STATE OF MICHIGAN
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
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]., Docket No. 2011-25225 HHS
Case No. [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.,* upon the Appellant's request for a hearing.

After due notice, a hearing was held [redacted]. [redacted]., the Appellant, appeared on his own behalf. [redacted] daughter, appeared as a witness for the Appellant. [redacted], represented the Department. [redacted], appeared as witnesses for the Department.

ISSUE

Did the Department properly propose a suspension of the Appellant's Home Help Services (HHS) case?

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 [redacted] year old Medicaid beneficiary.

2. On [redacted], the Department issued an Advance Negative Action Notice to the Appellant indicating his HHS case could be suspended effective [redacted], because new medical verification was needed to renew his Home Help Services. (Exhibit 1, pages 4-7)

3. Department policy requires verification of a medical need for assistance on a Medical Needs (DHS 54-A) form signed and dated by a Medicaid enrolled physician, nurse practitioner, occupational therapist, or physical therapist. (Exhibit 1, page 15)

4. On [redacted] the Department received a Medical Needs form completed but not signed or dated by the Appellant's physician. (Exhibit 1, page 3)

5. On [redacted] the Appellant filed a hearing request contesting the proposed suspension noting that he just received the Medical Needs form back from the Department to have the doctor sign and date it. (Exhibit 1, page 2)

6. The Department has since received the Medical Needs form back from the doctor with a signature and date. (Adult Services Worker Testimony)

7. The Department never implemented the proposed suspension and the Appellant's HHS payments never stopped.

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 362) 12-1-2007, page 2 of 5 addresses the issue of eligibility for Home Help Services:

- The client must be eligible for Medicaid.
- Have a scope of coverage code of:
    - 1F or 2F.
    - 1D or 1K, (Freedom to Work), **or**
    - 1T (Healthy Kids Expansion).
- The client must have a need for service, based on
    - Client Choice, **and**
    - Comprehensive Assessment (DHS-324) indicating a functional limitation of level 3 or greater in ADL or IADL.
- Medical Needs (DHS 54A) form signed and dated by a medical professional certifying a medical need for personal care services. The medical professional

> must by and enrolled Medicaid provider and hold one of the following professional licenses:
>
> - Physician.
> - Nurse practitioner.
> - Occupational therapist.
> - Physical therapist.
>
> Adult Services Manual (ASM 362) 12-1-2007,
> Page 2 of 5
> (Exhibit 1, page 15)

Adult Services Manual (ASM 363) 9-1-2008, pages 7-9 of 24 also 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:
    - o Physician.
    - o Nurse practitioner.
    - o Occupational therapist.
    - o 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 requires verification of medical need for assistance on the Medical Needs form signed and dated by a Medicaid enrolled provider in order to authorize Home Help Services. In this case, it is not clear if the Department made any attempts to let the Appellant know updated medical verification was needed prior to proposing a suspension of Appellant's HHS case. However, the ASW explained that the Appellant's physician did not sign nor date the DHS-54A Medical Needs form received by the Department on [redacted]. (ASW Testimony) It is also noted that the doctor did not indicate if he was a Medicaid enrolled provider or enter a Medicaid provider identification number. (Exhibit 1, page 3)

It is uncontested that after the Appellant filed the hearing request, the Department received the Medical Needs form with the required signature and date. It is also uncontested that the Department has not implemented the proposed suspension and the Appellant's HHS payments never stopped.

The Appellant testified that he has lost good workers due to paperwork issues and noted the delay in getting the unsigned Medical Needs form back to him to have his doctor sign and date it. While this ALJ understands the Appellant's concerns regarding losing good workers because of paperwork issues, there is no remedy this ALJ can order to prevent similar issues in the future.

In this case, the policy is clear; verification from a Medicaid enrolled medical professional certifying the client's medical need for services must be signed and dated. The evidence shows that the Medical Needs form was initially returned by the Appellant's doctor without the required signature, date, and Medicaid provider identification number. A suspension of payments until the properly completed Medical Needs form could be obtained would have been appropriate. However, the suspension was never implemented in this case because the Appellant filed a timely hearing request, and a correctly completed Medical Needs form has been submitted to the Department.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, finds the Department properly proposed a suspension of the Appellant's Home Help Services case, but never implemented the suspension because the required medical verification has since been properly completed and submitted to the Department.

IT IS THEREFORE ORDERED that:

The Department's decision is AFFIRMED.

Colleen Lack
Administrative Law Judge
for Olga Dazzo, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 6/16/2011

***** NOTICE *****

The Michigan Administrative Hearing System 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 Michigan Administrative Hearing System 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.