STATE OF MICHIGAN
STATE OFFICE OF ADMINISTRATIVE HEARINGS AND RULES
FOR THE DEPARTMENT OF COMMUNITY HEALTH
P.O. Box 30763, Lansing, MI 48909
(877) 833-0870; Fax: (517) 334-9505

IN THE MATTER OF:

[redacted]

Appellant
_____/

Docket No. 2010-25083 HHS
[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]. [redacted] appeared on her own behalf. [redacted], chore provider, appeared as a witness for the Appellant. [redacted], Appeals and Review Officer, represented the Department. [redacted], Adult Services Worker, and [redacted] Adult Services Supervisor, were present as Department witnesses.

ISSUE

Did the Department properly determine the effective date of 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. On [redacted], the Appellant filed and Adult Services Application and DHS 54-A Medical Needs form with the Department of Human Services. (Exhibit 1, pages 8-10)

2. The DHS 54-A Medical Needs form certifying that the Appellant had a medical need for assistance with personal care activities was signed by the physician on [redacted]. (Exhibit 1, page 10)

3. On [redacted] an Adult Services Worker (worker) completed a home visit and comprehensive assessment of the Appellant's case. (Exhibit 1, pages 4-5)

4. On [redacted] the worker issued a Services and Approval Notice to the Appellant indicating that her Home Help Services (HHS) payments were approved for [redacted] with a start date of [redacted] (Exhibit 1, pages 3-4)

5. On [redacted], the State Office of Administrative Hearings and Rules received the Appellant's Requests for Hearing. (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 health professional and may be provided by individuals or by private or public agencies.

Adult Services Manual (ASM 363) 9-1-2008, addresses when Home Help Services can be authorized:

> **APPLICATION FORSERVICES**
>
> The client must sign the DHS-390, Adult Services Application (RFF 390) to receive independent living services. An authorized representative or other person acting for the client may sign the DHS-390, **if** the client:
>
> - Is incapacitated.
> - Has been determined incompetent.
> - Has an emergency.
>
> A client unable to write may sign with an "X" witnessed by one other person (e.g. relative or department staff). Adult services workers must not sign the DHS-390 on behalf of the client.
>
> The ILS specialist must determine eligibility within the 45 day standard of promptness which begins from the time the referral is registered on the computer system. The computer system calculates the 45 days beginning the day after the referral date and counting 45 calendar days. If the due date falls on a weekend or holiday, the due date is the next business day. A referral may be received by phone, mail or in person and must be registered on the computer timely.

Note: When a signed DHS-390, Adult Services Application serves as the initial request for services, the registration date must be the date the DHS-390 was received in the local office.
The DHS-390 remains valid **unless** the case record is closed for more than 90 days.

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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 rate by the number of eligible days.

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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 1 – 9

In the present case, the Appellant submitted the DHS 390 Adult Services Application and DHS 54-A Medical Needs form on [redacted]. (Exhibit 1, pages 8-10) The worker testified that referral was registered [redacted] and the Department had 45 days to determine eligibility. (Exhibit 1, pages 11-12) The worker completed a home visit and comprehensive assessment of the Appellant's case on [redacted]. (Exhibit 1, pages 4-5) On [redacted] the Department approved HHS payments to the appellant with a start date of [redacted]. (Exhibit 1, pages 3-4)

The Appellant disagrees with the [redacted] start date and testified that her chore provider has been caring for her since [redacted] However, in the Hearing Request, the Appellant wrote that the chore provider has been caring for her since [redacted] (Exhibit 1, page 2) The Appellant stated that when additional paperwork was filled out in [redacted], the worker said that she would get all the back money. The Appellant is requesting retroactive payments to [redacted] (Exhibit 1, page 2)

Department policy imposes a 45 day standard of promptness for determining eligibility, which begins from the time the referral is registered on the computer system. Policy also states that a referral may be received by phone, mail or in person and must be registered on the computer timely. Specifically, policy notes that when a signed DHS-390, Adult Services Application serves as the initial request for services, the registration date must be the date the DHS-390 was received in the local office. The Department erred by entering a referral date of [redacted] for the Appellant's application when the date stamped indicates it was received at the local office on [redacted]. (Exhibit 1, page 9)

The Department policy only address the issue of the start date for services in relation to Medicaid eligibility and when the physician signs the DHS 54-A Medical Needs form. The Department did not present any evidence that the Appellant only became Medicaid eligible as of [redacted]. Since the Appellant's physician signed the DHS 54-A Medical Needs form prior to the date the Adult Services Application was received, the prohibition from authorizing HHS payments prior to the signature date on the DHS 54-A Medical Needs form would not apply in this case.

The Appellant's request for payments back to [redacted] can not be granted as there was no application for services for that time period. The Department should have considered eligibility for the Home Help Services program starting the date the Adult Services Application was received. Department policy does allow for a prorated payment when the eligibility period is less than a full month. The Department did not present sufficient authority for authorizing the Appellant's home help services effective [redacted] instead of the [redacted] application date.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the Department did not properly determined [redacted], as the effective date of Home Help Services payments for Appellant's [redacted] application.

IT IS THEREFORE ORDERED that:

The Department's decision is REVERSED. The Department shall issue a retroactive HHS payment to the Appellant for the part of [redacted] she should have been found eligible for services. The HHS payment shall be prorated to allow for eligibility effective [redacted].

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

cc: [redacted]

Date Mailed: 5/28/2010

***** 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.