**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. 2011-52734 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], the Appellant, appeared on her own behalf. [redacted], daughter, appeared as a witness for the Appellant. [redacted], Appeals Review Officer, represented the Department. [redacted], Adult Service Worker (ASW), and [redacted], Adult Services Supervisor, 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. The Appellant is a [redacted] year old Medicaid beneficiary has been diagnosed with gastric cancer. (Exhibit 1, page 9)

2. On or about [redacted], the Appellant applied for the HHS program. (Exhibit 1, page 8)

3. Department policy requires verification of a medical need for assistance by a Medicaid enrolled physician, nurse practitioner, occupational therapist, or physical therapist. (Exhibit 1, page 10)

4. On [redacted], the Appellant's physician completed a DHS 54-A Medical Needs Form, but did not certify a medical need for any of the specified personal care activities. (Exhibit 1, page 9)

5. On [redacted], the Department issued an Adequate Negative Action Notice to the Appellant indicating her Home Help Services application was denied because her doctor did not certify a medical need for chore services. (Exhibit 1, pages 5-8)

6. The Appellant requested a formal, administrative hearing contesting the denial on [redacted]. (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.

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

In order to authorize Home Help Services, the Adult Services Manual requires verification of medical need for assistance by a Medicaid enrolled provider. On [redacted], the Appellant's doctor completed the DHS-54A Medical Needs form, but did not certify a medical need for assistance with any of the specified personal care activities.

(Exhibit 1, page 9) Accordingly, the ASW issued the Adequate Action Notice indicating the Appellant's Home Help Services application was denied.

The Appellant and her daughter disagree with the termination and testified that she really does need help. As noted during the telephone hearing proceedings, the Department can take a new referral for HHS and provide the Appellant with a new DHS 54-A Medical Needs form to obtain verification of her medical need for assistance.

In this case, the policy is clear; verification is required from a Medicaid enrolled medical professional certifying the client's medical need for services. The Appellant's doctor did not certify that the Appellant has a medical need for assistance on the DHS-54A Medical Needs form submitted to the Department. The Department properly denied the Appellant's Home Help Services application based on the information available at that time.

## DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, finds the Department properly denied the Appellant's Home Help Services application.

**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: 12/1/2011

***** 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.