

**STATE OF MICHIGAN
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
FOR THE DEPARTMENT OF COMMUNITY HEALTH**

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IN THE MATTER OF:

██████████,

Appellant

Docket No. 2013-45809 HHS
Case No. ██████████

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 without representation. He had no witnesses. The Department was represented by ██████████, Appeals Review Officer. Her witness was ██████████, ASW.

ISSUE

Did the Department properly deny the Appellant's request 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 ██████-year-old Medicaid beneficiary. (Appellant's Exhibit #1)
2. The Appellant is afflicted with DM, CHF, SOB, HTN, neuropathy, GERD and foot amputation. (Department's Exhibit B and See Testimony)
3. The Appellant said he needs home assistance for bathing, transportation, shopping and doctor appointments. (See Testimony)
4. The Appellant was sent a DHS 1212A Adequate Negative Action notice on ██████████ when his physician failed to certify any medical need for assistance with personal care. (Department's Exhibit A, p. 5 and Department's Exhibit B)

5. His further appeal rights were contained therein.
6. The request for hearing on the instant appeal was received by the Michigan Administrative Hearing 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.

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Adult Service Manual (ASM), §120, page 1 of 5, 5-1-2012.

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

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.

ASM 115, pp. 1 and 2, *Supra*

The Department witness testified that a denial notice was sent to the Appellant because the Department did not receive the Medical Needs form DHS-54A which certified the Appellant as needing personal care services under the HHS program.

She said that the denial was effective on ██████████.

The Appellant explained the difficulty he has getting around and that he was advised "by the nurses to apply for home services."

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Hearing Decision & Order**

On review, the Adult Service Manual clearly states – as underscored above – that HHS benefits cannot issue prior to certification by the medical professional. Accordingly, the Appellant has failed to preponderate his burden of proof that the Department erred in denying his application for home help services.

DECISION AND ORDER

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

IT IS THEREFORE ORDERED that:

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

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

cc: [REDACTED]

Date Signed: 8/8/2013

Date Mailed: 8/8/2013

***** 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.