STATE OF VERMONT

HUMAN SERVICES BOARD

In re	)	Fair Hearing No. B-03/16-235
	)	
Appeal of	)	
	)	
	)	

INTRODUCTION

Petitioner seeks Medicaid reimbursement, ostensibly on behalf of her son as well as herself, for out-of-state ambulance services incurred several years ago when he was covered by Dr. Dynasaur. Her request for reimbursement was denied by the Department for Children and Families ("Department"). The following facts are adduced from a hearing held March 21, 2016 and telephone status conference on May 3, 2016, as well as documents submitted by both parties. At petitioner's request, the record was held open through June of 2016 for submission of additional information (nothing has been submitted to date).

FINDINGS OF FACT

1. Petitioner's son was a minor child in October of 2009, when he required ambulance services related to his

participation in the Chicago Marathon. At the time, he was covered by Dr. Dynasaur.

2. In December of 2009, Petitioner received a bill from the ambulance service for $1,040. She contacted the ambulance service and provided them with her son's (Dr. Dynasaur) insurance information. She was informed by someone with the ambulance service that they would not submit the bill to an out-of-state insurer. When she continued to be billed, she contacted them again in February of 2010, at which time she was informed that they would not submit a bill to "out-of-state public insurance."

3. Petitioner testified that she contacted Vermont Medicaid during this time – in both December of 2009 and February of 2010 - to find out if the ambulance bill could be covered. She produced summary notes of what she indicates are a copy of records of her conversations, by which she understood that the bill would be covered and that she only needed to send the invoices to Medicaid (which she states that she did).

4. The Department has no record of any calls, invoices, or other contact from petitioner during this time in its "Case Action Notes," relating to these bills. The Department indicates that any recordings of telephone

conversations from that period of time would have been deleted by now.

5. Petitioner continued to receive bills from the ambulance provider, as well as a bill for hospital services related to the same events. She received bills in March, June and July of 2010, copies of which she submitted at hearing, and by her own account she continued to receive bills until approximately two years ago. At some point in 2010 the bills were assigned to a collection agency. Despite receiving these bills, petitioner did not contact Vermont Medicaid again. She believed that the collection efforts had been dropped when she eventually stopped receiving bills.

6. However, earlier this year, petitioner's son, now living on his own at a new address, began receiving bills from a collection agency (relating to the ambulance services only – the hospital services bill has apparently never resurfaced and is not at issue here). Petitioner contacted the Department earlier this year, and was informed that there was no record of any contact by her in 2009 and 2010 regarding the bill(s). The Department denied her request to cover the costs, and petitioner appealed.

ORDER

The Department's decision is affirmed as petitioner fails to establish any grounds for relief under the rules; to the extent petitioner's appeal can be construed as stemming from Department action/inaction in 2010, is dismissed as untimely.

REASONS

Review of the Department's determination is de novo. The Department has the burden of proof at hearing if terminating or reducing existing benefits; otherwise the petitioner bears the burden. *See* Fair Hearing Rule 1000.3.0.4.

Petitioner's appeal stems from a period of her son's eligibility for Dr. Dynasaur more than six years ago. The costs she seeks payment for no longer stem from the medical provider of services, but a collection agency seeking payment from her son, no longer living in her household and no longer a minor. Even accepting her testimony that she contacted the Department at the time, and was informed that the bills would be addressed, she failed to take any further action when it became clear that the bills had not been paid. By petitioner's own acknowledgment, she failed to follow up

because she believed that the collection efforts had been dropped, not because she believed the Department had paid the bill (nor would that have been a reasonable conclusion).

Petitioner is therefore well beyond the 90-day period of time that is normally allowed to raise a grievance (that she was aware of or reasonably should have been aware of) under the Medicaid rules. *See* Health Benefits Eligibility and Enrollment Rules, § 80.04. For similar reasons, it cannot be found that principles of equity allow petitioner to raise this appeal more than six (6) years later, as it cannot be found that she relied exclusively (or at all) on the Department's (alleged) representations or even that she believed (for whatever reason) that the bill had been paid by Vermont Medicaid. *See Stevens v. Dept. of Social Welfare*, 159 Vt. 408 (1992).[1]

Even assuming arguendo that petitioner has brought a timely appeal – either based on equitable estoppel or the Department's most recent denial of her request to pay for these costs - she has not established grounds for relief

[1] The four elements are:(1) the party to be estopped must know the facts;(2) the party to be estopped must intend that its conduct shall be acted upon or the acts must be such that the party asserting estoppel has a right to believe it is so intended;(3) the party asserting estoppel must be ignorant of the true facts; and (4) the party asserting estoppel must detrimentally rely on the conduct of the party to be estopped. *Id.* at 421.

under the rules. It is not clear that her son (who has not directly participated in this appeal) has any liability for costs incurred when he was a minor or even that such aged bills are otherwise legally actionable against him. Moreover, petitioner's records establish that the ambulance provider was refusing to bill "out-of-state public insurance" and thus any effort by the Department to enroll the provider (a prerequisite to payment) would have been fruitless. *See* Fair Hearing No. B-04/11-217 (out-of-state provider of emergency services must be enrolled in Vermont Medicaid to receive payment). The availability of this remedy, in any event, is patently expired – without any evidence establishing otherwise - given the passage of time and long-ago transfer of the debt to collection agencies.

As such, the Department's denial of payment of the collection bill must be affirmed by the Board. *See* 33 V.S.A. § 3091(d); Fair Hearing Rule No. 1000.4D.

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