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

[redacted]

Docket No. 2011-3979 HHS
Case No. 38234689

Appellant
_____/

DECISION AND ORDER

This matter is before the undersigned Administrative Law Judge 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] was present for the hearing. She was represented by [redacted] of [redacted]. [redacted], the Appellant's [redacted] appeared as a witness for the Appellant. [redacted] represented the Department. [redacted] (worker), and [redacted], appeared as the Department's witnesses.

ISSUE

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

FINDINGS OF FACT

The Administrative Law Judge, based on the competent, material, and substantial evidence on the whole record, finds as material fact:

1. The Appellant is a Medicaid beneficiary.

2. The Appellant is [redacted], who underwent spinal surgery in [redacted]. (Testimony of [redacted]; Testimony of [redacted])

3. The Appellant applied for HHS in [redacted]. At that time, a DHS-54A medical needs form was provided to the Appellant to have her physician complete and return to the worker. (Exhibit 1, page 7; Testimony of [redacted])

4. On [redacted], the worker received a partially completed

medical needs form, i.e., the form was not signed or dated and it did not provide a diagnosis. Further, the form was not completed by a Medicaid-enrolled provider. (Exhibit 1, page 17)

5. On [redacted], the Department issued an Adequate Negative Action Notice, denying HHS because the medical needs form was not completed by a Medicaid-enrolled provider. (Exhibit 1, pages 4-7)

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 (Emphasis Added)*

Policy requires the worker to verify a medical need for assistance from a Medicaid-enrolled provider in order to authorize HHS. Here, the DHS 54-A medical needs form was not completed by a Medicaid-enrolled provider. (Exhibit 1, page 17)

The Appellant testified that she did not know that her physician was not a Medicaid-enrolled provider. The Appellant's [redacted] argued that the Appellant's [redacted] should be compensated for the assistance that she provided the Appellant before the HHS payments were authorized in this case. She asserted that it was not the Appellant's fault that her physician was not a Medicaid-enrolled provider. The Appellant's [redacted] argued that this Administrative Law Judge should overrule policy or make an exception in this case because the Appellant is not at fault. However, as was explained at the hearing, this Administrative Law Judge has no equitable jurisdiction. I have no authority to "make decisions on constitutional grounds, overrule statutes, overrule promulgated regulation[s] or overrule or make exceptions to Department policy." (Delegation of Hearing Authority, effective August 29, 2006). Accordingly, I am without jurisdiction to award any payment for services rendered before a medical need was certified by a Medicaid-enrolled provider.

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 denied the Appellant's HHS application based on the information available at the time it made its decision. However, this Administrative Law Judge notes that the Appellant has since reapplied and was approved for HHS retroactive to the date a need was certified by a Medicaid-enrolled provider.

DECISION AND ORDER

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

IT IS THEREFORE ORDERED that:

The Department's decision is AFFIRMED.

Kristin M. Heyse
Administrative Law Judge
for Olga Dazzo, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 2/16/2011

***** 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.