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:

Appellant
____________________________/

Docket No. 2010-7028 HHS

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 . , niece, appeared as the Appellant's representative. appeared and testified. Appeals and Review Officer, represented the Department. Adult Services Worker, and , Adult Services Supervisor, were present as Department witnesses.

ISSUE

Did the Department properly deny the Appellant's Home Help Services application?

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.

2. The Appellant filed an application for Home Help Services on

3. The Appellant is a year-old female who has been diagnosed with severe cervical stenosis, allergic rhinitis, glaucoma, and hypertension. (Exhibit 1, page 10)

4. 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 10)

5. On , the Department issued an Adequate Negative Action Notice denying Home Help Services, due to the lack of certification of need by the Appellant's physician. (Exhibit 1, pages 7-8)

6. On the Department received the Appellant's Request for Hearing. On a signed hearing request was received. (Exhibit 1, pages 3-6)

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 must have verification of medical need 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. Further, the physician also indicated he was not a Medicaid enrolled provider. (Exhibit 1, page 10) The Department testified that they also called the doctor's and confirmed that he is not a Medicaid enrolled provider.

The Appellant's representative testified that she now understands why the Department denied the [redacted], Home Help Services application. The Appellant's representative explained the Appellant's former doctor left for a new position and the office had just assigned her to the doctor who completed the Medical Needs form for the [redacted] Home Help Services application. Therefore, the doctor did not have all of the Appellant's information when he filled out the medical needs form and did not certify a need for assistance with the specified personal services.

In this case, the policy is clear and the medical needs form unambiguous. The Department properly denied the [redacted], Home Help Services application 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 and the doctor is not a Medicaid enrolled provider.

The Appellant's representative testified that the Appellant has since changed to a new doctor who is a Medicaid enrolled provider. A new Home Help Services Application was filed which the Department testified is still pending. The Appellant had her new doctor complete a DHS 54-A Medical Needs form, which she was to submit to the Department at the conclusion of the hearing. The Department stated that they would review the new medical needs form for the current Home Help Services Application.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, finds the Department has properly denied the Appellant's [redacted] Home Help Services application based on the available information.

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: 1/27/2010

***** 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.