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. 2013-27152 HHS
Case No. [redacted]

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

After due notice, a hearing was held on May 2, 2013. [redacted] Appellant's mother, appeared and testified on Appellant's behalf. Appellant was also present during the hearing. [redacted], Appeals Review Officer, represented the Department of Community Health. Adult Services Worker (ASW) [redacted] from the [redacted] County DHS Office appeared as a witness for the Department.

ISSUE

Did the Department properly deny Appellant's 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. Appellant is a [redacted]-year-old Medicaid beneficiary who was referred for HHS on [redacted]. (Respondent's Exhibit A, page 8).

2. After that referral, on [redacted], ASW [redacted] sent Appellant an introduction letter, an application form, and a DHS 54-A Medical Needs Form. The medical needs form was to be completed and returned within twenty-one days, *i.e.* [redacted] (Respondent's Exhibit A, page 5; Testimony of Appellant's representative; Testimony of ASW [redacted]).

3. Appellant and his representative received the letter and forms in the mail on or around (Testimony of Appellant's representative).

4. No 54-A Medical Needs form was returned by (Testimony of Appellant; Testimony of ASW).

5. On the Department issued an Adequate Negative Action Notice stating that Appellant's application was denied because no medical needs form had been received. (Respondent's Exhibit A, pages 5-7).

6. According to Appellant's representative, she obtained a signed medical needs form on (Testimony of Appellant's representative).

7. On the Michigan Administrative Hearing System (MAHS) received a Request for Hearing in this matter. (Respondent's Exhibit A, 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 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 115 (11-1-2011) (hereinafter "ASM 115") addresses the need for a Medical Needs Form certifying a medical need for the specified personal services prior to authorizing HHS:

> **APPLICATION FOR SERVICES (DHS-390)**
>
> The client must complete and sign a DHS 390, Adult Services Application
> to receive independent living services. An authorized representative
> or other person acting for the client may sign the DHS-390 if the client either:

- Is incapacitated.
- Has a court-appointed guardian.

A client unable to write may sign with an X, witnessed by one other person (for example, relative or department staff). The adult services specialist **must not** sign the DHS-390 on behalf of the client. The DHS-390 remains valid unless the case record is closed for more than 90 days.

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 form must be completed by the medical professional and not the the [sic] 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.
>
> **Example:** The local office adult services unit receives a DHS-54A signed on 1/18/2011 but a referral for home help was never made. The adult services staff enters a referral on ASCAP and mails an application to the client. The application is returned to the office with a signature date of 2/16/2011. Payment cannot begin until 2/16/2011, or later, if the provider was not working during this time period.
>
> 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. [ASM 115, pages 1-2 of 3.]

Therefore, as described above, ASM 115 expressly provides the ASW must have verification of medical need from a Medicaid enrolled provider in order to authorize HHS. Here, as discussed above, it is undisputed that Appellant did not return a completed medical needs form prior to the denial. The policies are clear in this case and the Department properly denied the HHS application based on the information available at that time of the decision.

In response, Appellant's representative argues that Appellant should have been given more time to submit the medical needs form. However, Adult Services Manual 110 (11-1-2011) (hereinafter "ASM 110") provides that

> **REFERRAL INTAKE**
>
> A referral may be received by phone, mail or in person and must be entered on ASCAP upon receipt. The referral source does not have to be the individual in need of the services.

Registration and Case Disposition

Action

Complete a thorough clearance of the individual in the ASCAP client search and Bridges search.

Complete the **Basic Client** and **Referral Details** tabs of the **Client** module in **ASCAP**.

Supervisor or designee assigns case to the adult services specialist in the Disposition module of ASCAP.

Documentation

Print introduction letter, the DHS-390, Adult Services Application and the DHS-54A, Medical Needs form and mail to the client. *The introduction letter allows the client 21 calendars days to return the documentation to the local office.*

Note: The introduction letter does not serve as adequate notification if home help services are denied. The specialist must send the client a DHS-1212A, Adequate Negative Action Notice; see ASM 150, Notification of Eligibility Determination. [ASM 110, page 1 of 2 (italics added).]

Accordingly, Appellant was properly given 21 calendar days from the date the documentation was sent to return the medical needs form. Appellant's representative asserts that she should have had 21 days from the day she received the letter, but there is no basis for such a position in the above policy and such an interpretation would be impracticable as there is no way to tell on what day a client receives the documentation. Additionally, this Administrative Law Judge would note that, even if Appellant had 21 days from the day he receive the documentation to return the medical needs form, Appellant's representative's confirms that they would not have met that deadline either as they only obtained the medical needs form on

Appellant's representative further testified that Appellant's doctor subsequently completed a medical needs form, but the Department has no record of it and, in any event, it would not change the validity of the Department's decision given the information it had at the time it made that decision. ASW did testify that Appellant can reapply for HHS at any time and, during the hearing, she offered to assist Appellant in reapplying. This Administrative Law Judge would also like to make clear that, while the Department's previous denial is affirmed for the reasons discussed above, Appellant is free to reapply for HHS.

DECISION AND ORDER

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

IT IS THEREFORE ORDERED THAT:

The Department's decision is AFFIRMED.

Steven Kibit
Administrative Law Judge
for James K. Haveman, Director
Michigan Department of Community Health

Date Signed: [redacted]

Date Mailed: [redacted]

***** 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 March 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.

SK/db

cc: [redacted]