RICK SNYDER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
Christopher Seppanen
Executive Director

SHELLY EDGERTON
DIRECTOR

[redacted]

Date Mailed: October 25, 2016
MAHS Docket No.: 16-009718
Agency No.: [redacted]
Petitioner: [redacted]

ADMINISTRATIVE LAW JUDGE: Eric J. Feldman

HEARING DECISION

Following Petitioner'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; and Mich Admin Code, R 792.11002. After due notice, an in-person hearing was held on [redacted], from Detroit, Michigan. The Petitioner was represented by [redacted] (Petitioner) and her mother, [redacted]. The Department of Health and Human Services (Department) was represented by [redacted], Assistance Payment Supervisor.

ISSUES

1. Did the Department properly provide Petitioner with Medical Assistance (MA) coverage she is eligible to receive from [redacted], ongoing?

2. Did the Department properly process Petitioner's submitted medical expenses?

FINDINGS OF FACT

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

1. Petitioner is an ongoing recipient for MA - Group 2 Caretaker Relatives (G2C) coverage (with a monthly $[redacted] deductible).

2. On an unspecified date, Petitioner submitted an inpatient hospitalization/nursing care bill for $[redacted] with an incurred date [redacted]. Exhibit A, p. 66.

3. The Department took the $[redacted] medical bill and applied it as an allowable old bill, which resulted in the Department delaying Petitioner's deductible from on or

about [redacted] and [redacted] (except October 2015 – applied different old bills to delay deductible) and did not provide a budget for [redacted] Exhibit A, pp. 41-66.

4. On [redacted] the Department sent Petitioner a Health Care Coverage Determination Notice (Determination Notice) notifying her that she was found eligible for full MA coverage for the following months: (i) [redacted] (ii) [redacted]; and (iii) [redacted]. Exhibit A, pp. 1-3.

5. On [redacted] the Department sent Petitioner a Determination Notice notifying her that she was found eligible for full coverage from [redacted]. Exhibit A, pp. 7-9.

6. On [redacted], the Department sent Petitioner a Determination Notice notifying her that she was found eligible for full coverage from [redacted], ongoing. Exhibit A, pp. 4-6.

7. Petitioner's Medicaid Eligibility showed the following MA coverage, which the Determination Notices might have not addressed: (i) full MA coverage from [redacted]; (ii) limited Qualified Medicare Beneficiaries (QMB) – Medicare Savings Program (MSP) coverage from [redacted] to [redacted]; (iii) full MA coverage from [redacted]; (iv) limited QMB coverage for [redacted]; (v) full MA coverage from [redacted] (vi) limited QMB coverage for [redacted]; and (vii) full MA coverage from [redacted]. Exhibit C, pp. 1-6.

8. On [redacted], Petitioner filed a hearing request, protesting the Department's action. Exhibit A, pp. 68-69.

CONCLUSIONS OF LAW

Department policies are contained in the Department of Health and Human Services Bridges Administrative Manual (BAM), Department of Health and Human Services Bridges Eligibility Manual (BEM), Department of Health and Human Services Reference Tables Manual (RFT), and Department of Health and 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 Department of Human Services) administers the MA program pursuant to 42 CFR 435, MCL 400.10, and MCL 400.105-.112k.

Preliminary matters

First, Petitioner sought to dispute medical bills that were dated after her hearing request. The undersigned Administrative Law Judge (ALJ) informed Petitioner that he lacks the jurisdiction to address any medical bills dated subsequent to her hearing request. Exhibit A, pp. 68-69. Petitioner can attempt to file another hearing request to dispute her medical bills dated after her hearing request, which was [redacted]. See BAM 600 (October 2015), pp. 1-6.

Second, the Department presented as evidence a "MI Health Plan Benefits," which showed a history of her medical coverage. Exhibit A, pp. 10-40. During the hearing, Petitioner indicated that some of the transactions located in this document were fraudulent and wanted to dispute these fraudulent transactions. However, the undersigned ALJ lacks any such jurisdiction to address her alleged concerns regarding the fraudulent transactions. See BAM 402 (October 2015), pp. 17-18 (policy provides phone contacts for Medicaid questions). The undersigned will not further address these concerns.

Third, on [redacted], the Department sent Petitioner a Determination Notice notifying her about the type of MA coverage she received from [redacted], ongoing. Exhibit A, pp. 1-3. Petitioner filed a proper hearing request to dispute this determination notice. Exhibit A, pp. 68-69. Because Petitioner's hearing request was filed within 90 days of the Determination Notice dated [redacted], this gives the undersigned ALJ the jurisdiction to address Petitioner's MA coverage from [redacted], ongoing. See BAM 600, pp. 1-6.

MA coverage

In the present case, Petitioner claimed that the Department failed to process several of her medical bills that she submitted to the Department. As a result, Petitioner argued that she had medical bills in past-due status; and she did know what to do with these outstanding bills.

It was determined during the hearing that from at least [redacted], ongoing, Petitioner was an ongoing recipient of G2C coverage (with a monthly $[redacted] deductible). See Exhibit A, pp. 41-66. The evidence failed to establish, though, whether Petitioner received G2C coverage (with a monthly deductible) prior to this date. Now turning to the deductible program, Petitioner was confused during the hearing on how the deductible program actually works. The undersigned ALJ explains this program below:

As stated above, Petitioner was an ongoing recipient of G2C coverage (with a monthly deductible). MA is available to parents and other caretaker relatives who meet the eligibility factors in this item. BEM 135 (October 2015), p. 1. All eligibility factors must be met in the calendar month being tested. BEM 135, p. 1. Income eligibility exists when net income does not exceed the Group 2 needs in BEM 544. BEM 135, p. 2. If the net income exceeds Group 2 needs, Medicaid eligibility is still possible. BEM 135, p. 2.

The 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 (January 2016 and July 2016), p. 10. Each calendar month is a separate deductible period. BEM 545, p. 10. The fiscal group's monthly excess income is called a deductible amount. BEM 545, p. 11. Meeting a deductible means reporting and verifying allowable medical expenses (defined in "XHIBIT I) that equal or exceed the deductible amount for the calendar month tested. BEM 545, p. 11.

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.

BEM 545, p. 1.

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).
- Long-term care (defined in EXHIBIT IC).

BEM 545, p. 1.

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.

BEM 545, p. 1.

To simplify the above policy, individuals are liable for their medical expenses up to their deductible amount and any medical expenses incurred in excess of their deductible, would be covered by Medicaid. For example, Petitioner has a $[redacted] monthly deductible for [redacted]; she would be liable for the first $[redacted] in her medical bills because that is her deductible; but any amount in excess of this deductible, would be covered. However, policy also allows for instances where the deductible can be delayed for one or more future months based on old medical bills. This is what happened in this case

from at least [redacted], ongoing. A group with excess income can delay deductible for one or more future months based on allowable old bills. BEM 545, p. 9. On an unspecified date, Petitioner submitted an inpatient hospitalization/nursing care bill for $[redacted] Exhibit A, p. 66. The Department took the $[redacted] medical bill and applied it as an allowable old bill, which resulted in the Department delaying Petitioner's deductible. Exhibit A, pp. 41-66. This means that any month in which her deductible was delayed by an old bill and Petitioner had incurred medical expenses, those medical expenses should be covered. To determine whether Petitioner's medical bills are covered by Medicaid, the undersigned will address each bill she submitted for review. Moreover, the undersigned ALJ needs to see if there was even any MA coverage for the month in which services were incurred. As a side note, Petitioner provided the undersigned ALJ with multiple bills that were duplicates and not in chronological order. The undersigned ALJ attempted to the best of his ability to sort the medical bills and determine which ones were duplicates and their chronological order. After a thorough review, Petitioner submitted twenty (20) medical bills, which the undersigned ALJ addresses separately below:

First, Petitioner submitted a bill from "[redacted];" date of expense incurred was [redacted]; statement date of [redacted]; and Petitioner was liable for $[redacted] (hereinafter referred to as "medical bill A"). Exhibit 1, p. 1. A review of Petitioner's "Medical Expense-Summary" showed that she reported medical bill A on [redacted], to the Department. See Exhibit D, p. 4. A review of Petitioner's "Current and Old Bill Details" document for the benefit month of [redacted] finds that the Department did not utilize medical bill A as an old bill to meet her deductible for [redacted]. Exhibit A, p. 66. The Department provided Petitioner with full MA coverage for the month services were incurred for medical bill A in [redacted]. See Exhibit C, p. 6. Because medical bill A has not been utilized to meet her deductible and she received full MA coverage for the month the services were incurred, she should have her service provider attempt to resubmit this bill to Medicaid in order for it to be paid. There is nothing further the Department can do in this instance for medical bill A.

Second, Petitioner submitted a bill from "[redacted];" date of expense incurred was [redacted]; statement date of [redacted] and Petitioner was liable for $[redacted] (hereinafter referred to as "medical bill B"). Exhibit 1, pp. 2-3. A review of Petitioner's "Medical Expense-Summary" showed that she reported medical bill B to the Department on [redacted]. Exhibit D, p. 4. A review of Petitioner's "Current and Old Bill Details" document for the benefit month of [redacted] finds that the Department did not utilize medical bill B as an old bill to meet her deductible for [redacted]. Exhibit A, p. 66. The Department provided Petitioner with full MA coverage for the month the services were incurred for medical bill B in [redacted]. See Exhibit C, p. 6. Because medical bill B has not been utilized to meet her deductible and she received full MA coverage for the month the services were incurred, she should have her service provider attempt to resubmit this bill to Medicaid in order for it to be paid. There is nothing further the Department can do in this instance for medical bill B.

Third, Petitioner submitted duplicate bills from "[redacted];" date of expense incurred was [redacted]; last recent statement date of [redacted]015; and Petitioner was liable for $[redacted] (hereinafter referred to as "medical bill C"). Exhibit 1, p. 4-11. A review of Petitioner's "Medical Expense-Summary" showed that she reported medical bill C to the Department on [redacted]. Exhibit D, p. 4. A review of Petitioner's "Current and Old Bill Details" document for the benefit month of [redacted] finds that the Department utilized this bill as an old bill to meet her deductible for [redacted] Exhibit A, p. 66. Thus, Petitioner cannot be reimbursed for medical bill C as it had already been used as an old bill to meet her deductible. As such, the Department acted in accordance with Department policy when it properly processed medical bill C in accordance with Department policy.

Fourth, Petitioner submitted a bill from "[redacted];" date of expense incurred was [redacted]; statement date of [redacted]; and Petitioner was liable for $[redacted] (hereinafter referred to as "medical bill D"). Exhibit 1, pp. 5-6. A review of Petitioner's "Medical Expense-Summary" showed that she reported medical bill D to the Department on [redacted]. Exhibit D, p. 4. A review of Petitioner's "Current and Old Bill Details" document for the benefit month of [redacted] finds that the Department did not utilize medical bill D as an old bill to meet her deductible for [redacted]. Exhibit A, p. 66. However, the Department did not provide Petitioner with full MA coverage for [redacted] which was the month that the services were incurred for medical bill D. The Department failed to provide any evidence or testimony as to why she did not receive any coverage for this month. As such, the Department will redetermine Petitioner's MA eligibility for [redacted] in accordance with Department policy.

Fifth, Petitioner submitted a bill from "[redacted];" date of expense incurred was [redacted], and [redacted]; statement date of [redacted]; and Petitioner was liable for $[redacted] (hereinafter referred to as "medical bill E"). Exhibit 1, pp. 7-8. A review of Petitioner's "Medical Expense-Summary" showed that she reported medical bill E to the Department on [redacted]. Exhibit D, p. 1. A review of Petitioner's "Current and Old Bill Details" document for the benefit month of [redacted] finds that the Department utilized this bill as an old bill to meet her deductible for [redacted]. Exhibit A, p. 66. Thus, Petitioner cannot be reimbursed for medical bill E as it had already been used as an old bill to meet her deductible. As such, the Department acted in accordance with Department policy when it properly processed medical bill E in accordance with Department policy.

Sixth, Petitioner submitted multiple bills from [redacted];" date of expense incurred was [redacted]; last statement date of [redacted], [redacted] and Petitioner was liable for $[redacted] (hereinafter referred to as "medical bill F"). Exhibit 1, pp. 9-11. A review of Petitioner's "Medical Expense-Summary" showed that she reported medical bill F to the Department on [redacted]. Exhibit D, p. 3. A review of Petitioner's "Current and Old Bill Details" document for the benefit month of [redacted] finds that the Department did not utilize medical bill F as an old bill to meet her deductible for [redacted]. Exhibit A, p. 66. Moreover, the Department provided

Petitioner with full MA coverage from [redacted], which was the month that the services were incurred for medical bill F. Exhibit C, p. 3. Because medical bill F has not been utilized to meet her deductible and she received full MA coverage for the month the services were incurred, she should have her service provider attempt to resubmit this bill to Medicaid in order for it to be paid. There is nothing further the Department can do in this instance for medical bill F.

Seventh, Petitioner submitted bills from [redacted];" date of expense incurred was [redacted]; recent statement date of [redacted]; and Petitioner was liable for $[redacted] (hereinafter referred to as "medical bill G"). Exhibit 1, pp. 12-14 (appeared to be different account numbers, but same amount on the bills submitted). A review of Petitioner's "Medical Expense-Summary" showed that she reported medical bill G to the Department on [redacted]. Exhibit D, p. 3. A review of Petitioner's "Current and Old Bill Details" document for the benefit month of [redacted] finds that the Department did not utilize medical bill G as an old bill to meet her deductible for [redacted]. Exhibit A, p. 66. The Department provided Petitioner with full MA coverage for the month services were incurred for medical bill G in [redacted]. See Exhibit C, p. 3. Because medical bill G has not been utilized to meet her deductible and she received full MA coverage for the month the services were incurred, she should have her service provider attempt to resubmit this bill to Medicaid in order for it to be paid. There is nothing further the Department can do in this instance for medical bill G.

Eighth, Petitioner submitted multiple bills from "[redacted];" date of expense incurred was [redacted]; recent statement date of [redacted]; and Petitioner was liable for $[redacted] (hereinafter referred to as "medical bill H"). Exhibit 1, pp. 15-18. A review of Petitioner's "Medical Expense-Summary" showed that she reported medical bill H to the Department on [redacted] Exhibit D, p. 1. A review of Petitioner's "Current and Old Bill Details" document for the benefit month of [redacted] finds that the Department did not utilize medical bill H as an old bill to meet her deductible for [redacted]. Exhibit A, p. 66. The Department provided Petitioner with full MA coverage for the month services were incurred for medical bill H in [redacted]. See Exhibit C, p. 3. Because medical bill H has not been utilized to meet her deductible and she received full MA coverage for the month the services were incurred, she should have her service provider attempt to resubmit this bill to Medicaid in order for it to be paid. There is nothing further the Department can do in this instance for medical bill H.

Ninth, Petitioner submitted a bill from [redacted] date of expense incurred was [redacted] statement date of [redacted]; and Petitioner was liable for $[redacted] (hereinafter referred to as "medical bill I"). Exhibit 1, pp. 19-20. A review of Petitioner's "Medical Expense-Summary" showed that she reported medical bill I to the Department on [redacted]. Exhibit D, p. 3. A review of Petitioner's "Current and Old Bill Details" document for the benefit month of [redacted] finds that the Department did not utilize medical bill I as an old bill to meet her deductible for [redacted]. Exhibit A, p. 66. The Department provided Petitioner with full

MA coverage for the month service were incurred for medical bill I in [redacted]. See Exhibit C, p. 3. Because medical bill I has not been utilized to meet her deductible and she received full MA coverage for the month the services were incurred, she should have her service provider attempt to resubmit this bill to Medicaid in order for it to be paid. There is nothing further the Department can do in this instance for medical bill I.

Tenth, Petitioner submitted multiple bills from [redacted];" date of expense incurred was [redacted]; recent statement date of [redacted]; and Petitioner was liable for $[redacted] (hereinafter referred to as "medical bill J"). Exhibit 1, pp. 21-26. A review of Petitioner's "Medical Expense-Summary" showed that she reported medical bill J to the Department on [redacted]. Exhibit D, p. 1. A review of Petitioner's "Current and Old Bill Details" document for the benefit month of [redacted] finds that the Department did not utilize medical bill J as an old bill to meet her deductible for [redacted]. Exhibit A, p. 66. The Department provided Petitioner with full MA coverage for the month services were incurred for medical bill J in [redacted]. See Exhibit C, p. 3. Because medical bill J has not been utilized to meet her deductible and she received full MA coverage for the month the services were incurred, she should have her service provider attempt to resubmit this bill to Medicaid in order for it to be paid. There is nothing further the Department can do in this instance for medical bill J.

Eleventh, Petitioner submitted multiple bills from "[redacted] date of expense incurred was [redacted]; recent statement date of [redacted]; and Petitioner was liable for $[redacted] (hereinafter referred to as "medical bill K"). Exhibit 1, pp. 27-31. A review of Petitioner's "Medical Expense-Summary" showed that she reported medical bill K to the Department on [redacted]. Exhibit D, p. 1. The Department, though, did not provide a "Current and Old Bill Details" document for the benefit month of [redacted] to see if this bill was utilized as an old bill. Thus, the Department failed to establish whether it properly processed medical bill K. As such, the Department is ordered to reprocess medical bill K in accordance with Department policy.

Twelfth, Petitioner submitted multiple bills from [redacted] date of expense incurred was [redacted]; recent statement date of [redacted]; and Petitioner was liable for $[redacted] (hereinafter referred to as "medical bill L"). Exhibit 1, pp. 36-40. A review of Petitioner's "Medical Expense-Summary" showed that this bill was not reported to the Department and/or utilized as an old bill. Exhibit D, pp. 1-4. Nevertheless, the Department provided Petitioner with full MA coverage for the month services were incurred for medical bill L in [redacted]. See Exhibit C, p. 3. As such, Petitioner should have her service provider attempt to resubmit this bill to Medicaid in order for it to be paid. There is nothing further the Department can do in this instance for medical bill L.

Thirteenth, Petitioner submitted a bill from "[redacted] date of expense incurred was [redacted]; statement date of [redacted]; and Petitioner was liable for $[redacted] (hereinafter referred to as "medical bill M"). Exhibit 1, pp. 44-46. A review of

Petitioner's "Medical Expense-Summary" showed that she reported medical bill M to the Department on [redacted]. Exhibit D, p. 1. A review of Petitioner's "Current and Old Bill Details" document for the benefit month of [redacted] finds that the Department did not utilize medical bill M as an old bill to meet her deductible for [redacted]. Exhibit A, p. 66. The Department provided Petitioner with full MA coverage for the month services were incurred for medical bill M in [redacted]. See Exhibit C, p. 3. Because medical bill M has not been utilized to meet her deductible and she received full MA coverage for the month the services were incurred, she should have her service provider attempt to resubmit this bill to Medicaid in order for it to be paid. There is nothing further the Department can do in this instance for medical bill M.

Fourteenth, Petitioner submitted a bill from [redacted] date of expense incurred was [redacted], and [redacted] recent statement date of [redacted]; and Petitioner was liable for $[redacted] (hereinafter referred to as "medical bill N"). Exhibit 1, p. 47. A review of Petitioner's "Medical Expense-Summary" showed that this bill was not reported to the Department and/or utilized as an old bill. Exhibit D, pp. 1-4. Nevertheless, the Department provided Petitioner with full MA coverage for the month services were incurred for medical bill N in [redacted] and [redacted]. See Exhibit C, pp. 2-3. As such, Petitioner should have her service provider attempt to resubmit this bill to Medicaid in order for it to be paid. There is nothing further the Department can do in this instance for medical bill N.

Fifteenth, Petitioner submitted multiple bills from [redacted] date of expense incurred was [redacted], [redacted], [redacted] and [redacted]; recent statement date of [redacted]; and Petitioner was liable for $[redacted] (hereinafter referred to as "medical bill O"). Exhibit 1, pp. 48-51. A review of Petitioner's "Medical Expense-Summary" showed that this bill was not reported to the Department and/or utilized as an old bill. Exhibit D, pp. 1-4. Nevertheless, the Department provided Petitioner with full MA coverage for the month services were incurred for medical bill O from [redacted], and [redacted] See Exhibit C, pp. 2-3. As such, Petitioner should have her service provider attempt to resubmit this bill to Medicaid in order for it to be paid. There is nothing further the Department can do in this instance for medical bill O.

Sixteenth, Petitioner submitted multiple bills from [redacted] date of expense incurred was [redacted], and [redacted]; recent statement date of [redacted]; and Petitioner was liable for $[redacted] (hereinafter referred to as "medical bill P"). Exhibit 1, pp. 52-57. A review of Petitioner's "Medical Expense-Summary" showed that this bill was not reported to the Department and/or utilized as an old bill. Exhibit D, pp. 1-4. Nevertheless, the Department provided Petitioner with full MA coverage for the month services were incurred for medical bill P in [redacted]. See Exhibit C, p. 2. As such, Petitioner should have her service provider attempt to resubmit this bill to Medicaid in order for it to be paid. There is nothing further the Department can do in this instance for medical bill P.

Seventeenth, Petitioner submitted a bill from [redacted] date of expense incurred was [redacted], and [redacted]; recent statement date of [redacted]; and Petitioner was liable for $[redacted] (hereinafter referred to as "medical bill Q"). Exhibit 1, pp. 58-59. A review of Petitioner's "Medical Expense-Summary" showed that this bill was not reported to the Department and/or utilized as an old bill. Exhibit D, pp. 1-4. Nevertheless, the Department provided Petitioner with full MA coverage for the month services were incurred for medical bill Q in [redacted] and [redacted]. See Exhibit C, p. 2. As such, Petitioner should have her service provider attempt to resubmit this bill to Medicaid in order for it to be paid. There is nothing further the Department can do in this instance for medical bill Q.

Eighteenth, Petitioner submitted a bill from [redacted] with no date of expense incurred; recent statement date of [redacted]; and Petitioner was liable for $[redacted] (hereinafter referred to as "medical bill R"). Exhibit 1, pp. 60-61. A problem arises with this bill because it does not contain the date expense was incurred. BEM 545 states that the Department verifies the following before using an allowable medical expense to determine eligibility, the date expenses incurred, etc. See BEM 545, p. 14. Petitioner failed to provide sufficient verification of medical bill R because it failed to provide the date of expense incurred. As such, the Department acted in accordance with Department policy for not processing medical bill R.

Nineteenth, Petitioner submitted a bill from "[redacted] date of expense incurred was [redacted]; statement date of [redacted]; and Petitioner was liable for $[redacted] (hereinafter referred to as "medical bill S"). Exhibit 1, pp. 33-35. A review of Petitioner's "Medical Expense-Summary" showed that she reported medical bill S to the Department on [redacted]. Exhibit D, p. 3. A review of Petitioner's "Current and Old Bill Details" document for the benefit month of [redacted] finds that the Department did not utilize medical bill S as an old bill to meet her deductible for [redacted]. Exhibit A, p. 66. The Department provided Petitioner with full MA coverage for the month services were incurred for medical bill S in [redacted]. See Exhibit C, p. 3. Because medical bill S has not been utilized to meet her deductible and she received full MA coverage for the month the services were incurred, she should have her service provider attempt to resubmit this bill to Medicaid in order for it to be paid. There is nothing further the Department can do in this instance for medical bill S.

Twentieth, Petitioner submitted a bill from [redacted] date of expense incurred was on or about [redacted]; statement date of [redacted]; and Petitioner was liable for $[redacted] (hereinafter referred to as "medical bill T"). Exhibit 1, pp. 41-43. A review of Petitioner's "Medical Expense-Summary" showed that she reported medical bill T to the Department on [redacted]. Exhibit D, p. 1. A review of Petitioner's "Current and Old Bill Details" document for the benefit month of [redacted] finds that the Department did not utilize medical bill S as an old bill to meet her deductible for [redacted]. Exhibit A, p. 66. The Department provided Petitioner with full MA coverage for the month services were incurred for medical bill T in [redacted]. See Exhibit C, p. 3. Because medical bill T has not been utilized to meet her deductible

and she received full MA coverage for the month the services were incurred, she should have her service provider attempt to resubmit this bill to Medicaid in order for it to be paid. There is nothing further the Department can do in this instance for medical bill T.

Based on the foregoing information and evidence, (i) the Department properly processed medical bills A, B, C, D, E, F, G, H, I, J, L, M, N, O, P, Q, R, S, and T in accordance with Department policy; (ii) the Department failed to satisfy its burden of showing that it properly processed medical bill K; and (iii) the Department failed to satisfy its burden of showing that it properly provided Petitioner with MA coverage for [redacted]

DECISION AND ORDER

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 (i) the Department properly processed medical bills A, B, C, D, E, F, G, H, I, J, L, M, N, O, P, Q, R, S, and T in accordance with Department policy; (ii) the Department failed to satisfy its burden of showing that it properly processed medical bill K; and (iii) the Department failed to satisfy its burden of showing that it properly provided Petitioner with MA coverage for [redacted].

Accordingly, the Department's decision is **AFFIRMED IN PART** with respect to medical bills A, B, C, D, E, F, G, H, I, J, L, M, N, O, P, Q, R, S, and T; and **REVERSED IN PART** with respect to medical bill K, and Petitioner's MA eligibility for [redacted]

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. Reprocess Petitioner's submitted medical bill K in accordance with Department policy;

2. Redetermine Petitioner's MA eligibility for [redacted];

3. Issue supplements to Petitioner for any MA benefits she was eligible to receive but did not for [redacted] and

4. Notify Petitioner of its decision.

EJF/jaf

Eric J. Feldman
Administrative Law Judge
for Nick Lyon, Director
Department of Health and Human Services

NOTICE OF APPEAL: A party may appeal this Order in circuit court within 30 days of the receipt date. A copy of the circuit court appeal must be filed with the Michigan Administrative Hearing System (MAHS).

A party may request a rehearing or reconsideration of this Order if the request is received by MAHS within 30 days of the date the Order was issued. The party requesting a rehearing or reconsideration must provide the specific reasons for the request. MAHS will not review any response to a request for rehearing/reconsideration.

A written request may be mailed or faxed to MAHS. If submitted by fax, the written request must be faxed to (517) 335-6088; 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 48909-8139

DHHS [redacted]

Petitioner [redacted]

Via email [redacted]