STATE OF MICHIGAN
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
FOR THE DEPARTMENT OF COMMUNITY HEALTH
P.O. Box 30763, Lansing, MI 48909
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IN THE MATTER OF:

[redacted],

Appellant.
_____/

Docket No. 2011-42120 HHS
Case No. 24720455

DECISION AND ORDER

This matter is before the undersigned Administrative Law Judge (ALJ) pursuant to M.C.L. § 400.9 and 42 C.F.R. § 431.200 *et seq.,* upon the Appellant's request for a hearing.

After due notice, a hearing was held on [redacted]. Appellant appeared on his own behalf. [redacted], Appellant's chore provider, also testified on his behalf. [redacted], Appeals Review Officer, represented the Department of Community Health. [redacted], Adult Services Supervisor, from the Wayne County DHS-District 45 Office appeared as a witness for the Department.

ISSUE

Did the Department properly determine the start date of 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 2, page 4).

2. Appellant has been diagnosed by a physician with hypertension (HTN), gastroesophageal reflux disease (GERD), peripheral vascular disease (PVD), shoulder and back pain, and Hepatitis C. Appellant also self-reported a heart murmur and arthritis in his back. (Exhibit 1, page 10).

3. In [redacted], Appellant applied for HHS. (Exhibit 3, page 7).

4. On [redacted], ASW [redacted] conducted a home visit and

comprehensive assessment of Appellant's needs. (Exhibit 3, pages 5-6).

5. During that initial visit, ASW [redacted] informed Appellant and Appellant's provider that the DHS 54-A Medical Needs Form Appellant had submitted along with his application was unacceptable because it was not filled out correctly and it contained different inks on it. ASW [redacted] also advised Appellant that he would have to submit another medical needs form. (Exhibit 2, page 1; Exhibit 3, pages 5-6).

6. Appellant's provider understood why the form was unacceptable. Her testimony also confirmed that there were two types of ink on the form because some parts of the form were completed by Appellant's doctor while other parts were completed by Appellant. (Testimony of [redacted]).

7. Appellant and [redacted] provided another medical needs form in [redacted], but that form was still unacceptable for the same reasons as the first one. ASW [redacted] then sent a blank medical needs form to Appellant's doctor. (Exhibit 2, page 3; Exhibit 3, page 5; Testimony of Evans).

8. In [redacted], ASW [redacted] called Appellant's doctor directly and spoke with his office about completing the form. (Exhibit 3, page 4). ASW [redacted] and [redacted] also spoke about the required medical needs form on several occasions. (Exhibit 3, page 4; Testimony of [redacted]).

9. On [redacted], ASW [redacted] received a medical needs form completed by Appellant's doctor. The signature date on the form was [redacted]. (Exhibit 1, page 8; Exhibit 2, page 4).

10. On [redacted], the Department issued a Services and Payment Approval Notice providing that Appellant had been approved for HHS in the amount of $[redacted] per month. The start date of payments was identified as [redacted]. (Exhibit 1, pages 5-6).

11. On [redacted], the Department received Appellant's Request for Hearing. In that request, Appellant states that his chore provider should be paid for the work she did between [redacted] and [redacted]. (Exhibit 1, page 4).

12. On [redacted], the Department issued another Services and Payment Approval Notice. However, that second notice simply identified Appellant's new worker and there was no change in HHS. (Exhibit 1, page 7).

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:
>
> ***
>
> - 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)

As described above, ASM 362 and ASM 363 expressly provide that the Department must have verification of medical need from a Medicaid enrolled provider in order to authorize HHS. In this case, it is undisputed that Appellant did not provide an acceptable, signed medical needs form prior to [redacted]. After receiving the form, the Department promptly authorized HHS to start [redacted], the date Appellant's doctor signed the medical needs form.

The applicable policy in this case expressly states "Do **not** authorize HHS prior to the date of the medical professional signature on the DHS-54A." ASM 363, page 9 of 24. That policy was followed here and the Department's decision regarding the start date of Appellant's HHS must be sustained.

DECISION AND ORDER

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

IT IS THEREFORE ORDERED that:

The Department's decision is AFFIRMED.

[redacted]
Administrative Law Judge
for Olga Dazzo, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 9/2/2011

***** 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.