

**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:

Docket No. 2012-13655 HHS

██████████,

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 ██████████. ██████████ was present at hearing. She consented to have her daughter, ██████████ represent her.

██████████, Appeals and Review Officer, represented the Department of Community Health. ██████████, Adult Services Worker, appeared as a witness on behalf of the Department. ██████████, Adult Services Supervisor was present on behalf of the Department.

ISSUE

Did the Department properly terminate the Home Help Services (HHS) assistance of the Appellant?

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 ██████ year old Medicaid beneficiary who had been receiving Home Help Services.
2. The Appellant has care provided to her by her daughter, who resides with her.
3. The Appellant's doctor completed a 54-A Medical Needs form ██████████
██████████

4. The doctor who completed the 54-A stated that the Appellant did not have a medical need for assistance with any of the personal care activities listed on the form.
5. The Department sent the Appellant an Advance Notice of Termination [REDACTED].
6. The Appellant requested a formal, administrative hearing [REDACTED].

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.

Program requirements are set forth in Adult Services Manual item 362, below:

GENERAL SERVICES REQUIREMENTS The client must sign an Adult Services Application (DHS-390) to receive ILS. An authorized representative or other person acting for the client may sign the DHS-390 if the client:

- Is incapacitated, **or**
- Has been determined incompetent, **or**
- Has an emergency. A client unable to write may sign with an "X", witnessed by one other person (e.g., relative or department staff). Adult services workers must not sign the services application (DHS-390) for the client. Eligibility must be determined within 45 days of the signature date on the DHS-390.

Note: ASSIST (Automated Social Services Information and Support) requires a disposition within 30 days of the registered request. See ASSIST User Manual (AUM) 150-7/8. The DHS-390 is valid indefinitely unless the case is closed for more than 90 days.

ELIGIBILITY CRITERIA

Independent Living Services The following **nonpayment** related independent living services are available to any person upon request **regardless** of income or resources:

- Counseling.
- Education and training.
- Employment.
- Family planning.
- Health related.
- Homemaking.
- Housing.
- Information and referral.
- Money management.
- Protection (For adults in need of a conservator or a guardian, but who are not in any immediate need for protective service intervention.)

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, 12-1-2007

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 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.

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.

Payment for Medical Exams:

The Medicaid card is to be used to pay for medical professional charges for examinations or tests to certify the client's need for services and for completing the DHS-54A for MA recipients. Use the Examination Authorization/Invoice for Services (DHS-93) to pay for professional charges for non-MA clients. Payment is limited to the medical procedures and tests necessary to certify the client's need for home help services. See SRM 234, Diagnostic Fee Schedule.

Medical Review Team (MRT)

If the client refuses to see a physician, or the physician refuses to complete a DHS-54A, forward medical and case information to the Medical Review Team (MRT) through the local office medical contact worker and/or the local office's designated person responsible for reviewing medical information. Attach a cover memo explaining the reason a MRT evaluation is needed. The local office designee will forward the packet to the regional Disability Determination

Services (DDS) MRT. The MRT will make a determination and return the forms. See L-letter 00-130, June 20, 2000. The MRT may also be used if the client's physician does not certify a need for personal care services, but services appear to be justified.

Services not Covered by Home Help Services

Do **not** authorize HHS payment for the following:

- Supervising, monitoring, reminding, guiding or encouraging (functional assessment rank 2);
- Services provided for the benefit of others;
- Services for which a responsible relative is able and available to provide;
- Services provided free of charge;
- Services provided by another resource at the same time;
- Transportation - See Program Administrative Manual (PAM) 825 for medical transportation policy and procedures.
- Money management, e.g., power of attorney, representative payee;
- Medical services;
- Home delivered meals;
- Adult day care.

Note: If it appears the client's primary need is for adult foster care (AFC) or foster care is being provided without a license, the case should be referred to the local AFC licensing consultant.

ASM 363, 9-1-2008

At hearing, the Appellant stated her doctor did not complete the form at issue. She asserted it was given to the desk at her doctor's office and then completed by another person there who filled it out as she wished at the time. She did not otherwise challenge the legal basis of the Department's action.

The worker for the Department stated she had performed a comprehensive assessment for an annual review in ██████████. At that assessment she had determined the Appellant was no longer eligible for services because she did not require assistance with activities of daily living. Furthermore, she received the Medical Needs form DHS-54A indicating her doctor had not certified a medical need for personal care assistance. She thereafter sent the Advance Negative Action Notice advising the Appellant of the same.

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This ALJ must follow the DHS policy as published. There is no authority to make an exception or disregard it. The determination made by the DHS on [REDACTED], pertaining to the HHS case was proper.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, finds that the Department's termination of the Appellant's Home Help Services was proper.

IT IS THEREFORE ORDERED that:

The Department's decision is **AFFIRMED**.

Jennifer Isiogu
Administrative Law Judge
for Olga Dazzo, Director
Michigan Department of Community Health

cc:

[REDACTED]

Date Mailed: 2/23/2012

***** 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.