STATE OF MICHIGAN
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
FOR THE DEPARTMENT OF COMMUNITY HEALTH
P.O. Box 30763, Lansing, MI 48909
(517) 335-2484; Fax: (517) 373-4147

IN THE MATTER OF:

Docket No. 2013-32532 HHS

[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 [redacted]. Appellant appeared and testified on his own behalf. [redacted], Appeals Review Officer, represented the Department of Community Health. [redacted], Adult Services Worker (ASW), from the [redacted] County DHS-[redacted] Office, appeared as a witness for the Department. [redacted], Adult Services Supervisor, also appeared but did not testify.

ISSUE

Did the Department properly deny Home Help Services (HHS) payments prior to January 17, 2013?

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 ([redacted]) Medicaid beneficiary who had been diagnosed with carpal tunnel, osteoarthritis, chronic back pain, asthma, and PTSD due to depression. (Exhibit A, pp. 11, 17 and testimony).

2. Appellant made an application for HHS and his case was assigned to ASW Davis.

3. On [redacted], Appellant submitted a medical needs form that was signed by a nurse practitioner with the VA on [redacted]. ASW [redacted] could not verify that the person who signed the medical needs form was a Medicaid enrolled medical professional, and it was later determined that she was not an enrolled Medicaid provider. (Exhibit A, pp. 8-9, 15, 16 and testimony).

[redacted]

4. On [redacted], the ASW conducted an in-home visit and assessment of Appellant's application. The Appellant was present during the visit, but the Provider Agency was not present. (Exhibit A, pp. 8-9).

5. Appellant was sent another medical needs form which was completed and signed by his doctor on [redacted] and received by DHS on [redacted] (Exhibit A, p. 17 and testimony).

6. On [redacted], the Department sent Appellant a Services Payment and Approval Notice. The notice stated that Appellant had been approved for [redacted] hours and [redacted] minutes of HHS services, with a monthly total care cost of [redacted]. The start date for the payments was identified as [redacted]. (Exhibit A, p. 7).

7. On [redacted], MAHS received a Request for Hearing from Appellant. In that request, Appellant claims that his provider's pay was not fair and that the provider should receive payments for back pay because the first medical needs form went back to [redacted]. (Exhibit A, p. 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 Administrative Code, and the State Plan under Title XIX of the Social Security Act Medical Assistance Program.

Home Help Services 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 105 (11-1-2011) (hereinafter "ASM 105") addressed the **Eligibility Criteria** for Home Help Services at the time of the denial in this case:

> **GENERAL**
>
> Home Help Services are available if the client meets all eligibility requirements. An independent living services case may be opened to supportive services to assist the client in applying for Medicaid.
>
> Home Help Services payments cannot be authorized prior to establishing Medicaid eligibility and a face-to-face assessment completed with the client. Once MA eligibility has been established, the case service methodology **must** be changed to case management.

[redacted]

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.

Medicaid/Medical Aid (MA)

The client may be eligible for MA under one of the following:

- All requirements for Medicaid have been met.
- MA deductible obligation has been met.

The client must have a scope of coverage of either:

- 1F or 2F.
- 1D or 1K (Freedom to Work).
- 1T (Healthy Kids Expansion).

Clients with a scope of coverage 20, 2C or 2B are **not** eligible for Medicaid until they have met their MA deductible obligation.

Note: A change in the scope of coverage in Bridges will generate a system tickler in ASCAP for active services cases.

Medicaid Personal Care Option

Clients in need of home help personal care services may become eligible for MA under the Medicaid personal care option.

Discuss this option with the client and coordinate implementation with the eligibility specialist.

[redacted]

Conditions of eligibility:

- The client meets all Medicaid eligibility factors except income.
- An independent living services case is open.
- The client is eligible for home help services.
- The cost of personal care services is **more** than the MA excess income amount.

If **all** the above conditions have been satisfied, the client has met MA deductible requirements. The Adult Services Specialist can apply the personal care option in ASCAP. The deductible amount is entered on the **MA History** tab of the Bridges **Eligibility** module in ASCAP.

Use the DHS-1210, Services Approval Notice to notify the client of home help services approval when MA eligibility is met through this option. The notice must inform the client that the home help payment will be affected by the deductible amount, and that the client is responsible for paying the provider the MA deductible amount each month.

Do **not** close a case eligible for MA based on this policy option if the client does not pay the provider. It has already been ensured that MA funds will not be used to pay the client's deductible liability. The payment for these expenses is the responsibility of the client.

Changes in the client's deductible amount will generate a system tickler from Bridges.

MA eligibility under this option **cannot** continue if the cost of personal care becomes **equal to or less than** the MA excess income amount.

Note: See Bridges Eligibility Manual (BEM) 545, Exhibit II, regarding the Medicaid Personal Care Option.

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 Services Requirements.

[redacted]

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.

Appropriate Level of Care Status

Verify client's level of care to avoid duplication of services. The level of care will determine if the client is enrolled in other programs. The level of care information can be found in ASCAP under the **Bridges Search** or **Bridges Eligibility** module, **MA History** tab; see ASM 125 Coordination With Other Services for a list of level of care codes.

Moreover, with respect to the **Adult Services Requirements**, Adult Services Manual 115 (11-1-2011) (hereinafter "ASM 115") states in part:

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:

[redacted]

- 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 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. [Emphasis added].

In this case, the Department authorized payments starting on [redacted] and its decision not to award payments for any services provided prior to that date must be affirmed. The policy quoted above supports the Department's decision.

[redacted]

ASM 105 makes it clear that home help eligibility requirements include certification of medical need. ASM 105 further provides that medical needs are certified utilizing the DHS-54A, Medical Needs form and **must be completed by a Medicaid enrolled medical professional**. In addition, ASM 115 provides that 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, or physical therapist. ASM 115 further provides that 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. Finally, ASM cautions: "Do **not** authorize home help services **prior to the date of the medical professional signature** on the DHS-54A". (Emphasis added).

This Administrative Law Judge cannot award additional payments for services in this case. This Administrative Law Judge does not possess equitable powers and, therefore, cannot award benefits or payments as a matter of fairness. Certain criteria have to be met and specific events have to occur before HHS payments can be authorized. The preponderance of evidence in this case demonstrates that the medical needs form was not signed and dated by the Appellant's physician until [redacted]. The Adult Services and Payment Approval notice was then sent out on [redacted], notifying the Appellant that his home help services had been approved and the care cost payment was approved for [redacted] per month effective [redacted]. Consequently, any services provided prior to [redacted] were unauthorized and the Department cannot pay for them.

Appellant's claim that his provider's pay is not fair is not properly before the undersigned administrative law judge. The Department correctly pointed out that the Appellant has an Agency provider. The Agency is paid [redacted] per hour to provide his HHS services. (Exhibit A, pp. 8-9, 14). The Agency is responsible for the amount of pay the individual worker receives, and any complaint the individual provider has concerning the amount of their pay should be addressed to the Agency providing the worker.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the Department properly denied payments for Home Help Services prior to [redacted].

[redacted]

IT IS THEREFORE ORDERED THAT:

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

William D. Bond
Administrative Law Judge
for James K. Haveman, Director
Michigan Department of Community Health

Date Signed: [redacted]

Date Mailed: [redacted]

WDB/db

cc: [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 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.