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: November 4, 2016
MAHS Docket No.: 16-012505
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). The Department of Health and Human Services (Department) was represented by [redacted], Eligibility Specialist.

ISSUES

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

2. Did the Department properly implement and certify two previous hearing decisions?

3. Did the Department properly notify Petitioner that periods of Medical Assistance (MA) coverage were added to his active deductible case?

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 of MA benefits.

2. On [redacted], Petitioner previously requested a hearing protesting the Department's actions with regard to the processing of his medical bills and the Department's failure to place Petitioner and his wife in the same MA fiscal group. Exhibit B, pp. 1-2.

3. On [redacted], an administrative hearing was held in which Administrative Law Judge (ALJ) Lynn Ferris issued a hearing decision on [redacted], and reversed the Department (Reg. No. 14-019584). Exhibit B, pp. 1-9.

4. On [redacted], Petitioner requested another hearing disputing the Department's failure to comply with ALJ Ferris's hearing decision. Exhibit C, p. 2.

5. On [redacted], another administrative hearing was held in which the undersigned issued a hearing decision on March 31, 2016. Exhibit C, pp. 1-6.

6. On [redacted], the undersigned issued a hearing decision ordering the Department to implement and certify ALJ Ferris's hearing decision (Reg. No. 15-024848). Exhibit C, pp. 1-6.

7. On or about [redacted] the Department requested a Help Desk Ticket (BR-023953) to resolve Petitioner's outstanding issues with his medical expenses. Exhibit A, p. 6.

8. On [redacted], the Michigan Department of Health and Human Services (MDHHS) Application Support informed Petitioner's caseworker by e-mail that the Help Desk Ticket regarding Petitioner's medical expenses had been resolved. Exhibit A, pp. 7-8.

9. On [redacted], the Department sent Petitioner a Benefit Notice (to the wrong address, but it was eventually handed to him) informing him that he is eligible for full coverage from [redacted], but that an MSA-1038, Request for Exception to the Twelve Month Billing Limitation for Medical Services, will be completed. Exhibit A, pp. 13-14.

10. On an unspecified date, the MSA-1038, Request for Exception to the Twelve Month Billing Limitation for Medical Services, was approved; and Petitioner was eligible for benefits from [redacted]. Exhibit A, pp. 11-12.

11. The Department properly processed Petitioner's medical expenses, but failed to provide written notice that periods of MA coverage were added to his active deductible case, other than [redacted].

12. The Department complied with ALJ Ferris's hearing decision dated [redacted], (Reg. No. 14-019584) and the undersigned's hearing decision dated [redacted] (Reg. No. 15-024848). Exhibit B, pp. 1-9 and Exhibit C, pp. 1-6.

13. On [redacted], Petitioner filed a hearing request, protesting the Department's action. Exhibit A, p. 3.

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 matter

Petitioner previously attended an administrative hearing on [redacted], in front of the undersigned. Exhibit C, p. 1. On [redacted], the undersigned issued a hearing decision concerning Petitioner's dispute with his MA benefits (See Reg. No. 15-024848). Exhibit C, pp. 1-6. However, during the present hearing, Petitioner claimed that the undersigned failed to address all of his concerns in the hearing decision. The undersigned, though, cannot address these additional issues at the present hearing. Petitioner's only remedy at the time was to appeal the hearing decision. If Petitioner disagreed with the undersigned's hearing decision, then he could have appealed the hearing decision by filing a request for rehearing or reconsideration within 30 days of the mailing of the hearing decision issued on [redacted], or appeal the decision to circuit court. See BAM 600 (October 2015), pp. 38 and 43-46. However, there was no evidence that Petitioner appealed the undersigned's previous hearing decision. As such, the undersigned will not further address Petitioner's concerns that the undersigned failed to address all of his issues in the hearing decision issued on [redacted].

MA benefits

In the present case, Petitioner requested a hearing due to the "mismanagement" of his MA case. Exhibit A, p. 3. Petitioner provided five bullet point reasons why he requested the hearing. Exhibit A, p. 3. The undersigned will address each bullet point below:

Petitioner's first bullet point stated the following:

> When the effort to resolve certain issues at a [redacted] pre-hearing conference failed (specifically those referenced in a hearing request dated [redacted], and this office's arbitrary misuse of this client's old bills), this client was informed on [redacted] by official

> notice from [redacted] that a Help Desk Ticket would be submitted, if necessary, to resolve these differences.
>
> Exhibit A, p. 3.

The undersigned reviewed Petitioner's first bullet point and finds nothing that he is actually disputing. There is nothing the undersigned can address or resolve with the first bullet point. Petitioner references a hearing request dated [redacted] however, the undersigned lacks any such jurisdiction to address the previous hearing request. BAM 600, pp. 1-6. The undersigned can only address the hearing request dated for the present hearing, which is [redacted]. Exhibit A, p. 3.

Petitioner's second bullet point stated the following:

> The Ticket was resolved on [redacted], but was received by this client on [redacted], but did not appear to have included most of the issues of concern. It would appear these were again overlooked, and were not included in the Help Desk Ticket, but why?
>
> Exhibit A, p. 3.

The undersigned disagrees with Petitioner's conclusion that the Help Desk Ticket failed to address all of the issues of his concern. Petitioner's ongoing dispute with the Department's alleged failure to process the submitted medical bills began with a hearing held in front of ALJ Ferris back on [redacted]. Exhibit B, pp. 1-9.

On [redacted] ALJ Ferris issued a hearing decision and ordered the Department to do the following: (i) the Department shall process the medical bills for [redacted] in accordance with Department policy and activate full MA coverage for [redacted] in accordance with Department policy; (ii) the Department shall process the medical bills submitted to it by the Petitioner on [redacted] and determine whether the Petitioner's spend down has been met in accordance with this Decision and Department policy and activate coverage accordingly; (iii) the Department shall place the Petitioner and his wife in the same MA fiscal group and consolidate them under one case number; and (iv) the Department shall provide the Petitioner written notice of the Department's actions and its determinations as required by this Decision and in accordance with Department policy (Reg. No. 14-019584). Exhibit B, pp. 1-9.

On [redacted], Petitioner appeared in front of the undersigned again concerning his medical bills (Reg. No. 15-024848). Exhibit C, pp. 1-6. The undersigned concluded in that hearing that the Department failed to fully and properly implement ALJ Ferris's hearing decision and ordered them to implement the hearing decision correctly. Exhibit C, p. 4.

The undersigned discusses Petitioner's past history of the hearing decisions because they address Petitioner's concerns related to his medical bills, specifically, whether the Department complied with ALJ Ferris's original hearing decision that ordered the Department to process the medical bills for [redacted], activate full MA coverage for [redacted], and process the medical bills submitted on [redacted] and determine whether his spend down has been met. These are Petitioner's ongoing issues with his medical bills. The undersigned reviewed the Help Desk Ticket and found that the Department complied with ALJ Ferris's hearing decision and addressed all of his issues related to the medical bills. The Help Desk Ticket indicated that it processed the medical bills for [redacted], it activated full MA coverage for [redacted], and processed the medial bills on [redacted] and indicated whether his spend down had been met based on the bills submitted in [redacted]. Exhibit A, pp. 7-8. As such, the undersigned finds that the Department presented by a preponderance of evidence that the Help Desk Ticket addressed all of his concerns. Furthermore, the undersigned finds that the Department complied with ALJ Ferris's hearing decision issued on [redacted], as well as the undersigned's hearing decision issued on [redacted]. Exhibit B, pp. 1-9 and Exhibit C, pp. 1-6. There is nothing further the undersigned can address as to second bullet point.

Petitioner's third bullet point stated the following:

> The Ticket clearly indicates MA expenses have not been applied correctly by this Office, and indicated this client met deductible for five (5) months in [redacted] and three (3) months in [redacted] This client was never notified of this coverage, and thus, was unable to take advantage of this eligibility. Should client be deprived this eligibility that is due entirely to DHS mismanagement?
>
> Exhibit A, p. 3.

The undersigned agrees that the Help Desk Ticket stated that the MA expenses had not been applied correctly. Exhibit A, pp. 7-8. However, the Help Desk Ticket further stated that the Department corrected its action and processed the bills correctly. Exhibit A, pp. 7-8. Petitioner argues that he was never notified of his coverage being met for the five months in [redacted] and three months in [redacted] A review of the Help Desk Ticket indicated that Petitioner met the deductible for the following months: (i) [redacted]; (ii) [redacted] (iii) [redacted] (iv) [redacted]; (v) [redacted]; (vi) [redacted]; and (vii) [redacted] Exhibit A, p. 7. The Help Desk Ticket further states that Petitioner should have met the deductible from [redacted], based on old bills provided on [redacted]. Exhibit A, p. 7. Thus, Petitioner should have met the deductible from [redacted].

On [redacted], the Department sent Petitioner a Benefit Notice (to the wrong address, but it was eventually handed to him) informing him that he is eligible for full coverage from [redacted], but that an MSA-1038, Request for Exception to the Twelve Month Billing Limitation for Medical Services, will be completed. Exhibit A, pp. 13-14 and see BAM 402 (October 2015), p. 10 (Twelve Month Billing Exceptions). In fact, the Department presented proof that the MSA-1038 was approved and that Petitioner was eligible for benefits from [redacted]. Exhibit A, pp. 11-12.

Based on the above information and evidence, the undersigned finds that Petitioner did receive notice of his coverage for [redacted], which was the Benefit Notice dated [redacted]. However, the Department failed to present any evidence that it issued Petitioner notice that he met his deductible for the remaining months (i.e., [redacted]). Policy states that the Department send the group a DHS-1606, Health Care Coverage Notice, when you:

- Approve or deny MA.
- Add periods of MA coverage to an active deductible case.
- Transfer an active deductible case to ongoing MA coverage.

BEM 545 (July 2016), p. 13 and see BAM 220 (July 2016), pp. 3-4 (An adequate notice is a written notice sent to the client at the same time an action takes effect (not pended). For MA cases, adequate notice is given when there is an addition of MA coverage on a deductible case).

Based on the above policy, the Department failed to send Petitioner adequate notice of the additional MA coverage he received for his deductible case in accordance with Department policy. As such, the Department is ordered to issue Petitioner a Health Care Coverage Determination Notice notifying him of the addition of MA coverage that was added to his deductible case. BEM 545, p. 13, and BAM 220, pp. 3-4.

Finally, Petitioner's third bullet point argued if whether he should be deprived of his eligibility due to the Department's mismanagement. There is no other remedy for Petitioner other than the undersigned's order that the Department is to send Petitioner notice. There is nothing further the undersigned can address as to third bullet point.

Petitioner's fourth bullet point stated the following:

> In light of the foregoing, this client asks that the DHS be required to re-submit the previously wrongfully submitted medical bills that have not been used for MA coverage, or do whatever necessary to allow this client to have access to the coverage these bills would have provided absent DHS error.
>
> Exhibit A, p. 3.

In regards to Petitioner's fourth bullet point, the undersigned reviewed the Help Desk Ticket and have concluded that the Department properly processed Petitioner's medical bills in accordance with Department policy. In the present case, Petitioner claims that the Department did not process the medical bills properly. In fact, Petitioner points out that the total of all the bills in the Help Desk Ticket was in excess of $[redacted] and believes that they were not properly applied. For example, Petitioner testified that the Department did not properly apply the medical bill in the amount of $[redacted] with an incurred date of [redacted]. Exhibit A, p. 7. Petitioner argued that this medical expense bill should have been applied as an allowable old bill.

In response, the Department testified that Petitioner's medical expense was not an old bill because it was reported timely on [redacted]. The Department testified that the bill was current and applied it to the month the services were incurred, which was [redacted]. This resulted in Petitioner meeting his deductible for that month; and he received full coverage from [redacted]. Exhibit A, p. 7.

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 (July 2013), 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. 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, p. 11. BAM 130 explains verification and timeliness standards. BEM 545, p. 11

Based on the above policy, Petitioner reported the [redacted], expense on [redacted] which was by the last day of the third month following the month in which the group wants MA coverage. The Department argued that because he submitted the bill timely, it properly applied the bill to the [redacted] benefits month, which resulted in the deductible being met and Petitioner receiving full coverage from [redacted].

Petitioner, though, disagreed with how the Department applied the bill. Instead, Petitioner believed the Department should have processed this bill as an old bill. Petitioner directed the undersigned to BEM 545, Exhibit IB – Old Bills policy. See BEM 545, p. 19. A group with excess income can delay deductible for one or more future months based on allowable old bills; see EXHIBIT IB in this item. BEM 545, p. 9. Petitioner, in fact, began reading the following policy section to show how this expense should have been an old bill. Specifically, BEM 545 states that medical expenses listed under **Medical Services** in "'EXHIBIT I can be used as **old bills** if they meet **all** of the following criteria…'" BEM 545, p. 19. However, Petitioner failed to review the first line of this policy section that states "Medical expenses listed under Medical Services in 'Exhibit I can be used as old bills.'" BEM 545, p. 19. The undersigned first needs to review Exhibit I of BEM 545 to see if the medical expense can even be used as an old bill.

Exhibit 1 – Medical expenses state that the expenses must be incurred for a medical service listed in BEM 545. BEM 545, pp. 15-17. Exhibit 1 further states that the Department counts allowable expenses incurred during the month you are determining eligibility for, whether paid or unpaid. BEM 545, p. 15. The Department may also count certain unpaid expenses from prior months that *have not been used to establish MA eligibility*; see OLD BILLS, EXHIBIT IB. BEM 545, p. 15 (emphasis added). The undersigned emphasizes this policy section because the Department cannot use the [redacted], expense as an old bill as it was already used to establish MA eligibility from [redacted]. Policy states that once the Department used this bill to establish MA eligibility, it cannot be used again. As such, the undersigned finds that the Department properly processed the medical expense dated [redacted]. Furthermore, the undersigned reviewed the evidence record and concluded that the Department properly processed Petitioner's medical bills in accordance with Department policy. BEM 545, pp. 1-2, 11, 15, and 19.

Petitioner's fifth bullet point stated the following:

> The Benefit Notice issued by [redacted] in response to the Ticket resolution, and accompanying this resolution, is at best, incomplete, and should be revised to include the client's correct address, and an accurate deductible amount, which would include medical bills being entered prior to processing deductible.
>
> Exhibit A, p. 3.

The undersigned has already addressed Petitioner's fifth bullet point in the previous sections. Yes, the address was improper on the Benefit Notice dated [redacted], but ultimately, Petitioner received the Benefit Notice. Moreover, the undersigned finds that the Benefit Notice was properly written to notify him that he was eligible for full MA coverage for [redacted] and his deductible has been met. Exhibit A, pp. 13-14. However, as stated previously, the Department failed to send Petitioner adequate notice of the additional MA coverage he received for his deductible case in accordance with Department policy. For example, the Help Desk Ticket stated he met his deductible for [redacted]. Exhibit A, p. 7. However, the Department did not present any evidence that notice was sent to him informing that MA coverage on his deductible case was added for this time period. As such, the Department is ordered to issue Petitioner a Health Care Coverage Determination Notice notifying him of the addition of MA coverage on his deductible case in accordance with Department policy. BEM 545, p. 13 and BAM 220, pp. 3-4.

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 acted in accordance with Department policy when it properly processed Petitioner's medical

bills; (ii) the Department acted in accordance with Department policy when it complied with ALJ Ferris's hearing decision dated [redacted], (Reg. No. 14-019584) and the undersigned's hearing decision dated [redacted], (Reg. No. 15-024848); (iii) the Department properly provided notice to Petitioner that he received MA coverage for [redacted]; and (iv) the Department failed to provide written notice of the additional MA coverage he was found eligible for on his deductible case, other than [redacted].

Accordingly, the Department's decision is **AFFIRMED IN PART** with respect to the medical bills; ALJ Ferris's hearing decision dated [redacted], (Reg. No. 14-019584); the undersigned's hearing decision dated [redacted], (Reg. No. 15-024848); MA coverage, including notice, for [redacted] and **REVERSED IN PART** with respect to written notice of the additional MA coverage he was found eligible for on his deductible case.

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. Issue Petitioner written notice of the additional MA coverage he was found eligible for on his deductible case, other than [redacted] in accordance with Department policy.

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]

[redacted]