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. 2010-13163 HHS
Case [redacted]

DECISION AND ORDER

This matter is before the undersigned Administrative Law Judge (ALJ) 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 [redacted]. [redacted] appeared on her own behalf. [redacted], chore provider, appeared as a witness on the Appellant's behalf. [redacted], Appeals and Review Officer, represented the Department. [redacted], Adult Services Worker, appeared as a witness for the Department.

ISSUE

Did the Department properly terminate 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] Medicaid beneficiary who was receiving adult Home Help Services.

2. The Appellant has been diagnosed with degenerative arthritis knee and left hip avascular necrosis. The Appellant has undergone hip replacement surgery. (Exhibit 1, pages 11-12)

3. On [redacted], an Adult Services Worker (ASW) conducted an in home assessment with the Appellant for continuing eligibility for Home Help Services. (Exhibit 1, page 8)

4. As a result of the information gathered from the Appellant and her doctor for the assessment, the ASW determined that eligibility for continuing Home Help Services was not supported. (Exhibit 1, pages 4-12)

5. On [redacted], the Department issued an Advance Negative Action Notice to the Appellant that her Home Help Services payments would terminate, effective [redacted]. (Exhibit 1, pages 4-7)

6. The Appellant requested a formal, administrative hearing contesting the termination on [redacted] (Exhibit 1, page 3)

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.

Adult Services Manual (ASM 363) 9-1-2008, pages 2-5 of 24 addresses the issue of eligibility for Home Help Services:

> **ELIGIBILITY FOR HOME HELP SERVICES**
> Home help services (HHS) are defined as those which the department is paying for through Title XIX (Medicaid) funds. The client must be eligible for Medicaid in order to receive these services.
>
> **Medicaid/Medical Aid (MA)**
> Verify the client's Medicaid/Medical aid status.
>
> The client may be eligible for MA under one of the following:
> - All requirements for MA have been met, **or**
> - MA deductible obligation has been met.
>
> The client must have a scope of coverage of:
> - 1F or 2F, **or**
> - 1D or 1K (Freedom to Work), **or**
> - 1T (Healthy Kids Expansion).

Clients with eligibility status 07 (Income scale 2-Non MA) and scope of coverage 20 or 2B are **not** eligible for Medicaid until they have met their MA deductible obligation.

An ILS case may be opened (service program 9) to assist the client in becoming MA eligible. However, do **not** authorize HHS payment prior to the MA eligibility date. The payment must be prorated if the eligibility period is less than the full month. To prorate, divide the monthly care cost by the number of days in the month. Then, multiple that daily rates by the number of eligible days.

Note: A change in the scope of coverage by the eligibility specialist (ES) will generate a DHS-5S for cases active to services programs 1, 7, and 9.

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.
>
> Adult Services Manual (ASM 363) 9-1-2008, Pages 7-9 of 24

The Adult Services Manual addresses the fact that the Adult Services Worker (ASW) must have verification of medical need from a Medicaid enrolled provider in order to authorize Home Help Services (HHS). In this case, the Appellant's physician originally certified a need for HHS for 4-6 months following her total hip replacement surgery. (Exhibit 1, page 11) However, this physician did not certify a continuing need for assistance with any of the listed personal care services on the updated DHS 54-A Medical Needs form signed [redacted], despite listing the additional diagnosis of degenerative knee arthritis. (Exhibit 1, page 12)

The Appellant disagrees with the HHS termination and testified that she still needs HHS due to the knee arthritis. The Appellant explained that there was a plan for knee surgery until it was determined the hip replacement needed to be performed first. The Appellant explained that while her hip is better since that surgery, her knee still bothers her and the doctor instructed her to avoid walking up and down stairs and recommended physical therapy which the Appellant plans to begin soon.

In this case, there was also some testimony from the ASW that another doctor, the Appellant's primary care physician, originally completed a DHS 54-A listing additional diagnoses. This documentation was not admitted into the hearing record as the Department Representative's objection was sustained. Additionally, the ASW explained that an updated DHS-54A Medical Needs form was not sought from the Appellant's primary care provider at the time of the redetermination assessment because the Appellant stated her need for HHS was based upon her knee arthritis. Therefore, the ASW obtained the DHS 54-A Medical Needs form from the specialist treating this impairment, noting that the specialist did not certify a need for continuing HHS despite including this diagnosis on the form and noting limitations to standing and walking. (Exhibit 1, page 12)

Department policy is clear and the medical needs form unambiguous. The Department properly terminated the Appellant's Home Help Services payments based on the information available at that time. The Appellant testified she needs continuing HHS due to her knee arthritis. However, the Appellant's doctor who is treating this

impairment did not certify a need for continuing HHS. Based on the information available to the Department at the time of the re-determination, eligibility for continuing Home Help Services is not supported.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, finds the Department has properly terminated home help assistance payments for the Appellant based on the information available at the time of the re-determination.

IT IS THEREFORE ORDERED that:

The Department's decision is AFFIRMED.

Colleen Lack
Administrative Law Judge
for Janet Olszewski, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 2/24/2010

***** 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.