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:

Docket No. 2013-21952 HHS
Case No.

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 . , the Appellant, appeared on own behalf. , appeared as a witness for the Appellant. , represented the Department. Adult Services Worker ("ASW"), appeared as a witness for the Department.

ISSUE

Did the Department properly assess the Appellant's Home Help Services ("HHS") case?

FINDINGS OF FACT

The Administrative Law Judge, based upon the competent, material and substantial evidence on the whole record, finds as material fact:

1. On the Department received a referral for the Appellant for the HHS program. (Exhibit 1, page 9)

2. The Department received medical certification dated of the Appellant's diagnoses and need for assistance with personal care activities. (Exhibit 1, page 10)

3. On , the ASW went to the Appellant's home and completed an in-home assessment for a review of the Appellant's HHS case. The Appellant and provider were present. The Appellant noted had applied for home help before, but had been filling out the blue book. It was reported the provider had been working since . (Exhibit 1, page 8)

4. The ASW determined that the Appellant was eligible for HHS and authorized a total of and per month with a care cost of . (Exhibit 1, page 13)

5. On [redacted], the Department sent the Appellant a Services and Payment Approval Notice which informed [redacted] that [redacted] was approved for HHS with a start date of [redacted] (Exhibit 1, pages 6-7)

6. On [redacted], the Appellant's request for hearing was received by the Michigan Administrative Hearing System. (Exhibit 1 pages 4-5)

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 Social Welfare Act, 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) 105, 11-1-11, addresses HHS eligibility requirements:

> **Requirements**
>
> Home help eligibility requirements include all of the following:
>
> - Medicaid eligibility.
> - Certification of medical need.
> - Need for service, based on a complete comprehensive assessment (DHS-324) indicating a functional limitation of level 3 or greater for activities of daily living (ADL).
> - Appropriate Level of Care (LOC) status.
>
> ***
>
> **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 forms are acceptable for individual treated by a VA physician; see ASM 115, Adult Services Requirements.
>
> **Necessity For Service**

The adult services specialist is responsible for determining the necessity and level of need for home help services based on:

- Client choice.

- A completed DHS-324, Adult Services Comprehensive Assessment. An individual must be assessed with at least one activity of daily living (ADL) in order to be eligible to receive home help services.

  Note: If the assessment determines a need for an ADL at a level 3 or greater but these services are not paid for by the department, the individual would be eligible to receive IADL services.

Example: Ms. Smith is assessed at a level 4 for bathing however she refuses to receive assistance. Ms. Smith would be eligible to receive assistance with IADL's if the assessment determines a need at a level 3 or greater.

- Verification of the client's medical need by a Medicaid enrolled medical professional via the DHS-54A. The client is responsible for obtaining the medical certification of need; see ASM 115, Adult Services Requirements.

Adult Services Manual (ASM) 105,
11-1-2011, Pages 1-3 of 3

Adult Services Manual (ASM) 115, 11-1-11, addresses the DHS-54A Medical Needs form:

MEDICAL NEEDS 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.

Note: A physician assistant (PA) is not an enrolled Medicaid provider and **cannot** sign the DHS-54A.

> 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 medical professional and not the client must complete the form. 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.
>
> <u>Do **not** authorize home help services prior to the date of the medical professional signature on the DHS-54A.</u>

Adult Services Manual (ASM) 115,
11-1-2011, Pages 1-2 of 3
(Underline added by ALJ)

On [redacted], the Department received a referral for the Appellant for the HHS program. (Exhibit 1, page 9) The Department received medical certification dated [redacted], of the Appellant's diagnoses and need for assistance with personal care activities. (Exhibit 1, page 10) On [redacted] the ASW went to the Appellant's home and completed an in-home assessment for a review of the Appellant's HHS case. The Appellant and [redacted] provider were present. The Appellant noted [redacted] had applied for home help [redacted] before, but had been filling out the blue book. It was reported the provider had been working since [redacted]. (Exhibit 1, page 8) There was no evidence of an earlier medical certification. (ASW Testimony)

The ASW determined that the Appellant was eligible for HHS and authorized a total of [redacted] hours and [redacted] per month with a care cost [redacted] (Exhibit 1, page 13) On [redacted] the Department sent the Appellant a Services and Payment Approval Notice which informed [redacted] that [redacted] was approved for HHS with a start date of [redacted] (Exhibit 1, pages 6-7)

The Appellant disagrees with the effective date of the HHS authorization. The Appellant testified [redacted] sent in three packets stating [redacted] needed help and a chore provider. The

Appellant had a chore provider a few years ago. The Appellant stated current chore provider started on The Appellant wants chore provider to be paid for the work has done. The Appellant explained tha sent in three packets within two weeks because during this time period case worker changed and packets got lost. The Appellant described these packets as page booklets. The Appellant did not believe a DHS-54A Medical Needs form was turned in before (Appellant Testimony)

The ASW correctly determined the HHS authorization could not start prior to the date of the medical certification, Based on the Appellant's testimony, it appears was completing the DHS-1171 packet, which includes an information booklet and the assistance application for multiple other programs. A separate smaller application, the DHS 390 Adult Services Application, is used for independent living services including the HHS program. The evidence indicates there were errors made by the Department in this case, such as not making an earlier referral for the Appellant for the HHS program when the large 20 page application packets were submitted stating wanted a HHS chore provider. However, this ALJ does not have equitable authority. There is no remedy this ALJ can order for the Department's failure to make an earlier referral for the Appellant for the HHS program and provide with the correct application and required medical certification form. The above cited policy does not allow the HHS authorization to begin prior to the date of the medical certification. The medical certification for the Appellant was dated and there was no evidence of any medical certification with an earlier date. Accordingly, the effective date for the HHS authorization must be upheld.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, finds that the Department properly assessed the Appellant's HHS case based on the available information.

IT IS THEREFORE ORDERED THAT:

The Department's decision is AFFIRMED.

____
Colleen Lack
Administrative Law Judge
for James K. Haveman, Director
Michigan Department of Community Health

cc:

Date Mailed: __________

***** 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.