013, the Department processed Claimant’s bills and his deductible was met based on the January 16, 2013 service date. However, Claimant later received a bill in the amount of $932.00 from his cardiologist for services rendered on January 15, 2013. When Claimant attempted to forward the January 15, 2013 bill to the Department to count toward his deductible, the Department refused to process it. The Department takes the position that BEM 545 prohibits the Department from including Claimant’s medical bills from January 15, 2013 because they were submitted after Claimant’s deductible had been met on January 25, 2013. Claimant, on the other hand, disagrees and largely disputes the policies that govern the Department’s action.

Testimony and other evidence must be weighed and considered according to its reasonableness. *Gardiner v Courtright*, 165 Mich 54, 62; 130 NW 322 (1911); *Dep't of Community Health v Risch*, 274 Mich App 365, 372; 733 NW2d 403 (2007). The weight and credibility of this evidence is generally for the fact-finder to determine. *Dep't of Community Health*, 274 Mich App at 372; *People v Terry*, 224 Mich App 447, 452; 569 NW2d 641 (1997). Moreover, it is for the fact-finder to gauge the demeanor and veracity of the witnesses who appear before him, as best he is able. See, e.g., *Caldwell v Fox*, 394 Mich 401, 407; 231 NW2d 46 (1975); *Zeeland Farm Services, Inc v JBL Enterprises, Inc*, 219 Mich App 190, 195; 555 NW2d 733 (1996).

This Administrative Law Judge has carefully considered and weighed the testimony and other evidence in the record. There is no dispute that Claimant submitted his January 15, 2013 bill after his deductible was met on January 25, 2013. Based on the competent, material, and substantial evidence presented during the hearing, this Administrative Law Judge finds that the instant matter is similar to the scenario set forth in BEM 545. BEM 545 clearly provides that the Department shall not apply the January 15, 2013 bills from Claimant’s cardiologist toward his deductible for January 2013 because Claimant met his deductible for January 2013. As indicated above, BEM 545 does not permit the Department to alter the MA eligibility beginning date if he or she has already authorized coverage on Bridges. However, any expenses the group reports that were incurred from the first of such a month through the day before the MA eligibility begin date might be countable as old bills.

[1] Although the Department’s hearing summary indicated that Claimant’s cardiologist appointment was on January 11, 2013, Claimant’s exhibits indicated that the appointment took place on January 15, 2013. See Claimant’s Exhibit C-12.

Based upon the above Findings of Fact and Conclusions of Law, and for the reasons stated on the record, the Administrative Law Judge concludes that the Department properly refused to use Claimant's January 15, 2013 bills toward his deductible because the bills were submitted after his January 2013 deductible using a January 16, 2013 date of service had been met on January 25, 2013. The Department acted properly in accordance with BEM 545.

DECISION AND ORDER

The Administrative Law Judge, based upon the above Findings of Fact and Conclusions of Law, and for the reasons stated on the record, finds that the Department did act properly.

Accordingly, the Department's MA decision is **AFFIRMED**.

IT IS SO ORDERED.

/s/______________________________
C. Adam Purnell
Administrative Law Judge
for Maura Corrigan, Director
Department of Human Services

Date Signed: August 19, 2013

Date Mailed: August 20, 2013

NOTICE OF APPEAL: Michigan Administrative Hearing System (MAHS) 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. MAHS 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 (60 days for FAP cases).

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 or Reconsideration was made, within 30 days of the receipt date of the Decision and Order of Reconsideration or Rehearing Decision.

A Request for Rehearing or Reconsideration may be granted when one of the following exists:

- Newly discovered evidence that existed at the time of the original hearing that could affect the outcome of the original hearing decision;
- Misapplication of manual policy or law in the hearing decision which led to a wrong conclusion;
- Typographical, mathematical or other obvious error in the hearing decision that affects the rights of the client;
- Failure of the ALJ to address in the hearing decision relevant issues raised in the hearing request.

The Department, AHR or the claimant must specify all reasons for the request. MAHS will not review any response to a request for rehearing/reconsideration. A request must be *received* in MAHS within 30 days of the date the hearing decision is mailed.

The written request must be faxed to (517) 335-6088 and be labeled as follows:

Attention: MAHS Rehearing/Reconsideration Request

If submitted by mail, the written request must be addressed as follows:

Michigan Administrative Hearings
Reconsideration/Rehearing Request
P.O. Box 30639
Lansing, Michigan 48909-07322

CAP/aca

cc: