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:

Docket No. 2010-35087 HHS

[redacted]

Appellant
_____/

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.,* following the Appellant's request for a hearing.

After due notice, a hearing was held on [redacted]. The Appellant's brother, guardian, and chore provider, [redacted] appeared on the Appellant's behalf. [redacted] Appeals Review Officer, represented the Department. [redacted], Adult Services Worker (worker), and [redacted], Adult Services Supervisor, were present as Department witnesses.

ISSUE

Did the Department properly suspend the Appellant's Home Help Services (HHS)?

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 receives HHS.

2. The Appellant has been diagnosed with paranoid schizophrenia. (Exhibit 1, page 8)

3. In [redacted], the worker visited the Appellant and his chore provider at the Appellant's house to conduct an annual review. At that time, pursuant to policy, the worker requested an updated DHS 54-A medical needs form from the Appellant's physician. (Exhibit 1, page 5; Testimony of Percy)

4. The Department never received a completed DHS 54-A medical needs form because the Appellant's treating physician refused to complete the form and, instead, submitted copy of the Appellant's medical records to the DHS office. In addition, the Appellant's chore provider requested a second medical needs form. (Exhibit 1, page 5; Testimony of Smith)

5. In [redacted], the worker advised the Appellant's chore provider that HHS payments had been suspended since [redacted], because she had not received a completed medical needs form. However, the case remained open pending receipt of the form. (Testimony o[redacted])

6. On [redacted], the Department received the Appellant's Request for Hearing. (Exhibit 1, page 2)

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.

The purpose of HHS is 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 7-10 of 24 addresses the issue of eligibility for HHS:

> **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.
>
> * * *
>
> **Medical Review Team (MRT)**
> If the client refuses to see a physician, or the physician refuses to complete a DHS-54A, forward medical and case information to the Medical Review Team (MRT) through the local office medical contact worker and/or the local office's designated person responsible for reviewing medical information. Attach a cover memo explaining the reason a MRT valuation is needed.
>
> The local office designee will forward the packet to the regional Disability Determination Services (DDS) MRT.
>
> The MRT will make a determination and return the forms. See L-letter 00-130, [redacted].
>
> The MRT may also be used if the client's physician does not certify a need for personal care services, but services appear to be justified.
>
> *Adult Services Manual (ASM 363) 9-1-2008, Pages 7-10 of 24*

The Appellant's representative testified that the Appellant needs help due to his illness. He stated that the Appellant is unable to do anything for himself. He acknowledged that the Department has not received a completed medical needs form. He explained that the clinic where the Appellant's physician is located refused to complete the form due an internal policy. However, the clinic did forward the Appellant's medical records to the Department. (Testimony of [redacted]) The worker's narrative notes confirm that this is the

reason that the medical needs form was not completed and that the Appellant's medical records were provided instead. (Exhibit 1, pages 5-6)

Policy requires that the worker obtain verification of a medical need for assistance from a Medicaid enrolled provider in order to authorize HHS. Here, the Department did not receive a completed DHS 54-A medical needs form from the Appellant's physician because the clinic refused to complete form based on its own internal policy. However, policy also states that when a physician refuses to complete a medical needs form, the worker is to forward the medical and case information to the MRT for a determination of medical need. That was not done in this case. Instead, the Appellant's HHS payments were improperly suspended.

In addition, the Department failed to properly notify the Appellant of the suspension of payments. The Code of Federal Regulations, Chapter 42 addresses the Appellant's rights with respect to Advance Negative Notice of an agency action:

> **§ 431.211 Advance notice.**
> The State or local agency must mail a notice at least 10 days before the date of action, except as permitted under §§ 431.213 and 431.214 of this subpart.
>
> **§ 431.213 Exceptions from advance notice.**
> The agency may mail a notice not later than the date of action if—
> (a) The agency has factual information confirming the death of a recipient;
> (b) The agency receives a clear written statement signed by a recipient that—
> (1) He no longer wishes services; or
> (2) Gives information that requires termination or reduction of services and indicates that he understands that this must be the result of supplying that information;
> (c) The recipient has been admitted to an institution where he is ineligible under the plan for further services;
> (d) The recipient's whereabouts are unknown and the post office returns agency mail directed to him indicating no forwarding address (See § 431.231 (d) of this subpart for procedure if the recipient's whereabouts become known);
> (e) The agency establishes the fact that the recipient has been accepted for Medicaid services by another local jurisdiction, State, territory, or commonwealth;
> (f) A change in the level of medical care is prescribed by the recipient's physician;

> (g) The notice involves an adverse determination made with regard to the preadmission screening requirements of section 1919(e)(7) of the Act; or
> (h) The date of action will occur in less than 10 days, in accordance with § 483.12(a)(5)(ii), which provides exceptions to the 30 days notice requirements of § 483.12(a)(5)(i)
>
> **§ 431.214 Notice in cases of probable fraud.**
> The agency may shorten the period of advance notice to 5 days before the date of action if—
> (a) The agency has facts indicating that action should be taken because of probable fraud by the recipient; and
> (b) The facts have been verified, if possible, through secondary sources.

No Advance Negative Action Notice has been issued by the Department in this case. None of the exceptions to the advance-notice requirement were present in this case. Therefore, the Appellant's HHS payments should be reinstated retroactively to the date of suspension—[redacted].

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, finds that the Department improperly suspended the Appellant's HHS payments. The Department shall reinstate payments retroactively to [redacted], and it shall forward the Appellant's medical and case information to the MRT for determination of medical need.

IT IS THEREFORE ORDERED that:

The Department's decision is REVERSED.

_____
Kristin M. Heyse
Administrative Law Judge
for Janet Olszewski, Director
Michigan Department of Community Health

[redacted]
Docket No. 2010-35087 HHS
Decision and Order

cc: [redacted]

Date Mailed: 8/2/2010

***** 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.