

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

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IN THE MATTER OF:

██████████,
Appellant

Docket No. 2013-55820 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. ██████████, Appeals Review Officer, represented the Department. Her witnesses were; ██████████, ASW and ██████████, ASW supervisor.

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 unknown maladies. (See Department's Exhibit – throughout)
3. The Department witness testified that a required document – the DHS 54A medical needs form was never received – although it had been provided to the Appellant. (See Testimony)
4. On ██████████ the Department sent the Appellant a DHS 1212-A Adequate Negative Action Notice denying services effective ██████████. (Department's Exhibit A, pp. 2 and 5)
5. The Appellant claimed he dropped off the DHS 54A medical needs form at his doctor's office. (See Testimony of ██████████)

6. The Department's witness said that the DHS 54A medical needs form was never received, but that the Appellant had reapplied – but did not withdraw his request for hearing. (See Testimony)
7. The request for hearing on the instant appeal was received by the Michigan Administrative Hearings System (MAHS) for the Department of Community Health on ██████████. (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.

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

The Department witness testified that they never received the DHS 54A medical needs form and testified that they are not authorized to proceed without it. The Appellant testified that he didn't know what happened – but he wanted to have his HHS approved anyway – although he had no testimony or explanation to account for the whereabouts of the missing document.

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On review, the Appellant seeks an equitable resolution to a policy-based decision over which the ALJ has no authority. The Department's decision to deny was properly dictated by policy [above]. The ALJ has no equitable jurisdiction to change that result.

Accordingly, the Appellant has failed to preponderate his burden of proof that the Department erred in denying his request for HHS. The Department properly denied the Appellant's request for HHS owing to non-receipt of the required DHS 54A medical needs form.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the Department properly assessed the Appellant's HHS on December 5, 2012.

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: 8/30/2013

Date Mailed: 8/30/2013

***** NOTICE *****

The State Office of Administrative Hearings and Rules 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 State Office of Administrative Hearings and Rules 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.