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]
Case No. 21740754

[redacted]

Appellant
_____/

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 [redacted]. [redacted], [redacted] appeared on the Appellant's behalf. [redacted] appeared. [redacted], Appeals Review Officer, represented the Department. [redacted], Adult Services Worker, and [redacted], Adult Services Supervisor, appeared as witnesses on behalf of the Department.

ISSUE

Did the Department properly terminate the Appellant's Home Help Services payments?

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 Medicaid beneficiary who was receiving Home Help Services (HHS).

2. The Appellant is a [redacted] who has been diagnosed with bipolar disorder. (Exhibit 1, page 4)

3. On [redacted], the Appellant's physician completed a DHS 54-A Medical Needs Form, but did not certify a medical need for any of the specified personal services. (Exhibit 1, page 4)

4. On [redacted], the Department issued an Advance Negative Action Notice terminating Home Help Services effective [redacted] 2010, based on the Appellant's physician's assessment. (Exhibit 1, pages 5-7)

5. On [redacted], the Department received the Appellant's Request 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 physician and may be provided by individuals or by private or public agencies.

Adult Services Manual (ASM 363) 9-1-2008, page 7-9 of 24 addresses the issue of reviewing eligibility for Home Help Services:

> **REVIEWS**
>
> ILS cases must be reviewed every six months. A face-to-face contact is required with the client, in the home. If applicable, the interview must also include the caregiver.
>
> **Six Month Review**
>
> Requirements for the review contact must include:
> - A review of the current comprehensive assessment and service plan.
> - A reevaluation of the client's Medicaid eligibility, if home help services are being paid.
> - Follow-up collateral contacts with significant others to assess their role in the case plan.
> - Review of client satisfaction with the delivery of planned services.
>
> ***
>
> **Annual Redetermination**
>
> Procedures and case documentation for the annual review are the same as the six month review, with the following additions:

Requirements

- A reevaluation of the client's Medicaid eligibility, if home help services are being paid.
- A new medical needs (DHS-54A) certification, if home help services are being paid.

Note: The medical needs form for SSI recipients will **only** be required at the initial opening and is no longer required in the redetermination process. All other Medicaid recipients will need to have a DHS-54A completed at the initial opening and then annually thereafter.

- A face-to-face meeting with the care provider, if applicable. This meeting may take place in the office, if appropriate.

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 6-9 of 24

The Adult Services Manual addresses the fact that the Adult Services Worker must have verification of medical need for assistance from a Medicaid enrolled provider in order to authorize Home Help Services. In this case, the Appellant's physician did not certify a need for assistance with any of the listed personal care services on the DHS 54-A Medical Needs form. (Exhibit 1, page 4)

The Appellant's representative testified that the Appellant's prior psychologist indicated the Appellant needs help and that the Appellant has had problems with her current psychologist. The Appellant's representative stated that the Appellant does need assistance.

In this case, the policy is clear; verification is required from a Medicaid enrolled medical professional certifying the client's medical need for services. The Appellant's doctor did not certify that the Appellant has a medical need for personal assistance services. The Department properly terminated the Appellant's Home Help Services application based on the available information.

The Appellant's representative also contests that the HHS payments did not continue pending this Hearing Decision. The Hearing Rights page from the Department's Advance Negative Action Notice states:

> You will continue to receive the affected services until the hearing decision is rendered **if** your request for a fair hearing is received prior to the effective date of action.
>
> If you continue to receive benefits because you requested a fair hearing, you may be required to repay the benefits. This may occur if:
>
> - The proposed termination or denial of benefits is upheld in the hearing decision.
> - You withdraw your hearing request.
> - You or the person you asked to represent you does not attend the hearing.
>
> Reference Forms & Publications Manual,
> State of Michigan Department of Human Services) Page 4 of 5
> (RFF 1212) DHS-1212, Advance Negative Action Notice 6-1-2007

In the present case, the Appellant did file the initial hearing request prior to the [redacted], effective date indicated on the Advance Negative Action Notice. (Exhibit 1, pages 3 and 5) Accordingly, the HHS payments should have continued pending this hearing decision. However, if the Department had continued the Appellant's HHS payments pending this hearing decision, the Appellant would now be obligated to re-pay the benefits as the proposed termination is being upheld. Therefore, this ALJ can not order the Department to retroactively issue payment for the months the hearing request was pending.

DECISION AND ORDER

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

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: 6/2/2010

***** 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.