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. 2011-35843 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.[1] [redacted] Appeals Review Officer, represented the Department of Community Health. [redacted], Adult Services Supervisor, and [redacted], Adult Services Worker (ASW), from the [redacted] DHS-[redacted] Office appeared as witnesses for the Department.

ISSUE

Did the Department properly deny the Appellant's Home Help Services (HHS) 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. In [redacted], Appellant applied for HHS. (Exhibit 1, pages 5-8).

2. As part of the initial application and assessment, Appellant's physician completed a DHS 54-A Medical Needs Form. However, Appellant's physician did not certify a medical need for any of the specified personal services. (Exhibit 1, page 11).

3. Since [redacted], Appellant has had a monthly deductible/spend-down amount that must be met before his Medicaid becomes active. (Exhibit 1, page 10).

---

[1] In his Request for Hearing, Appellant indicated that he wished for [redacted] to represent him. (Exhibit 1, page 4). However, [redacted] was unavailable at the time of the hearing and Appellant decided to proceed without her. (Testimony of Appellant).

4. Appellant has never met his spend-down. (Testimony of Appellant).

5. On [redacted], the Department issued an Adequate Negative Action Notice denying HHS due to the lack of certification of need by the Appellant's physician and Appellant's failure to meet his spend-down. (Exhibit 1, pages 5-8).

6. On [redacted], the Department received Appellant's Request for Hearing. (Exhibit 1, page 4).

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.

In this case, the Department denied Appellant's application for HHS because (1) his physician failed to certify a medical need for personal care services and (2) Appellant have never met his monthly deductible/spend-down amount. For the reasons discussed below, this Administrative Law Judge finds that either of those reasons is sufficient and that the Department's decision should be affirmed.

Medical Needs Form

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:
>
> ***

- 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:

***

- 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)

As described above, ASM 362 and ASM 363 expressly provide the ASW must have verification of medical need from a Medicaid enrolled provider in order to authorize HHS.

In this case, it is undisputed that Appellant's physician checked the "No" box in response to the question of "Do you certify the patient has a medical need for assistance with any of the personal care activities listed below?" (Exhibit 1, page 11). However, Appellant's physician also circled four of the twelve listed activities, which suggests that the physician did believe that Appellant required assistance. (Exhibit 1, page 11). ASW [redacted] did not contact Appellant's physician about that apparent ambiguity, instead finding that the check in the "No" box was sufficient. (Testimony of ASW [redacted]). Nevertheless, Appellant does not dispute that the form is insufficient and he only asks for a new form and an opportunity to reapply for HHS. (Testimony of Appellant). ASW [redacted] testified that she would send Appellant a new medical needs form. (Testimony of ASW [redacted]).

Given the clear policy regarding medical needs forms and the agreement that the form Appellant submitted was insufficient, the Department properly denied the HHS application based on the information available at that time of the decision as Appellant's doctor did not certify that Appellant has a medical need for personal assistance services.

Spend-down

ASM 362 and ASM 363 also address the issue of eligibility for 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:

- The client must be eligible for Medicaid.
- Have a scope of coverage 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 an 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 be an enrolled Medicaid provider and hold one of the following professional licenses:
  - Physician.
  - Nurse practitioner.
  - Occupational therapist.
  - Physical therapist.

(ASM 362, pages 1-2 of 5)

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 of 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 (sic) that daily rate 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.

(ASM 363, page 7 of 24)

The Department must implement its programs in accordance with its policies. The Department policy listed immediately above mandates that a person must be eligible for Medicaid with a scope of coverage 1F or 2F; or the monthly spend-down must be met, in order to receive HHS.

Here, the material facts are not in dispute. Prior to and during the time his application was pending, Appellant has had a monthly deductible that must be met before his Medicaid was active and he has never met that monthly deductible. (Testimony of Appellant; Testimony of ASW [redacted]; Exhibit 1, page 10). Accordingly, Appellant's Medicaid was not active at any time, including the time the ASW sent the notice of denial, and the Department's denial must be affirmed.[2]

[2] Appellant did state that he wished to dispute the existence of the spend-down and it was explained that the Department of Human Services (DHS) office has jurisdiction over eligibility issues, not the Department

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, finds the Department properly denied Appellant's application for HHS based on the available information.

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: 8/1/2011

***** 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.

of Community Health (DCH). Appellant has been advised to speak with his Medicaid Eligibility Worker and, if necessary, file a hearing request in the appropriate forum.