

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:

██████████

Appellant.

Docket No. 2013-64489 HHS

██████████

██████████

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 ██████████. Appellant appeared and testified on his own behalf. ██████████ Appellant's cousin, was also present as a witness for Appellant. ██████████ Appeals Review Officer, represented the Department of Community Health. ██████████ Adult Services Worker (ASW), and ██████████, Adult Services Supervisor, testified as witnesses for the Department.

ISSUE

Did the Department properly terminate Appellant's 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 ██████ year-old Medicaid beneficiary who has been diagnosed with chronic low back pain, nerve damage, a bulging disc, and a spinal disorder. (Respondent's Exhibit A, pages 15, 18).
2. Appellant has been receiving HHS through the Department. Most recently, he was authorized for ██████ hours and ██████ minutes of HHS per month, with a total monthly care cost of ██████████ (Respondent's Exhibit A, pages 17).
3. Specifically, Appellant was authorized for assistance with mobility, housework, laundry, shopping, and meal preparation. (Respondent's Exhibit A, pages 17).

4. On ██████████ ASW ██████████ r conducted a home visit and reassessment with Appellant. (Respondent's Exhibit A, page 14).
5. During that assessment, Appellant was unable to provide any of his medications and, while he was walking with his cane at that time, ASW ██████████ r began to question his mobility needs given that she had earlier seen him ambulating independently and he reported that he was attending college full-time. (Respondent's Exhibit A, page 14).
6. Accordingly, ASW ██████████ asked Appellant to provide a current medical needs form and a copy of his college schedule by ██████████ (Respondent's Exhibit A, page 14).
7. No such medical needs form or schedule was received by ██████████ (Testimony of ASW Lewis-Taylor).
8. On ██████████ the Department issued an Advance Negative Action Notice to Appellant indicating that his HHS would be terminated effective ██████████ because Appellant had failed to provide the requested information. (Respondent's Exhibit A, pages 5-9).
9. On ██████████, ASW ██████████ received a medical needs form signed by Appellant's physician. However, in that form, Appellant's physician checked "NO" when asked to certify that Appellant has a medical need for assistance with any of the tasks encompassed within HHS. (Respondent's Exhibit A, page 18).
10. Appellant also sent in a letter indicating that he had lied when he said that he was attending college. (Petitioner's Exhibit 1, page 1).
11. On ██████████ the Department sent Appellant another written notice of termination. That second notice of termination provided that Appellant's services would be terminated on ██████████ because his physician certified that Appellant no longer needs HHS. (Respondent's Exhibit A, pages 10-13).
12. On ██████████, the Michigan Administrative Hearing System (MAHS) received the 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.

Here, the Department initially terminated Appellant's HHS due to his failure to provide an updated medical needs form. Moreover, once that medical needs form was received, it sent another notice of termination due to the fact that Appellant's physician had failed to certify a medical need for assistance on the submitted medical needs form.

Appellant bears the burden of proving by a preponderance of the evidence that the Department erred in terminating his services. For the reasons discussed below, Appellant has failed to meet that burden in this case.

Adult Services Manual 105 (11-1-2011) (hereinafter "ASM 105") and Adult Services Manual 115 (11-1-2011) (hereinafter "ASM 115") address the requirements for a medical needs form in order for an applicant to receive HHS. For example, ASM 105 states in part, on pages 1-2 of 3, that:

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.

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 form are acceptable for individual treated by a VA physician; see ASM 115, Adult Services Requirements.

Moreover, with respect to the required medical needs form, ASM 115, pages 1-2 of 3, also states:

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.

Therefore, pursuant to the above policy, an applicant must provide a medical needs form completed by enrolled Medicaid provider and certifying a medical need for services in order to receive HHS.

Here, Appellant failed to provide such a medical needs form. In the medical needs form he eventually did provide, the doctor checked "NO" when asked if the doctor would certify that Appellant has a medical need for assistance with any of the personal care activities listed on the form.

The requirements for HHS are clear and Appellant did not satisfy that criteria as he failed to provide a medical needs form that meets all of the requirements found in policy. Accordingly, the Department properly denied Appellant's application.

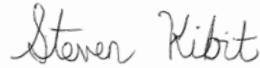
DECISION AND ORDER

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

[REDACTED]
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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]

SK/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.