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

Docket No. 2010-43200 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, [redacted], appeared on her own behalf. [redacted], the Appellant's daughter, appeared as a witness for the Appellant. [redacted], Appeals Review Officer, represented the Department. [redacted], Independent Living Specialist (worker), and [redacted], Adult Services Supervisor, were present as Department witnesses.

ISSUE

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

FINDINGS OF FACT

The ALJ, 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 HHS for the tasks of bathing, grooming, dressing, transferring, medication, housework, laundry, shopping, and meal preparation. Her monthly payment was [redacted]. (Testimony o[redacted])

2. The Appellant is a [redacted] female, who suffers from several medical conditions, including hypertension, type-2 diabetes, carpal tunnel, and hyperthyroidism. (Exhibit 1, page 7; Testimony of [redacted])

3. An annual assessment was conducted on [redacted]. At that time, the worker requested that the Appellant's physician complete an updated DHS 54-A medical needs form. (See Exhibit 1, pages 6-7)

4. The Appellant's physician completed a medical needs form but did not certify a medical need for any personal care services. (Exhibit 1, page 7)

5. On [redacted], the Department issued an Adequate Negative Action Notice, terminating HHS payments, effective [redacted], based on the medical needs form. (Exhibit 1, pages 4-6)

6. 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.

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.

The Adult Services Manual 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*

Policy requires the worker to verify a medical need for assistance from a Medicaid-enrolled provider in order to authorize HHS. Here, 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 7)

The Appellant testified that her physician was not aware of her circumstances at the time he completed the form. She stated that she has been treating with her physician for three or four years. The Appellant further testified that she did not believe her physician understood the form. She stated that her physician had since revised the medical needs form to certify a need for services.[1]

In this case, policy is clear: verification is required from a Medicaid-enrolled medical professional certifying the client's medical need for services. The Department properly terminated the Appellant's HHS payments based on the information available at that time. The Appellant's doctor did not certify that the Appellant has a medical need for personal assistance services. However, the Appellant may re-apply at any time and have her physician complete a new medical needs form.

[1] The Adult Services Supervisor advised the Appellant that her physician would need to complete a new medical needs form because the Department cannot accept an altered medical needs form.

DECISION AND ORDER

The ALJ, based on the above findings of fact and conclusions of law, finds the Department has properly terminated the Appellant's HHS payments based on the available information.

IT IS THEREFORE ORDERED that:

The Department's decision is AFFIRMED.

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

cc: [redacted]

Date Mailed: 9/30/2010

***** 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.