STATE OF MICHIGAN
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
FOR THE DEPARTMENT OF COMMUNITY HEALTH
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IN THE MATTER OF:

[redacted],

Docket No. 2011-27467 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]. Appellant [redacted] appeared on his own behalf. [redacted] also testified on Appellant's behalf. [redacted], represented the Department of Community Health. [redacted] Adult Services Supervisor, and [redacted], Adult Services Worker (ASW), from the [redacted] appeared as witnesses for the Department.

ISSUE

Did the Department properly terminate 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. Appellant is a [redacted] year-old Medicaid beneficiary. (Exhibit 1, page 10).

2. Appellant has been diagnosed with chronic obstructive pulmonary disease and he requires the use of oxygen nightly. (Exhibit 1, page 5).

3. Since at least [redacted], Appellant had been receiving HHS. (Exhibit 1, pages 6-8). As of [redacted], Appellant was receiving 36 hours and 7 minutes of HHS per month, with a care cost of [redacted] per month. (Exhibit 1, pages 7, 9).

4. On [redacted] ASW [redacted] mailed Appellant a DHS 54-A Medical Needs Form for Appellant's physician to fill out. (Exhibit 1, page 11). A new medical needs form is required every year for Appellant's HHS. (Testimony of ASW [redacted]).

5. On [redacted], the Department issued an Advance Negative Action Notice stating that Appellant had not returned an updated medical needs form and that he had to return one by [redacted] or his HHS would be terminated. (Exhibit 1, pages 2-4).

6. Appellant did not return an updated medical needs form by [redacted] (Testimony of Appellant; Testimony of ASW [redacted]).

7. Appellant's HHS were terminated on [redacted]. (Testimony of ASW [redacted]).

8. On [redacted], the Department received Appellant's Request for Hearing.

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.

Both Adult Services Manual 362 (12-1-07) (hereinafter "ASM 362") and Adult Services Manual 363 (9-1-08) (hereinafter "ASM 363") address the need for a Medical Needs Form certifying a medical need for the specified personal services prior to authorizing HHS:

> **Home Help Services (HHS)**
>
> Payment related independent living services are available if the client meets HHS eligibility requirements. Clients who may have a need for HHS should be assisted in applying for Medicaid (MA). Refer the client to an eligibility specialist. Cases pending MA determination may be opened to program 9 (ILS). HHS eligibility requirements include all of the following:

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- Medical Needs (DHS-54-A) form signed and dated by a medical professional certifying a medical need for personal care services. The medical professional must be an enrolled Medicaid provider and hold one of the following professional licenses:

  - Physician.
  - Nurse practitioner.
  - Occupational therapist.
  - Physical therapist.

(ASM 362, page 2 of 5)

Necessity For Service

The adult service worker is responsible for determining the necessity and level of need for HHS based on:

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- 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.
>
> (ASM 363, page 9 of 24)

Additionally, ASM 363 addresses how often a medical needs form needs to be updated in order to continue HHS:

> **Annual Redetermination**
>
> Procedures and case documentation for the annual review are the same as the six month review, with the following additions:
>
> ***
>
> 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.
>
> (ASM 363, page 7 of 24)

As described above, ASM 362 and ASM 363 expressly provide the ASW must have verification of medical need from a medical professional in order to authorize HHS and that the Appellant must provide an updated medical needs form every year. Here, it is undisputed that no updated medical needs form was ever returned, despite Appellant having numerous opportunities to do so. The above policies are clear and the

Department therefore properly terminated the Appellant's HHS based on the information available at that time of the decision.

Testimony during the hearing indicates that Appellant now has a completed medical needs form and he can reapply for HHS. However, the previous termination is affirmed based on the information available to the Department at the time of the decision.

DECISION AND ORDER

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

IT IS THEREFORE ORDERED that:

The Department's decision is AFFIRMED.

Steven Kibit
Administrative Law Judge
for Olga Dazzo, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 6/29/2011

***** 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.