STATE OF MICHIGAN
STATE OFFICE OF ADMINISTRATIVE HEARINGS AND RULES
FOR THE DEPARTMENT OF COMMUNITY HEALTH
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IN THE MATTER OF:

[redacted]

Appellant
_____/

Docket No. 2009-6471 HHS
Case No. [redacted]
Load No. [redacted]

DECISION AND ORDER

This matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9 and 42 CFR 431.200 *et seq.,* upon the Appellant's request for a hearing.

After due notice, a hearing was held on [redacted]. The Appellant appeared without representation. Her witness was her daughter and caregiver, [redacted]. [redacted], represented the Department. Her witness was [redacted].

ISSUE

Did the Department properly deny Home Help Services payments to the Appellant?

FINDINGS OF FACT

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

1. The Appellant is a [redacted]-year old Medicaid beneficiary. (Appellant's Exhibit #1)

2. The Appellant is afflicted with low blood pressure, arthritis, HTN, diverticulosis and a fractured left leg. (Department's Exhibit A, p. 5 and Appellant's Exhibit #1)

3. The Appellant said she experiences great pain, is limited to a wheelchair and requires 24/7 hour care following surgery on her afflicted extremity. (*See* Testimony)

4. The Appellant's HHS was denied on [redacted], because the medical needs form submitted by the Appellant's physican did not certify a need for assistance. (Department's Exhibit A, p. 5)

5. On [redacted], an adequate negative action notice (DHS 1212-A) was sent to the Appellant advising her of the denial. Her further appeal rights were contained therein. (Department's Exhibit A, pp. 2, 6)

6. On [redacted] the Appellant's appeal was received by SOAHR. (Appellant's Exhibit #1)

CONCLUSIONS OF LAW

The Medical Assistance Program is established pursuant to Title XIX of the Social Security Act and is implemented by Title 42 of the Code of Federal Regulations (CFR). It is administered in accordance with state statute, the Administrative Code, and the State Plan under Title XIX of the Social Security Act Medical Assistance Program.

Home Help Services (HHS) are provided to enable functionally limited individuals to live independently and receive care in the least restrictive, preferred settings. These activities must be certified by a physician and may be provided by individuals or by private or public agencies.

COMPREHENSIVE ASSESSMENT

The Adult Services Comprehensive Assessment (DHS-324) is the primary tool for determining need for services. The comprehensive assessment will be completed on all open cases, whether a home help payment will be made or not. ASCAP, the automated workload management system provides the format for the comprehensive assessment and all information will be entered on the computer program.

Requirements for the comprehensive assessment include, but are not limited to:

- A comprehensive assessment will be completed on all new cases.
- A face-to-face contact is required with the customer in his/her place of residence.
- An interview must be conducted with the caregiver, if applicable.
- Observe a copy of the customer's social security card.
- Observe a picture I.D. of the caregiver, if applicable.

- The assessment must be updated as often as necessary, but minimally at the six-month review and annual re-determination.

- A release of information must be obtained when requesting documentation from confidential sources and/or sharing information from the agency record.

- Follow specialized rules of confidentiality when ILS cases have companion APS cases.

Adult Service Manual (ASM), §363, page 2 of 24, September 1, 2008.

Necessity For Service

The adult services worker is responsible for determining the necessity and level of need for HHS based on:

- Client choice.
- A complete comprehensive assessment and determination of the client's need for personal care services.
- Verification of the client's medical need by a Medicaid enrolled medical professional. The client is responsible for obtaining the medical certification of need. The Medicaid provider identification number must be entered on the form by the medical provider. The Medical Needs form must be signed and dated by one of the following medical professionals:

  •• Physician.
  •• Nurse practitioner.
  •• Occupational therapist.
  •• Physical therapist.

Exception: DCH will accept a DHS-54A completed by a VA physician or the VA medical form in lieu of the medical needs form.

The medical professional certifies that the client's need for service is related to an existing medical condition. The medical professional does not prescribe or authorize personal care services.

If the medical needs form has not been returned, the adult services worker should follow-up with the client and/or medical professional.

If the case is closed and reopened within 90 days with no changes in the client's condition, a new DHS-54A is not necessary.

Do **not** authorize HHS prior to the date of the medical professional signature on the DHS-54A. ASM *Supra* page 9 of 24.

* * *

The Department witness testified that on review of the Appellant's application she discovered that the medical needs form was not certified by the submitting physican, [redacted].

The Appellant and her witness testified that the primary care physican was not aware of the Appellant's fractured leg - as this medical issue was handled by her surgeon. The primary care physician, [redacted], later ([redacted]) wrote a prescription-pad-note verifying that fracture diagnosis.

On review, while the ALJ has no reason to doubt the Appellant the fact remains that at the time of the adequate action and denial there was no certification of need in the hands of the ASW – as prepared and executed by a physician. Indeed, the physician's prescription pad note is dated well after the notice of denial was dispatched - [redacted]. While the Appellant is free to reapply for HHS, she has failed to meet her burden of proof in this instance.

It is the ASW's responsibility to determine necessity and level of need for home help services. Absent a timely medical certification the Appellant's petition fails for lack of proof.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the Department properly denied the Appellant's request for HHS.

IT IS THEREFORE ORDERED that:

The Department's decision is AFFIRMED.

Dale Malewska
Administrative Law Judge
for Janet Olszewski, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 3/12/2009

***** NOTICE *****

The State Office of Administrative Hearings and Rules may order a rehearing on either its own motion or at the request of a party within 30 days of the mailing date of this Decision and Order. The State Office of Administrative Hearings and Rules will not order a rehearing on the Department's motion where the final decision or rehearing cannot be implemented within 90 days of the filing of the original request. The Appellant may appeal the Decision and Order to Circuit Court within 30 days of the receipt of the Decision and Order or, if a timely request for rehearing was made, within 30 days of the receipt of the rehearing decision.