

**STATE OF RHODE ISLAND AND PROVIDENCE PLANTATIONS
EXECUTIVE OFFICES OF HEALTH AND HUMAN SERVICES
APPEALS OFFICE**

**Louis Pasteur Building- # 57 Howard Avenue
Cranston, Rhode Island 02920
(401) 462-2132/Fax# (401) 462-0458
TDD# (401) 462-3363**

Docket # 14-1109
Hearing Date: September 11, 2014

Date: September 23, 2014

ADMINISTRATIVE HEARING DECISION

The Administrative Hearing that you requested has been decided against you upon a de novo (new and independent) review of the full record of hearing. During the course of the proceeding, the following issue(s) and Agency policy reference(s) were the matters before the hearing:

**THE DHS POLICY MANUAL: MEDICAL ASSISTANCE
SECTION: 0310.05 RETROACTIVE COVERAGE**

The facts of your case, the Agency policy, and the complete administrative decision made in this matter follow. Your rights to judicial review of this decision are found on the last page.

Copies of this decision have been sent to the following: You (the appellant), and Agency representatives: Julie Hopkins, RN, Crystal Dodge, and Gail Scudieri.

Present at the hearing were: You (the appellant), a Spanish interpreter, and Julie Hopkins, RN (DHS Agency representative).

DHS POLICIES:

Please see the attached APPENDIX for pertinent excerpts from the Rhode Island Department of Human Services Policy Manual.

APPEAL RIGHTS:

Please see attached NOTICE OF APPELLATE RIGHTS at the end of this decision.

ISSUE: Is the appellant eligible for Medical Assistance (MA) program benefits retroactive to May 2013?

TESTIMONY AT HEARING:

The Agency representative testified:

- A summary of the events as documented by the field office Medical Assistance (MA) unit and the Medical Assistance Review Team (MART) would be itemized.
- The case logs noted that the client was being assisted by a Miriam Hospital representative who is not present at the hearing to answer questions or to verify claims that are being made.
- The date of the application that was processed by the MART was October 18, 2013.
- On December 20, 2013 the MART determined that he had not established that he was disabled according to the Social Security regulations based on the available medical evidence reviewed for that application.
- Due to some confusion regarding the proper field office assignment of the case, his denial notice was delayed.
- On February 12, 2014 an off-line denial notice was mailed, and in response, an appeal hearing was requested on March 7, 2014.
- A hearing was scheduled by the Appeals Office (June 5, 2014).
- After a review of updated medical records the MART determined that he met the disability criteria, and reversed their original denial on May 28, 2014.
- He was found eligible retroactively to July 1, 2013.
- A letter was sent from the MART to their client on May 28, 2014 explaining the reversal of their decision.
- On June 4, 2014, the hearing office also sent a letter of explanation.
- On June 16, 2014, an inquiry was made by the Miriam Hospital advocate regarding her claim that earlier applications had been submitted.

- She indicated that she had submitted applications on his behalf for May, June, July, and August of 2013.
- The field office supervisor made several searches attempting to confirm the filing of an earlier application, but no evidence of an application filed before October 2013 was found.
- Also, there were no inquires of record trying to ascertain if any decisions had been made prior to the reversal of the October 2013 application.
- The patient advocate submitted a copy of an application with a May 2013 date which she indicated was a re-submission.
- She was unable to provide any evidence that the application had previously been submitted and received by the field office.
- Ordinarily applications are submitted one at a time.
- Additional applications will be considered depending on the outcome of the previous determination.
- If information on the application is incomplete when received from a client, the field office staff will contact the client to request any missing information.
- If the agency has a copy of a release signed by the client they could be authorized to discuss the case with a hospital representative.
- No documentation that a hospital representative had contacted the agency was indicated until after the denial of the October 2013 was reversed.
- A copy of agency policy 0310.05 that was used to guide the MART determination of onset date of eligibility was submitted as evidence.

The appellant, assisted by a Spanish interpreter, testified:

- He remembers signing applications which he gave to the Miriam Hospital Patient Advocate to handle for him.
- After he signed his name, she kept the documents in her possession.
- He had contact with agency workers at the Pawtucket office just once after he signed the documents, but did not obtain any information regarding the status of his case.
- In preparation for the hearing, Laura did not give him any information about how she submitted the applications, or prepare him with any evidence of the date(s), or method(s) of submission.
- He believed that at some point she had told him that she had faxed each application on a separate date.
- He does not recall being advised to apply for community free care.
- The hospital gave to him copies of medical records relative to his hospitalization to bring to the hearing.
- He requested to hold the record of hearing open for one week (until September 18, 2014) for the submission of additional evidence.
- Rather than waiting for the held open agreement letter, he requested to have a list of information needed from the hospital to take with him in order to save time.
- He had spoken with Laura the day before the hearing, and believes she was aware of when the hearing would take place.

FINDINGS OF FACT:

- The appellant applied for Medical Assistance (MA) on October 7, 2013 as determined by documented receipt of his application.
- The agency processed the application as received on October 18, 2013 in error.
- The variation in the date used had no impact on the outcome of the eligibility finding or the month of onset, and therefore did not harm the appellant.
- The Medical Assistance Review Team (MART) determines disability for the MA Program.
- The MART processed the October 7, 2013 application, reviewed the available medical records, and found that the evidence did not establish that the appellant was disabled according to the Social Security disability regulations on December 20, 2013.
- Notification of that decision was delayed due to a record transfer.
- A denial notice dated February 12, 2014 was sent to the appellant.
- On March 7, 2014 a timely request for hearing relative to the denial based on the disability criteria was received by the EOHHS Appeals Office.
- A hearing was scheduled for June 5, 2014.
- On May 28, 2014, the MART notified the Appeals Office that additional evidence had established that the appellant was disabled, and reversed their decision.
- Based on Agency policy 0310.50 the appellant was found to be eligible for retroactive coverage, and was awarded the maximum of 90 days prior to receipt of the application as is allowed by that policy.
- Benefits were expected to begin for the month of July 2013.
- The Appeals Office notified the appellant on June 3, 2014 that the notice of denial under appeal had been withdrawn, and there was no longer any issue in dispute.
- The appellant was referred to the DHS field office to complete the eligibility process.

- On July 3, 2014 the appellant filed a new appeal challenging the July 2013 onset date of eligibility established in response to the October 2013 application.
- The hearing was scheduled for September 11, 2014.
- Per the appellant's request, the record of hearing was held open through the close of business on September 18, 2014 for the submission of additional evidence.
- Additional evidence from a Miriam Hospital patient advocate was received during the held open period by certified mail received on September 17, 2014, and was added to the record of hearing.
- The available evidence does not establish that delivery of an application for MA benefits took place prior to October 7, 2013.
- The agency decision that the onset of the appellant's MA benefits would begin in July 2013 is correct according to policy 0310.

DISCUSSION OF THE MEDICAL EVIDENCE RECORD:

The record of hearing consists of:

- ✓ A copy of Agency policy 0310 (Retroactive Coverage).
- ✓ A letter explaining filing of the applications dated September 12, 2014 and signed by a Patient Financial Advocate for The Miriam Hospital.
- ✓ A US Postal Service certified mail receipt form dated June 27, 2013 with no address in "Sent To" space, and no confirmation of delivery.
- ✓ A US Postal Service certified mail receipt form dated October 7, 2013 with verification of delivery to the DHS Pawtucket office on October 7, 2013.
- ✓ A three-page report of hospital patient services for May 5, 2013 to September 17, 2013.
- ✓ A copy of the DHS letter of denial dated February 12, 2014.
- ✓ A copy of the Agency DHS-2 Statement of Need dated May 5, 2013 and signed by the appellant.
- ✓ A copy of the Agency DHS-2 Statement of Need dated June 9, 2013 and signed by the appellant.
- ✓ Hearing testimony.

CONCLUSION:

It is the responsibility of the agency to process applications in accordance with agency policy pertaining to the specific program benefit requested. It is the responsibility of the appellant to ensure that the application is correctly filed, and to ascertain status of progress pertaining to that application if needed. Although the appellant in this matter relied on the assistance of a hospital advocate, both parties would be held to the same requirements when filing an application.

According to the appellant, actions including filing of applications, production of medical evidence records, and submission of appeal requests was handled by a patient financial advocate at Miriam Hospital. He was urged to appear at the hearing, but did so without support of a representative, witnesses, or any substantive evidence. He seemed to have very little understanding of the matter under appeal, and no direct involvement in the process that was being challenged. He was assisted by a Spanish interpreter.

His advocate has indicated repeatedly that multiple MA applications had been submitted to the DHS, and that two applications submitted prior to October 2013 were somehow lost or mishandled. At the time of this decision, however, there is no evidence that the earlier applications ever reached DHS prior to October 7, 2013. It is not in dispute that the appellant was actually hospitalized in May and in June of 2013.

The appellant and his advocate appear to be assuming that a date written on the application is the filing date to be recognized by the agency. However, the recognized date of application is the date the application reaches the DHS office and is actually available for processing. Therefore, multiple applications for the same benefit request (in this case MA) received together on the same date would be processed as having the same application date regardless of any dates written on the documents. In this matter the appellant had affixed his signature on two additional DHS-2 Statement of Need forms which specify on page three *"Medical Assistance benefits may be provided for up to three (3) months prior to the month in which the signed application is received provided all factors of eligibility are met for each month."*

Rhode Island Superior Court order (Cara Spry v. Rhode Island DHS) states that *"It was (the client's) responsibility to ensure that (DHS) received and filed her request..."* Also the Rhode Island Supreme court order (Mauricio v. Zoning Board of Review) states that any *"risk of non-delivery must be borne by the party who seeks the approval."*

The agency representative testified that attempts were made with cooperation of the field office supervisor to locate any evidence that an appeal had been filed prior to the submission of additional applications in October. No actual documents or electronic documentation of applications filed at an earlier date

have been found. Additionally, they searched for record of any inquiries into the status of the case originated by either the appellant or the hospital advocate prior to the denial in February 2014, with no results.

A letter was received from Miriam Hospital referring to an application sent on June 27, 2013 by certified mail. The postal receipt does not contain any information identifying the intended recipient. The writer admits that no receipt of delivery was returned to them. There is no information about whether a second application was submitted separately. Subsequently, three applications were sent by certified mail on October 7, 2014, and a signed receipt confirms that fact. The agency has acknowledged that the appellant applied in October 2014. Since that time, the medical evidence record had been developed by the MART, until a favorable disability determination resulted, and an administrative hearing based on the disability criteria was avoided. The MART properly applied the retroactive policy, and awarded coverage beginning in July 2013 (the maximum retroactive period specified by policy). The question as to whether or not the appellant was actually disabled prior to that date is rendered moot by the absence of proof that a valid application filing was made within the period that would cover retroactively to May 2013.

After careful and considerate review of the Agency's policies as well as the evidence and testimony submitted, this Appeals Officer concludes that the appellant has not established that a timely application covering the month of May 2013 was received by the agency. Consequently, the appellant's request for relief is denied.

Pursuant to DHS Policy General Provisions section 0110.60.05, action required by this decision, if any, completed by the Agency representative must be confirmed in writing to this Hearing Officer.



Carol J. Ouellette
Appeals Officer

APPENDIX

0310 Retroactive Coverage

0310.01 Applicability

REV: June 2014

The provisions in this section do not apply to the individuals and families in the Medicaid Affordable Care Coverage (MACC) Groups identified in MCAR section 1301 that take effect on January 1, 2014. The rule governing the application process for the Medicaid Affordable Coverage Groups included in section 1301 is located in MCAR section 1303.

0310.05 Retroactive Coverage Defined

REV: October 2013

Medicaid beneficiaries who meet the SSI-related eligibility criteria may request retroactive eligibility for UP TO THREE (3) MONTHS PRIOR TO THE MONTH OF APPLICATION. To obtain retroactive coverage, applicants must meet all eligibility criteria during the retroactive period.

Retroactive coverage is also available to IV-E and non IV-E foster children and adoption subsidy family-related coverage groups.

The following chart details the family-related coverage groups who are eligible/ineligible for retroactive services:

<i>Coverage Group</i>	
IV-E and non IV-E Foster Children	Y
Adoption Subsidy Children Coverage Groups	Y
SSI-related coverage groups categorically or medically needy	Y
Non-citizens who are ineligible for ongoing Medicaid due to immigration status - All coverage groups	Y

At the time of application for Medicaid, if the applicant indicates that an unpaid medical bill was incurred in the three month period preceding the application, eligibility for retroactive coverage must be determined.

Current eligibility for SSI, RI WORKS, or Medicaid does NOT affect retroactive eligibility. Individuals who are denied SSI, RI WORKS, or Medicaid in the month of application may be eligible for retroactive coverage.

An applicant need not be alive when an application for retroactive coverage is filed. Retroactive eligibility is not available to persons who were not residents of Rhode Island in the retroactive period and at the time the service was provided.

0310.10 Eligibility Requirements

REV: October 2013

Retroactive coverage applies only to unpaid medical bills for services provided within the scope of the Medicaid Program. The medical bills must have been incurred during the three month retroactive period. The applicant must meet Medicaid eligibility requirements for each month in which an unpaid medical bill was incurred. Thus, retroactive eligibility may be determined for one, two, or three months of the retroactive period.

ONLY THE INCOME AND RESOURCES AVAILABLE TO THE APPLICANT IN THE RETROACTIVE PERIOD ARE USED TO DETERMINE ELIGIBILITY.

All services are subject to the same Title XIX utilization review standards as all other medical services of the Medicaid Program.

0310.15 Procedures for Determining Retroactive Eligibility

REV: October 2013

In determining retroactive eligibility, the applicant's net income (after allowable deductions and disregards) and resources are compared to Medically Needy limits UNLESS the unpaid medical bill is for Categorically Needy service only. In this case, eligibility must be based on the applicable Categorically Needy limits.

To determine retroactive eligibility, complete the following:

- Verify that the bill is unpaid and is for a covered service provided within the three (3) months prior to the first of the month of application for SSI, RI WORKS, or Medicaid.
- Establish eligibility based on:
 - Residence
 - Characteristic (if required)
 - Relationship (if required)
 - Citizenship or alienage; and at the time of application, the applicant must fulfill cooperation and enumeration requirements.
- Compare the resources and net income (after allowable deductions and disregards) to the appropriate income limit for the month(s) in which there is a verified, unpaid bill(s) (income limits refer to Categorically Needy income limits, Medically Needy income limits and Low Income Aged and Disabled income limits). Resources must be within the applicable resource limit as of the first day of each month for which eligibility is being determined.
- Determine whether retroactive coverage is available to individual's coverage group.
- If eligible, certify the case for the month or months of eligibility. Retroactive eligibility is for one (1), two (2), or all of the three (3) months immediately preceding the month of application.
- If the income exceeds the Medically Needy Income Limits apply the Flexible Test of Income. If the Flexible Test of Income results in achieving Medicaid retroactive eligibility, only those bills not applied to excess income are authorized for retroactive coverage.

If the bill is for a service not provided under the Medically Needy scope of services, the application must be determined for eligibility as Categorically Needy.

- If an unpaid bill is for a Categorically Needy service and the applicant's income exceeds the Categorically Needy Income Limits, the application for retroactive eligibility is denied. There is no Flexible Test of Income for income in excess of the Categorically Needy Income Limits.
- If unpaid bills for both Medically Needy and Categorically Needy services are submitted, the applicant must be found eligible as Categorically Needy or the bill(s) for the Categorically Needy service(s) must be denied. If the individual is eligible as Medically Needy, only the bill(s) for Medically Needy services can be authorized for retroactive coverage.

0310.20 Authorization of Retroactive Eligibility

REV: October 2013

Retroactive eligibility is determined on a month by month basis.

No bill can be paid unless it is submitted by the provider and received by the Medicaid agency WITHIN TWELVE (12) MONTHS OF THE DATE THE SERVICE AS PROVIDED.

A copy of each medical bill or other verification that a medical expense exists during the retroactive period must be included in the case record to support the decision on the application.

0310.21 Severability

October 2013

If any provisions of these regulations or the application thereof to any person or circumstance shall be held invalid, such invalidity shall not affect the provisions or application of these regulations which can be given effect, and to this end the provisions of these regulations are declared to be severable.

NOTICE OF APPELLATE RIGHTS

This Final Order constitutes a final order of the Department of Human Services pursuant to RI General Laws §42-35-12. Pursuant to RI General Laws §42-35-15, a final order may be appealed to the Superior Court sitting in and for the County of Providence within thirty (30) days of the mailing date of this decision. Such appeal, if taken, must be completed by filing a petition for review in Superior Court. The filing of the complaint does not itself stay enforcement of this order. The agency may grant, or the reviewing court may order, a stay upon the appropriate terms.