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],

Appellant
_____/

Docket No. 2011-939 HHS
Case No. 2576014

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. She was represented by [redacted]. [redacted], represented the Department. [redacted] (worker), and [redacted], were present as Department 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 [redacted] Medicaid beneficiary, who applied for HHS from the Department of Human Services (DHS) in [redacted]. (Exhibit 1, page 4)

2. The Appellant suffers from fibromyalgia, HLD, depression, urinary incontinence, chronic back pain, and bipolar disorder. (Exhibit 1, page 11)

3. On [redacted], the worker received a partially completed a DHS 54-A medical needs form from the Appellant's physician. The physician did not

sign or date the form. In addition, the physician did not certify a medical need for any of the specified personal services. (Exhibit 2, page 1)

4. On [redacted], the worker sent the form back to the Appellant to be signed and dated by her physician. (Exhibit 1, page 10)

5. On [redacted], the worker received a signed a dated medical needs form. However, this form appeared to be altered. It had both the "yes" and "no" boxes checked with regard to certifying a need for services and the following tasks were circled: bathing, grooming, dressing, laundry, and housework. (Exhibit 2, page 2)

6. On [redacted], the Department issued an Adequate Negative Action Notice, denying HHS because the Appellant's physician did not certify a need for services. (Exhibit 1, pages 7-9)

7. 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

Policy requires the worker to verify a medical need for assistance from a Medicaid-enrolled provider in order to authorize HHS. The worker testified that she denied the Appellant's HHS application because it was not clear that the Appellant's physician certified a need for services as required by policy. She explained that the first medical needs form that she received from the Appellant's physician, which was returned to the Appellant because it was not signed or dated, did not certify a need for services. And the form when it was returned appeared to have been tampered with because both the "yes" and "no" boxes were checked with regard to certifying a need for services. The worker stated that she was unable to approve services based on the inconsistencies in the medical needs forms she received. The worker further testified that the Appellant re-applied for services. And on [redacted], services were approved effective [redacted], the date that she received a new medical needs form from the Appellant's physician.

The Appellant disagrees with the denial. She explained that she took the form to her physician, her physician marked "yes" and circled the tasks, and then she mailed the form back to her worker. The Appellant does not dispute that the "no" box was originally checked on the form. She stated that she believes the physician made a mistake in checking the "no" box, but she stated that she did not tamper with the form.

Given the inconsistencies between the medical needs forms that the worker received, she was unable to verify that the physician certified a need for services. Accordingly, this Administrative Law Judge concludes that the Department's decision to deny the Appellant's application was in accord with policy.

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.

IT IS THEREFORE ORDERED that:

The Department's decision is AFFIRMED.

Kristin M. Heyse
Administrative Law Judge
for Janet Olszewski, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 12/29/2010

***** 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.