

2014 IL App (2d) 140127-U  
No. 2-14-0127  
Order filed December 9, 2014

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IN THE  
APPELLATE COURT OF ILLINOIS  
SECOND DISTRICT

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CARLOS VALDEZ,	)	Appeal from the Circuit Court
	)	of Winnebago County.
Plaintiff-Appellant,	)	
	)	
v.	)	No. 13-MR-388
	)	
ILLINOIS DEPARTMENT OF HUMAN	)	
SERVICES, MICHELLE R.B. SADDLER,	)	
Secretary of the Illinois Department of Human	)	
Services, ILLINOIS DEPARTMENT OF	)	
HEALTHCARE AND FAMILY SERVICES,	)	
and JULIE HAMOS, Director of the Illinois	)	
Department of Healthcare and Family Services,	)	Honorable
	)	J. Edward Prochaska,
Defendants-Appellees.	)	Judge, Presiding.

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JUSTICE JORGENSEN delivered the judgment of the court.  
Justices Hutchinson and Schostok concurred in the judgment.

**ORDER**

¶ 1 *Held:* Administrative agencies erred in denying undocumented alien's claim for Medicaid reimbursement. Agencies applied proper standard to assess claim, but erred in determining that plaintiff failed to show he had an emergency medical condition, where, although plaintiff's condition was ultimately determined to be nonemergent, he was admitted to hospital to rule out a heart attack. Reversed and remanded.

¶ 2 Following his inpatient hospital admission for chest pain, plaintiff, an undocumented alien, sought Medicaid reimbursement for emergency care. After the Winnebago County Department of Human Services (local office) denied reimbursement on the basis that plaintiff was not hospitalized for an emergency medical condition, plaintiff appealed to the Illinois Department of Healthcare & Family Services (DHFS) and the Department of Human Services (DHS), and they jointly affirmed the local office's decision. On administrative review, the trial court affirmed the denial of Medicaid benefits. Plaintiff appeals. We reverse the agencies' decision and remand the cause.

¶ 3 I. BACKGROUND

¶ 4 Plaintiff, age 45, is an undocumented alien, is married, and cares for a minor child.

¶ 5 On July 12, 2011, plaintiff awoke at 4 or 5 a.m. with chest pain. The pain continued throughout that day. On July 13, 2011, he woke to more severe pain, which caused him to go to the emergency room at Swedish American Hospital in Rockford.

¶ 6 The emergency room report reflects that plaintiff complained of left-sided, pressure-like chest pain that woke him. He stated that it was radiating up the left side of his neck and down his left arm. Plaintiff reported that it was worse with deep breathing and shoulder movement and described the pain level as "10/10." He denied nausea, vomiting, or diaphoresis. He also denied any other abdominal pain, back pain, headache, dizziness, paresthesias, or black/bloody stools. He did, however, report a 25-year-old gunshot wound to the left chest and a family history of diabetes, of which he was recently diagnosed.

¶ 7 Plaintiff's EKG results were normal. X rays showed cardiomegaly (*i.e.*, an enlarged heart) and an old left-sided rib fracture with some metal debris that was consistent with the reported gunshot wound. His heartbeat was "[r]egular and rhythmic" with "[n]o murmurs or

rubs.” Emergency room personnel administered oxygen therapy to plaintiff and gave him aspirin, nitroglycerin, and morphine. Plaintiff complained that the medication was not alleviating the pain when he moved his left shoulder. However, plaintiff denied leg swelling, a history of “DVT” or pulmonary embolism, recent travel or immobilization, or dizziness. His lung sounds were noted as sounding clear. The emergency room doctor admitted plaintiff: “I have chosen to admit this man because of his risk profile and history to observation status in order to rule out MI.<sup>[1]</sup> He will be admitted to Dr. Allam for observation and stress testing.”

The report finally notes that the impression was: “Chest pain, rule out acute coronary syndrome.”

¶ 8 The hospital’s July 13, 2011, history and physical exam report (completed after plaintiff was under Dr. Allam’s care) reflects that plaintiff described his pain as sharp and stated that it hurt when he took a deep breath (and, thus, he felt short of breath). He also complained of pain radiating along his left side of his chest, into his left shoulder, and to the back of his neck. Plaintiff denied any dizziness, palpitations, diaphoresis, nausea, or trauma to the chest. Hospital personnel administered nitroglycerin and morphine, which did not relieve plaintiff’s pain. “Hence, he is admitted for further evaluation and monitoring.”

¶ 9 Dr. Allam’s impressions were: (1) chest pain; (2) diabetes mellitus type 2, uncontrolled, relatively newly diagnosed; (3) obesity; (4) abnormal liver function tests; and (5) dyslipidemia (*i.e.*, high cholesterol). Plaintiff’s treatment-plan summary reflected that his chest pain “is *more likely* a chest wall pain since the pain is reproducible with palpitation, and also he describes it [as] a pleuritic pain where his pain gets worse with deep breaths.” (Emphasis added.) The doctor further noted that: “Grossly it appears unremarkable for me, but it does look like he has cardiomegaly versus him being obese. It could be normal. So far, his EKG is without any acute

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<sup>1</sup> The reference to an “MI” presumably refers to a myocardial infarction, *i.e.*, heart attack.

changes.” The report notes that chest X ray results had not yet returned, that a 2-D echocardiogram would be ordered, and that plaintiff might need a stress test. The doctor’s plan concluded: “For now, he will be placed on aspirin, sublingual nitroglycerin. His heart rate is borderline. If that is stable, we may need to consider a low-dose beta blocker, but that will be kept on hold for now. Will give him some morphine as needed.”

¶ 10 Plaintiff was discharged the following day, on July 14, 2011. The hospital discharge summary lists his discharge diagnoses as: (1) musculoskeletal chest pain; (2) diabetes mellitus type 2, relatively newly diagnosed; (3) obesity; and (4) dyslipidemia.<sup>2</sup> The discharge report further reflects that plaintiff was given three courses of treatment (for his atypical chest pain, diabetes, hyperlipidemia). The chest pain course summary reflects that doctors ruled out that plaintiff’s pain was cardiac-related. It noted that, when he was 14 years old, plaintiff sustained a gunshot wound to the area. Plaintiff also “has a significant amount of degenerative [*sic*] along with arthritic changes in the upper clavicle area that could be related to this chest wall pain.” The report further noted that plaintiff denied any family history of any cardiac disease and denied any “radiation or any other symptoms associated with this such as diaphoresis, nausea, or vomiting.”

¶ 11 Plaintiff was uninsured and lacked the financial means to pay for his medical treatment. On August 4, 2011, he applied for Medicaid with the local office, seeking alien emergency Medicaid. (As an undocumented alien, plaintiff qualifies, at most, for emergency medical benefits.)

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<sup>2</sup> Plaintiff’s discharge medications were: (1) Naprosyn 250 mg p.o. b.i.d.; (2) Flexeril 10 mg 3 times a day as needed; (3) Zestril 5 mg daily; (4) Zocor 20 mg daily; (5) Aspirin 81 daily; (6) Tylenol 325 as needed; and (7) Metformin 500 mg b.i.d.

¶ 12 On December 19, 2011, the DHS's Client Assessment Unit (CAU), which determines emergent need, denied plaintiff's claim, finding that he was not eligible for reimbursement where the hospital discharge notes stated that plaintiff's pain was not cardiac-related. On January 12, 2012, the CAU, on reconsideration, again denied plaintiff's claim, finding that he failed to demonstrate that, on admission, he had an acute condition that required immediate medical attention and treatment to help prevent serious jeopardy to his health. The decision states that plaintiff's EKG, chest X ray, and CT scan were all negative and that his pain was determined to be musculoskeletal in nature and secondary to degenerative changes from his old gunshot wound.

¶ 13 After the initial CAU denial, local office issued a notice of decision on October 3, 2011, denying plaintiff's application. In November 2011, plaintiff filed an agency appeal.

¶ 14 The administrative hearing was held on June 1, 2012. Plaintiff was not personally present, but was represented by counsel. Deserie Beetle, a human service caseworker with the local office, testified that the CAU denied the claim because plaintiff did not demonstrate on admission an acute condition that required immediate medical attention and treatment to help prevent serious jeopardy to his health.

¶ 15 Plaintiff's counsel argued that the CAU applied impermissible criteria. She noted that plaintiff had woken on July 12, 2011, with an intense pain on his left side (its severity woke him) and that the pain lasted most of the day. The next day, he awoke experiencing more severe pain and, as a result, had difficulty breathing. For this reason, he went to the emergency room. Hospital personnel evaluated plaintiff for acute coronary syndrome (*i.e.*, heart attack), which was ultimately ruled out. Counsel further argued that, because plaintiff presented to the emergency

room with heart attack symptoms, the CAU should have ruled, applying a reasonableness test, that it was an emergent situation.

¶ 16 On April 11, 2013, the hearing officer upheld the local office's denial of plaintiff's application for emergency medical benefits. The hearing officer noted that the hospital report reflected that plaintiff complained of "constant left-sided pressure-like chest pain radiating up the left side of his neck and down the left arm that gets worse with deep breathing or shoulder movement." Hospital personnel, according to the hearing officer, ruled out acute coronary syndrome, but plaintiff was admitted for observation. (The officer did not further note that plaintiff was also admitted to rule out a heart attack.) His discharge records noted that a chest CT and X-ray showed significant degenerative issues, arthritic changes, and a history of a gunshot wound to the area.

¶ 17 The hearing officer first found that the *objective* medical evidence reflected "acute or severe pain likely related to degenerative and arthritic changes caused by an earlier injury, but no indication that immediate medical attention was required to prevent jeopardy to the [plaintiff's] health or serious impairment to bodily functions or parts." The officer noted that *Arellano v. Department of Human Services*, 402 Ill. App. 3d 665, 678 (2010), in which this court held that certain "sudden onset" language in federal regulations constituted an impermissible modification of the federal statute, did not set forth a reasonableness standard. Second, the hearing officer determined that the Illinois Administrative Code, however, addressed a *reasonable* expectation that, in the absence of immediate medical attention, serious health jeopardy, impairment, or dysfunction will result. He found: "Still, the pain precipitating the emergency room visit was described as the 'same thing' as experienced the previous day, apparently not giving rise to an expectation of serious health jeopardy at that time, and a day later evaluated as a non-emergent

medical condition.” Accordingly, he upheld the local office’s denial. On April 11, 2013, DHFS<sup>3</sup> and DHS jointly adopted the hearing officer’s findings as their final administrative decision.

¶ 18 On January 21, 2014, the trial court affirmed the agencies’ decision, finding that it was not clearly erroneous. The court first rejected plaintiff’s argument that the hearing officer’s citation to a DHS policy manual’s definition of “emergency medical condition” reflected that the agencies applied an incorrect standard. The court found that the hearing officer cited to the correct standard and that the agencies properly refused, pursuant to *Arellano*, to consider the “sudden onset” language in the manual.

¶ 19 Next, the court addressed whether the agencies’ decision was clearly erroneous. The court found that the hospital records contained a notation from the treating physician that plaintiff was currently in no acute cardiorespiratory distress and that he was given an EKG that showed a normal sinus rhythm. Further, chest X rays showed an old, left-sided rib fracture with some metal debris consistent with an old gunshot wound to the left chest. The court noted that the (attending) physician’s initial impression was that plaintiff’s chest pain was most likely a chest wall pain because it was reproducible with palpitation; further, the physician stated that, because it was reproducible and of pleuritic nature, plaintiff’s condition clearly was musculoskeletal. The trial court further noted that plaintiff’s admission diagnosis was for chest wall pain, that he was given injections that took away the pain, and that he received a course of treatment and observation for his musculoskeletal condition. Finally, the court noted that the

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<sup>3</sup> DHFS administers the Medicaid program (305 ILCS 5/2-12(3) (West 2012)), and DHS makes eligibility determinations (*Gillmore v. Illinois Department of Human Services*, 218 Ill. 2d 302, 314 (2006)). The agencies are successors to the Illinois Department of Public Aid. See 305 ILCS 5/2-12 (West 2012).

treating physician's discharge diagnosis reflected that plaintiff's condition was not cardiac-related. Accordingly, the court upheld the agencies' decision. Plaintiff appeals.

¶ 20

## II. ANALYSIS

¶ 21 Plaintiff argues that the agencies erred in denying him Medicaid reimbursement for his hospital charges. We agree.

¶ 22 The Administrative Review Law (735 ILCS 5/3-101 *et seq.* (West 2012)) applies to all proceedings in which a party seeks judicial review of an agency decision under article V of the Illinois Public Aid Code. See 305 ILCS 5/11-8.7 (West 2012). “When reviewing a decision of an administrative agency, the appellate court reviews the decision of the agency, not the decision of the circuit court.” *Vincent ex rel. Reed v. Department of Human Services*, 392 Ill. App. 3d 88, 93 (2009). Our review extends to all questions of law and fact presented in the administrative record. 735 ILCS 5/3-110 (West 2012). We review *de novo* any questions of law raised in an administrative appeal. *Arellano*, 402 Ill. App. 3d at 669. The agencies' factual findings and conclusions are held to be *prima facie* true and correct and will not be reversed unless they are against the manifest weight of the evidence. 735 ILCS 5/3-110 (West 2012); *Arellano*, 402 Ill. App. 3d at 669. Findings are considered to be against the manifest weight of the evidence only where “ ‘all reasonable and unbiased persons, acting within the limits prescribed by the law and drawing all inferences in support of the finding, would agree that the finding is erroneous and that the opposite conclusion is clearly evident.’ ” *Department of Human Services v. Porter*, 396 Ill. App. 3d 701, 722 (2009) (quoting *Sheehan v. Board of Fire & Police Commissioners*, 158 Ill. App. 3d 275, 287 (1987)). “An agency's resolutions of mixed questions of law and fact—those issues for which the historical facts are established and the rule of law undisputed, so that the only question is whether the facts satisfy a statutory standard or whether as applied to the facts

the rule of law is violated—will not be overturned on review unless clearly erroneous.” *Arellano*, 402 Ill. App. 3d at 669. This standard affords some deference to the administrative agency’s experience and expertise. *Id.*

¶ 23 Title XIX of the Social Security Act (42 U.S.C. §§ 1396 through 1396v (2012)), enacted in 1965, establishes a jointly-funded, cooperative federal-state program, known as Medicaid, designed to enable each state to furnish medical assistance to eligible individuals. *Atkins v. Rivera*, 477 U.S. 154, 156-57 (1986); *Gillmore v. Illinois Department of Human Services*, 218 Ill. 2d 302, 304 (2006). If a state chooses to participate in the program, it must do so in accordance with the broad framework set by the federal government. If the state satisfies these requirements, it has wide discretion in administering its program “including the responsibility for determining the eligibility of recipients, enlisting medical service providers, and paying those providers for services rendered.” *De Gregorio v. O’Bannon*, 500 F. Supp. 541, 545 (E.D. Pa. 1980).

¶ 24 Undocumented aliens or aliens not otherwise permanently residing in the United States under color of law generally are not entitled to full Medicaid coverage.<sup>4</sup> See 42 U.S.C. § 1396b(v)(1) (2012) (“no payment may be made to a State under this section for medical assistance furnished to an alien who is not lawfully admitted for permanent residence or

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<sup>4</sup> Because this case arose prior to the January 1, 2014, effective date of the federal Patient Protection and Affordable Care Act (Pub. L. No. 111-148, 124 Stat. 119 (Mar. 23, 2010)), as amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. No. 111-152, 124 Stat. 1029 (Mar. 30, 2010)), we do not address that statute’s effect, if any, on the issues in this appeal.

otherwise permanently residing in the United States under color of law”); 42 C.F.R. § 435.406.<sup>5</sup> The only exception to this exclusion is payment for medical assistance that is “necessary for the treatment of an emergency medical condition.”<sup>6</sup> 42 U.S.C. § 1396b(v)(2)(A) (2012). An “emergency medical condition” is:

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<sup>5</sup> As the *Arellano* court has noted, when enacted, the Medicaid statute was silent as to whether it provided benefits to undocumented aliens. *Arellano*, 402 Ill. App. 3d at 670. However, in 1986, in response to a federal court ruling, Congress incorporated benefits (with restrictions) to aliens via the Omnibus Budget Reconciliation Act of 1986 (OBRA 1986) (Pub. L. No. 99-509, 100 Stat. 1874 (1986)). *Id.* Pursuant to OBRA 1986, “the Medicaid statute now provides, with two exceptions, that ‘no payment may be made to a State [under Medicaid] for medical assistance furnished to an alien who is not lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law.’ 42 U.S.C. § 1396b(v)(1) (2006).” *Id.* The policy underlying the 1986 enactment has been explained as attempting both to remove the incentive for illegal immigration provided by the availability of public benefits and to make government more cost-effective. *Id.*

<sup>6</sup> Medicaid reimbursement rights are distinct from the laws imposing a duty on most hospitals to provide *diagnostic* services to all emergency room patients. The federal Emergency Medical Treatment and Active Labor Act (EMTALA), 42 U.S.C. § 1395dd (2008), also known as the “Patient Anti-Dumping Act,” generally prohibits hospital emergency rooms from refusing to treat indigent and uninsured patients or transferring patients to other hospitals without first stabilizing their condition. *Jackson v. East Bay Hospital*, 246 F.3d 1248, 1254 (9th Cir. 2001). EMTALA requires most hospitals with emergency departments (such as Swedish American Hospital) to provide a medical screening to anyone who enters an emergency room and requests

“a medical condition (including emergency labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could *reasonably* be expected to result in—

- (A) placing the patient’s health in serious jeopardy,
- (B) serious impairment to bodily functions, or
- (C) serious dysfunction of any bodily organ or part.” (Emphasis added.) 42 U.S.C. § 1396b(v)(3) (2012).

¶ 25 The corresponding regulation is found at 42 C.F.R. § 440.255(b)(1), which provides that aliens are entitled to Medicaid coverage for:

“[e]mergency services required after the *sudden onset* of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could *reasonably* be expected to result in:

- (i) Placing the patient’s health in serious jeopardy;
- (ii) Serious impairment to bodily functions; or
- (iii) Serious dysfunction of any bodily organ or part.” (Emphases added.)

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an examination for a medical condition. See 42 U.S.C. § 1395dd(a). If the hospital determines that the patient has an “emergency medical condition,” which is defined in substantially the same way as the Medicaid alien emergency care provision (compare 42 U.S.C. § 1395dd(e)(1) (2012) (EMTALA) with 42 U.S.C. § 1396b(v)(3) (2012) (certain alien Medicaid patients)), it must either provide medical services to stabilize the condition or transfer the patient to another medical facility. See 42 U.S.C. § 1395dd(b)(1)(A)-(B) (2012). The hospital must meet these obligations without regard to the patient’s ability to pay. See 42 U.S.C. § 1395dd(h) (2012).

(Again, in *Arellano*, this court held that the “sudden onset” language above was an impermissible modification of the federal Medicaid statute and, therefore, unenforceable. *Arellano*, 402 Ill. App. 3d at 678.)

¶ 26 A state Medicaid plan must conform with federal requirements. See 42 U.S.C. § 1396a(a) (2012). Illinois has chosen to participate in the Medicaid program and has enacted regulations that are substantially the same as those found in 42 U.S.C. § 1396b(v) and 42 C.F.R. § 440.255(b)(1). Section 120.310(b)(4) of Title 89 of the Illinois Administrative Code provides:

“Notwithstanding the provisions of subsections (b)(1) and (2) of this Section, any non-citizen is eligible for medical assistance if the non-citizen otherwise meets the income, asset and categorical requirements of the medical assistance program and is in need of emergency services required as a result of a medical condition (including labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain) that the absence of immediate medical attention could *reasonably* be expected to result in:

- A) placing the non-citizen’s health in serious jeopardy;
- B) serious impairments to bodily functions; or
- C) serious dysfunction of any organ or part (42 USC 1396(b)(v)).” (Emphasis added.) 89 Ill. Adm. Code 120.310(b)(4) (2012).

¶ 27 The DHS “Sash, SNAP, and Medical Policy Manual” (Medical Policy Manual), which is an internal department manual that guides its employees, is comprised of: (1) a policy manual describing the Medicaid laws and containing guidance on Medicaid issues; and (2) a Worker’s Action Guide that gives specific guidance to agency caseworkers in determining eligibility.

*McDonald v. Illinois Department of Human Services*, 406 Ill. App. 3d 792, 800 (2010). The Medical Policy Manual addresses emergency medical benefits as follows:

“To receive emergency medical benefits, ineligible noncitizens must need, or have received, emergency medical services during the month of application or during the 3 months before the month of application.

An emergency condition:

[1] occurs suddenly and unexpectedly,

[2] is caused by injury or illness,

[3] has acute and severe symptoms, such as pain, and

[4] *requires* immediate medical attention to prevent:

[a] jeopardy to patient’s health, or

[b] serious impairment to bodily functions or parts.” (Emphasis added.)

Medical Policy Manual, PM 06-05-02.

It further states that hospital emergency room services must meet these criteria. *Id.*

¶ 28 Plaintiff argues that, although the first three definitions (*i.e.*, federal statute, federal regulations, and state definition) are fairly similar, the agencies routinely apply the fourth definition (*i.e.*, Medical Policy Manual), which, he argues, is significantly more restrictive. Specifically, plaintiff asserts that the first three definitions state that the absence of immediate medical attention could “reasonably” be expected to result in: (1) placing the noncitizen’s health in serious jeopardy; (2) serious impairments to bodily functions; or (3) serious dysfunction of any organ or part. He argues that, in contrast, the Medical Policy Manual omits the word “reasonably” and states that an emergency medical condition “requires” immediate medical attention to prevent jeopardy to the patient’s health or serious impairment to bodily functions or

parts. Plaintiff urges that this is a substantially more restrictive standard than the federal statute and represents an impermissible modification of that enactment. Plaintiff notes that, in denying reimbursement, the agencies specifically referenced the definition found in the Illinois Administrative Code and the Medical Policy Manual. Defendants respond that the agencies applied the correct standard.

¶ 29 We conclude that the agencies erred in denying reimbursement, but for a reason other than that they applied the incorrect standard. In reading their decision, it is clear that they denied reimbursement on two *alternative* bases: first, by applying the Medical Policy Manual's language<sup>7</sup> and, second, by applying the Illinois Administrative Code. As explained below, we conclude that, although the second approach the agencies utilized clearly sets forth the correct language, the agencies nevertheless erred in applying it to the facts presented in this case.

¶ 30 In their decision, the agencies first quoted the Illinois Administrative Code and then the Medical Policy Manual. After quoting the Medical Policy Manual, the decision states that, taking *Arellano* into account, the "occurs suddenly and unexpectedly" language in the manual would "not be considered." The agencies then determined that plaintiff's condition would be evaluated "using the remaining criteria for an emergency condition," and then explicitly quoted the Medical Policy Manual's remaining requirements, including the "requires immediate medical attention" language. The agencies *first* denied reimbursement based on the following finding: "The objective medical evidence documents acute or severe pain likely related to degenerative and arthritic changes caused by an earlier injury, but no indication that immediate medical

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<sup>7</sup> Although we need not reach it, we note that plaintiff presents a compelling argument questioning the soundness of the agencies' decision to apply the Medical Policy Manual language.

attention was required to prevent jeopardy to the appellant's health or serious impairment to bodily function or parts.”

¶ 31 However, the decision *next* addressed plaintiff's claim that *Arellano* established a reasonableness standard. Plaintiff's counsel had argued that, because plaintiff “presented to the emergency room with classic symptoms of a heart attack, reasonably believed he was having a heart attack, and was evaluated and treated as having a heart attack, then, under this reasonableness standard[, plaintiff's] treatment qualifies as an emergent need.” For two alternative reasons, the agencies rejected this claim. First, they found that *Arellano* does not set forth, and makes no mention of, a reasonableness standard.

¶ 32 Second, and as critical here, they found that the Illinois Administrative Code nevertheless addresses the “reasonable expectation that in the absence of immediate medical attention serious health jeopardy, impairment, or dysfunction will result.” The decision continues: “Still[,] the pain precipitating the emergency room visit was described as the ‘same thing’ as experienced the previous day, apparently not giving rise to an expectation of serious health jeopardy at that time, and a day later evaluated as a non-emergent medical condition.” Accordingly, the agencies denied reimbursement.

¶ 33 In our view, although the first basis upon which the agencies denied plaintiff's claim involved application of the Medical Policy Manual, the soundness of which we need not reach, the alternative basis upon which they denied plaintiff's claim clearly did not. Accordingly, having determined that the agencies did not utilize a likely incorrect test (*i.e.*, contained in the Medical Policy Manual), we turn next to assessing whether their application of the test set forth in the aforementioned three enactments (*i.e.*, federal statute, federal regulations, and state definition) was erroneous. Under the circumstances presented in this case, we agree with

plaintiff that the fact that his condition was ultimately determined to be nonemergent does not warrant upholding the agencies' findings.

¶ 34 The agencies determined that “the pain precipitating the emergency room visit was described as the ‘same thing’ as experienced the previous day, apparently not giving rise to an expectation of serious health jeopardy at that time, and a day later evaluated as a non-emergent medical condition.”

¶ 35 The federal statute allows for Medicaid reimbursement only if the medical assistance is “necessary for the treatment of an emergency medical condition.” 42 U.S.C. § 1396b(v)(2)(A) (2012). Again, an “emergency medical condition” is: “a medical condition \*\*\* manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention *could reasonably be expected* to result in” (emphasis added) at least one of three serious health events. 42 U.S.C. § 1396(v)(3) (2012). Plaintiff argues that the agencies erred in finding that the evidence did not meet this test. We agree and conclude that the agencies' findings were clearly erroneous.

¶ 36 Plaintiff awoke on July 12, 2001, with chest pain that continued throughout the day. The following morning, he awoke to *more severe* pain and went to the emergency room. There, plaintiff's medical records reflect that he complained that the pain rated a “10/10.” His history reflected an old gunshot wound and a recent diabetes diagnosis. Also, his heartbeat at that time was “[r]egular and rhythmic” with “[n]o murmurs or rubs.” However, emergency room personnel administered oxygen therapy and gave plaintiff aspirin, nitroglycerin, and morphine. Further, on the basis of plaintiff's “risk profile and history,” the emergency room doctor admitted plaintiff “to observation status in order *to rule out MI*. He will be admitted to Dr. Allam for observation and stress testing.” (Emphasis added.) The report also noted that the emergency

room doctor's impression was: "Chest pain, rule out acute coronary syndrome." That same day the admitting doctor, in his treatment plan summary, noted that plaintiff's chest pain "is more likely a chest wall pain since the pain is reproducible with palpitation, and also he describes it [as] pleuritic pain where his pain gets worse with deep breaths." However, the doctor's plan concluded: "For now, he will be placed on aspirin, sublingual nitroglycerin. His heart rate is borderline. If that is stable, we may need to consider a low-dose beta blocker, but that will be kept on hold for now. Will give him some morphine as needed." Thus, even after plaintiff was admitted, the attending doctor had still not ruled out a heart attack.

¶ 37 We conclude that the statute is worded such that the assessment of whether "the absence of immediate medical attention *could reasonably be expected* to result in" (emphasis added) a serious health event (*e.g.*, heart attack) is properly made upon presentation (or at a reasonably close time thereto), not in hindsight. There is no suggestion in the record, or by defendants, that the emergency room doctor's concerns about ruling out a heart attack were unreasonable in light of plaintiff's presentation that day. Plaintiff presented with a medical condition that manifested itself in the form of severe pain. Again, the question is whether "the absence of immediate medical attention could reasonably be expected to result in" a heart attack. The emergency room doctor's answer to the question was that, absent immediate treatment for severe chest pain, there was a reasonable possibility that plaintiff could be expected to suffer a heart attack or other serious health event.

¶ 38 Again, the reasonableness of that initial impression is not challenged. Rather, in their brief, defendants, who only briefly address this issue, argue that, although admitting plaintiff for "observation" may have been the prudent course as part of diagnosing his medical condition (pursuant to EMTALA) and to rule out a heart attack, that fact alone should not turn the

admission into one necessary for the treatment of an emergency medical condition and warranting Medicaid reimbursement. In defendants' view, the "doctors simply needed additional time to understand the nature of [plaintiff's] ailment." We reject this reading as it does not specifically address the statutory definition, which, again, attempts to assess the risk at presentation (or at a reasonably close time thereto) and not in hindsight, and because they have not argued that any charges incurred after a heart attack (or any other emergency) was ruled out be excluded. Defendants also essentially ignore the "reasonably" language, arguing in a conclusory fashion that it does not suggest a subjective analysis. It remains that plaintiff's chest pain was not diagnosed as musculoskeletal until the day he was discharged. Finally, although we agree that, once a heart attack was ruled out and, therefore an emergency was dispelled, the reimbursement obligation terminates. Here, however, defendants do not argue that the charges should be (or could have been) itemized to reflect whether they were incurred before or after a heart attack was ruled out (although they are likely minimal here, as plaintiff was discharged on the day a heart attack was ruled out).

¶ 39

### III. CONCLUSION

¶ 40 For the reasons stated, the judgment of the circuit court of Winnebago County is reversed and the cause is remanded.

¶ 41 Reversed and remanded.