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

IN THE MATTER OF:

Reg. No.:	14-001038
Issue No.:	2004
Case No.:	
Hearing Date:	September 03,2014
County:	OAKLAND-(63-04)

ADMINISTRATIVE LAW JUDGE: Lynn Ferris

HEARING DECISION

Following Claimant's request for a hearing, this matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9 and 400.37; 7 CFR 273.15 to 273.18; 42 CFR 431.200 to 431.250; 45 CFR 99.1 to 99.33; and 45 CFR 205.10. After due notice, an in person hearing was held on September 3, 2014, from Detroit, Michigan. Participants on behalf of Claimant included the , the spouse of the Claimant. of the Claimant's Authorized Hearing Representative (AHR), also appeared. Participants on behalf of the Department of Human Services (Department) included Eligibility Specialist.

ISSUE

1. Did the Department properly decline to process the Claimant's medical bill submission as late?

2. Was the Claimant's Request for Hearing timely?

FINDINGS OF FACT

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

1. The Claimant applied for Medical Assistance on July 9, 2013. On July 26, 2013, the Claimant was approved for Medical Assistance GP2 C, with a $ deductible. Exhibit 1

2. The Claimant had a hospitalization and surgery in August 2013, and a second application was filed with the Department by the Claimant's AHR on August 9, 2013. The application indicates that the Claimant's admission date was August 8, 2014. The month the Claimant sought medical coverage was August 2013.

3. The Department did not register the August 9, 2013 application because the Claimant already had an active Medical Assistance case with a deductible.

4. On November 13, 2013, the Claimant's AHR emailed the Department regarding the Claimant's hospitalization and that the application was processed; however, the coverage was noted in the Champs system as Plan First for August and September, with the spend down for November 2013. The AHR requested who the Claimant's worker was, and received no response to the email from the Department.

5. On December 3, 2013, the Claimant's AHR submitted an MSA 2565 C Facility Admission Notice, that included and reported the hospitalization bill in the amount of $28,091.83. Claimant Exhibit B

6. The Claimant's AHR submitted the Claimant's bill for the August 2013 hospitalization on December 3, 2013. Claimant Exhibit B

7. The Department advised the AHR on March 4, 2014 that the bill could not be processed because it was untimely and had not been received.

8. The Claimant spoke by telephone with her then caseworker in September or October 2013, about the August 2013 hospital bill from an August 2013 surgery, and sought assistance regarding the hospital bill not being paid because she was shown as eligible for Plan First coverage, not Medical Assistance with a deductible.

9. The Champs system in August 2013 reported that the Claimant was only eligible for Plan First. The Provider submitted the bill on August 29, 2013, which was declined for payment because the system showed only Plan First coverage. Claimant Exhibits B and D.

10. The Claimant's AHR requested a hearing on April 9, 2014, requesting a hearing on the Department's failure to act on a spend down for the month of August 2013.

CONCLUSIONS OF LAW

Department policies are contained in the Department of Human Services Bridges Administrative Manual (BAM), Department of Human Services Bridges Eligibility Manual (BEM), Department of Human Services Reference Tables Manual (RFT), and Department of Human Services Emergency Relief Manual (ERM).

The Medical Assistance (MA) program is established by Title XIX of the Social Security Act, 42 USC 1396-1396w-5; 42 USC 1315; the Affordable Care Act of 2010, the collective term for the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152; and 42 CFR 430.10-.25. The Department (formerly known as the Family

Independence Agency) administers the MA program pursuant to 42 CFR 435, MCL 400.10, and MCL 400.105-.112k.

Additionally, in this case the first issue which must be addressed is whether the Claimant's Authorized Hearing Representative's hearing request on behalf of the Claimant was timely. The Claimant's AHR requested a hearing on April 8, 2014, which was received by the Department on April 9, 2014. The hearing request was filed in response to the Department's email to the AHR on March 4, 2014, which stated that the Department had no medical bill to process for August 2013, because a bill was never received. Due to timeliness, we cannot process the bill. The issue in this matter is whether the Department failed to process a medical bill and determine that the deductible was met for August 2013. For reasons explained below, it is determined the Claimant's AHR reported a medical bill and the Department never processed the bill or sought further verification; and thus, the Claimant's hearing request was timely. BAM 600 provides: The client or AHR has 90 calendar days from the date of the written notice of case action to request a hearing. The request must be received in the local office within the 90 days (10/1/14) p. 6. Because the Department never processed the bill, the hearing request is deemed timely as the Department failed to act or advise the Claimant's AHR until March 4, 2014.

Much of the confusion in this case arose because although the Claimant was eligible for Medical Assistance in August 2013 with a ███ deductible, the Champs system used by Providers and her AHR to determine eligibility for reimbursement showed the Claimant as eligible for Plan First which was incorrect information, and caused the Claimant's AHR to attempt to correct the problem so that she could submit the hospital bill. The Claimant's AHR submitted the Champs system reporting and advised the Department as early as November 2013, that Champs said Claimant was approved for Plan First which clearly showed the wrong coverage for the Claimant, and which caused the provider's August 29, 2013 billing to be rejected when submitted. Claimant Exhibit A, B and D.

CHAMPS

Providers may verify beneficiary eligibility using:

- CHAMPS Eligibility Inquiry
- HIPAA 270/271 (eligibility inquiry/response) transactions BAM 402 (10/1/14) pp.16.

Based upon this information in the Champs system, the AHR fairly believed that the error required correction so that the Claimant's bill could be submitted and applied correctly to her deductible. Even the Claimant attempted to resolve the problem as explained below.

Contrary to the Department's statement in its email to the AHR that it never received a bill, a review of the evidence submitted indicates that the Department did receive an MSA 2565 C Facility Admission Notice which provided notice, and reported to the Department a hospital admission on August 8, 2013, and reported an outstanding medical bill for $ 3 with the providers and Claimant's name affixed. The Department never processed this bill and did not seek verification of the amount. Claimant Exhibit B. The bill was submitted on December 3, 2013. The AHR with its submission noted that Customer was recently approved for Medicaid, she needs retro coverage for August. The Coverage for August is Plan First only which will not cover the attached service. The Department never responded to the submission by the AHR and did not process the bill or seek further verification.

Additionally, the Claimant credibly testified that in September or October 2013, she contacted her then case worker about the outstanding hospital bill for her August 2013 hospital admission. At the time, the Claimant advised her worker that the bill was not paid because she was shown to have Plan First coverage only, which does not cover hospitalization. The Claimant was not advised to submit the bill to the Department; in fact, she was told not to submit the bill. Based on this discussion, the Claimant was also never sent a verification to provide the bill, but instead was told by her caseworker that the Plan First "glitch" would go away, that she was eligible and that would take care of it. Claimant was further advised by her caseworker that all the caseworker could do was approve eligibility, but could not do anything about Medicaid and whether it pays. At no time did she advise the Claimant to submit the bill, or that the Claimant had to submit the bill so that the deductible could be met for August 2013. Based upon this credible and unrebutted testimony, it is determined that the Claimant was misled by the Department and following the Department's assistance and the information provided, did not submit the outstanding medical bill.

Thereafter, Claimant's AHR contacted the Department by email on November 13, 2013 advising the Department that the AHR, had submitted a Medical application on August 9, 2013, and that the Claimant was an inpatient in August 2013 at hospital; however, DHS has her coverage as Plan First for August and September for some odd reason. I am trying to find out who the worker is on the case so I can have this corrected. I called the front desk and they indicated that they do not have as the authorized representative, even though we submitted the application. So, the operator was not willing to give me the worker information; how can I have this corrected so we can find out who has the case? The second email was sent on November 19, 2013, requesting assistance with this case. No one from DHS responded until March 4, 2014, when the original addressee responded that she was no longer assigned to Oakland County, and had given the matter to the DHS representative, who finally responded on March 4, 2014.

In an email to the Claimant's AHR dated March 4, 2014 the Department stated:

"The medical bill was never received by DHS. The client applied for Medicaid w/retro on 7/9/13. This was processed by DHS Self Service Proc Ctr West. She was given a spend down. In August [redacted] filed an 1171, which was never registered because an active MA already existed. We needed to receive a bill to process. To date, neither the client nor [redacted] have submitted a bill. Due to timeliness, we cannot process this." Exhibit 2 pp. 11

The Claimant's AHR replied on March 4, 2014:

"Policy states: Meeting a deductible means reporting and verifying allowable medical expenses that equal or exceed the deductible amount for the calendar month tested. The group must report expenses by the last day of the third month following the month in which the group wants MA coverage. The Provider submitted the bills to Medicaid on 8/21/13 which was well within the 90 days. Why can't DHS use the attached proof of Medicaid denial as proof of Medicaid denial as proof?"

On April 14, 2014 the Department responded:

"Medicaid billing is not DHS, and DHS is where the bills need to be submitted. The Documents that you provided were bills to Medicaid; DHS who has to process the coverage did not receive these bills. Per policy, as you state below: Meeting a deductible means reporting and verifying allowable expenses…. DHS did not receive these bills and therefore cannot process."

BEM 545 provides: Each month is a separate deductible period. Meeting a deductible means reporting and verifying allowable medical expenses (defined in "EXHIBIT I) that equal or exceed the deductible amount for the calendar month tested. The group must report expenses by the last day of the third month following the month in which the group wants MA coverage. BAM 130 explains verification and timeliness standards. BEM 545 (7/1/13), pp. 11(Emphasis added)

Under the factual circumstances of this case, particularly the fact that the Claimant was given improper advice and the determination that the Claimant was misled by her caseworker, and the fact that the Claimant's AHR attempted to correct the Claimant's eligibility status to a deductible case instead of Plan First coverage shown in the Champs system, and the Department's lack of assistance to clarify or assist the Claimant's AHR, it is determined that the medical billing information reported by the AHR with the December 3, 2013 Facility Admission Notice was a reporting of a medical expense and was timely submitted under these circumstances.

The Administrative Law Judge, based on the above Findings of Fact and Conclusions of Law, and for the reasons stated on the record, if any, finds that the Department did not act in accordance with Department policy when it failed to process the December 3 2013 MSA 2565 Facility Admission Notice with the billing information attached.

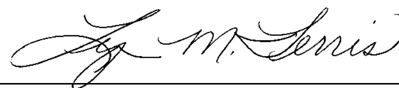
DECISION AND ORDER

Accordingly, the Department's decision is

REVERSED.

THE DEPARTMENT IS ORDERED TO BEGIN DOING THE FOLLOWING, IN ACCORDANCE WITH DEPARTMENT POLICY AND CONSISTENT WITH THIS HEARING DECISION, WITHIN 10 DAYS OF THE DATE OF MAILING OF THIS DECISION AND ORDER:

1. The Department shall process the medical billing information reported and attached to the December 3, 2014 Facility Admission Notice, and billing information attached to it contains the Claimant Exhibit B. The Department shall treat the information as a reporting of deductible and shall treat the billing submission as timely submitted to apply to the August 2013 deductible.



Lynn Ferris
Administrative Law Judge
for Maura Corrigan, Director
Department of Human Services

Date Signed: **10/2/2014**
Date Mailed: **10/2/2014**
LMF / tm

NOTICE OF APPEAL: A party may appeal this Hearing Decision in the circuit court in the county in which he/she resides, or the circuit court in Ingham County, within 30 days of the receipt date.

A party may request a rehearing or reconsideration of this Hearing Decision from the Michigan Administrative Hearing System (MAHS) within 30 days of the mailing date of this Hearing Decision, or MAHS may order a rehearing or reconsideration on its own motion.

MAHS may grant a party's Request for Rehearing or Reconsideration 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 party requesting a rehearing or reconsideration 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 this Hearing Decision is mailed.

A written request may be faxed or mailed to MAHS. If submitted by fax, 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

cc: