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) 373-4147

IN THE MATTER OF:

[redacted],

Docket No. 2012-59474 HHS
Case No. [redacted]

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.*, upon the Appellant's request for a hearing.

After due notice, a hearing was held on [redacted]. The Appellant appeared without representation. Her witnesses were [redacted] and [redacted]. [redacted], Appeals Review Officer, represented the Department. His witnesses were [redacted], ASW and [redacted], ASW supervisor.

ISSUE

Did the Department properly assess the Appellant and process her application for 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. The Appellant is a [redacted]-year-old Medicaid-SSI beneficiary. (Appellant's Exhibit #1)

2. The Appellant alleges disability by way of Post Traumatic Pain Syndrome [sic]. (Department's Exhibit A, p. 13)

3. On in-home assessment conducted on [redacted], the ASW determined that the Appellant needed assistance with the ADLs/IADLs of bathing, grooming, dressing, housework, laundry, shopping and meal preparation. She assessed the Appellant for HHS in the amount of 49:01 hours per month at a total cost of: $[redacted]. (Department's Exhibit A, pp. 9 and 12)

4. On [redacted] the ASW sent the Appellant a DHS 1210-A Service and Payment Approval Notice advising the Appellant that her HHS was approved in the amount of $[redacted] and that her start date would be retroactive to [redacted]. (Department's Exhibit A, pp. 2 and 5)

5. The Appellant does not appeal the assessment or the cost of care – she appeals the [redacted] start date. (Appellant's Exhibit #1)

6. The Appellant submitted "proof" of earlier receipt of DHS 390 and DHS 54A Medical Needs forms – received and admitted post hearing without objection. (*See* Appellant's Exhibit #2 and *See* Testimony)

7. The Department witness testified that the award and payment of HHS was made retroactive to [redacted] – the final execution date by the Appellant's physican. (*See* Testimony and Department's Exhibit A, pp. 8 – 11)

8. The request for hearing on the instant appeal was received by the Michigan Administrative Hearings System (MAHS) for the Department of Community Health on [redacted]. (Appellant's Exhibit #1)

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.

COMPREHENSIVE ASSESSMENT

The DHS-324, Adult Services Comprehensive Assessment is the primary tool for determining need for services. The comprehensive assessment must be completed on all open independent living services cases. ASCAP, the automated workload management system, provides the format for the comprehensive assessment and all information must be entered on the computer program.

Requirements for the comprehensive assessment include, but are not limited to:

- A comprehensive assessment will be completed on all new cases.
- A face-to-face contact is required with the client in his/her place of residence.

- The assessment may also include an interview with the individual who will be providing home help services.
- A new face-to-face assessment is required if there is a request for an increase in services before payment is authorized.
- A face-to-face assessment is required on all transfer-in cases before a payment is authorized.
- The assessment must be updated as often as necessary, but minimally at the six month review and annual redetermination.
- A release of information must be obtained when requesting documentation from confidential sources and/or sharing information from the department record.

….

Adult Service Manual (ASM), §120, page 1 of 6, 11-1-2011.

Medical Need Certification

Medical needs are certified utilizing the DHS-54A, Medical Needs form and must be completed by a Medicaid enrolled medical professional. A completed DHS-54A or veterans administration medical form are acceptable for individual treated by a VA physician; see ASM 115, Adult Service Requirements.

ASM §105, page 2 of 3, November 1, 2011

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ADULT SERVICES REQUIREMENTS - FORM (DHS-54A)

The DHS-54A, Medical Needs form must be 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 (M.D. or D.O.).
- Nurse practitioner.
- Occupational therapist
- Physical therapist.

….

The medical needs form is only required at the initial opening for SSI recipients and disabled adult children (DAC). All other Medicaid recipients must have a DHS-54A completed at the initial opening and annually thereafter.

The client is responsible for obtaining the medical certification of need but the form must be completed by the medical professional and not the client. The National Provider Identifier (NPI) number must be entered on the form by the medical provider and the medical professional must indicate whether they are a Medicaid enrolled provider.

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. Needed services are determined by the comprehensive assessment conducted by the adult services specialist.

If the medical needs form has not been returned, the adult services specialist should follow-up with the client and/or medical professional.

Do **not** authorize home help services prior to the date of the medical professional signature on the DHS-54A.

The medical needs form does not serve as the application for services. If the signature date on the DHS-54 is before the date on the DHS-390, payment for home help services must begin on the date of the application.

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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.

(Emphasis supplied by ALJ) ASM 115, pages 1 and 2 of 3, *Supra*

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The Department witness testified that a services approval notice was sent to the Appellant on [redacted] approving HHS in the amount of $[redacted] per month total cost of care.[1] There was no dispute in the record concerning necessity for service or that the Appellant was both disabled and in need of HHS via ADLs and IADLs.

The ASW testified that the earlier DHS 54A received on [redacted] was returned to the physican owing to illegible handwriting and signature – it was returned on [redacted] in final form – thus representing the last required piece of written data necessary to approve HHS.

On review, the Appellant's proof of a [redacted] start date was actually the transmittal letter sent along with the DHS 390 and the blank DHS 54A Medical Needs form. As policy says [above] it is the client's responsibility to obtain the medical certification – which in this case was slow in coming – but through no fault of the Department.

As "proof" of an earlier application date - the ALJ gave Appellant's Exhibit #2 very little weight. The Appellant may have a dispute with her physican about signature/certification delay – but she has no actionable complaint with the Department in terms of timely processing her application materials.

The greater weight of the evidence today supported the credible testimony of ASW [redacted] and her supporting documentation found in Department's Exhibit A – throughout. The mission of the Department in supplying these HHS services is broadly based.[2]

Unfortunately, case loads and process often results in backlog or delay – but this was not one of those instances. The evidence submitted at hearing credibly supported the Department's affirmative action in both timely granting HHS benefits and communicating that approval notice to the Appellant. It was the Appellant's burden to prove otherwise – a burden she failed to meet particularly when arguing, through her witnesses, that DHS approval was effective on receipt of their transmittal letter. (Appellant's Exhibit #2)

Based on the testimony of the ASW, I find that she comprehensively assessed the Appellant. She found that her need for HHS was appropriately established with a total cost care at $[redacted] for 49 hours and 01 minutes of service per month.

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[1] From the date of execution by a Medicaid enrolled medical professional.

[2] The mission statement is broadly worded: …[T]o accomplish this vision, DHS will:
● Act as resource brokers for clients.
● Advocate for equal access to available resources.
● Develop and maintain fully functioning partnerships that educate and effectively allocate limited resources on be half of our clients. (ASM 100 page 1 of 2) … As advocate, the specialist will:
●● Assist the client to become a self-advocate.
●● Assist the client in securing necessary resources.
●● Inform the client of options and educate him/her on how to make best possible use of available resources…
(ASM 102)

The Appellant has not met her burden of proof to establish that the Department erred in its assessment or the establishment of her start date. The required documents, properly executed, were not received until [redacted].

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the Department properly established HHS for the Appellant with a start date of [redacted].

IT IS THEREFORE ORDERED that:

The Department's decision is AFFIRMED.

Dale Malewska
Administrative Law Judge
for James K. Haveman, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 3/28/2013

***** 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.