STATE OF MICHIGAN
STATE OFFICE OF ADMINISTRATIVE HEARINGS AND RULES
FOR THE DEPARTMENT OF COMMUNITY HEALTH
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IN THE MATTER OF:

[redacted]

Appellant
_____/

Docket No. 2009-10605 HHS
Case No. [redacted]
Load No. [redacted]

DECISION AND ORDER

This matter is before the undersigned Administrative Law Judge (ALJ) 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 [redacted], the Appellant's sister and authorized hearing representative, appeared on behalf of the Appellant. [redacted], represented the Department. [redacted] and [redacted], appeared as witnesses on behalf of the Department.

ISSUE

Did the Department properly deny Home Help Services payments to the Appellant?

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 Medicaid beneficiary awaiting a heart transplant.

2. The Appellant has been receiving medical care relative to his heart condition at a hospital in Illinois.

3. The Appellant was admitted to a hospital and transferred to the hospital in [redacted] on an emergency basis.

4. The Appellant's sister telephoned the Department of Human Services in [redacted] seeking Home Help Services payments for the Appellant when he was temporarily out of state awaiting heart transplant in [redacted]

5. The Appellant did not have or seek Home Help Services payments prior to leaving the state temporarily for the purpose of obtaining medical care.

6. The Department was unable to conduct an in home assessment of the Appellant's needs for services because he was out of state at the time of the telephone inquiry. The Department Supervisor sought information regarding a possible special exception on behalf of the Appellant.

7. The Department's supervisor was informed no exception would apply and notified the Appellant of same on a Notice dated [redacted].

8. The Appellant is no longer out of state. He is receiving Home Help Services effective [redacted], the date of his first application for Home Help Service payments.

9. The DHS 54, medical needs form provided to the Department of Human Services is dated [redacted]

10. The Department opened his Home Help Services case effective [redacted]

11. The Appellant seeks a hearing regarding denial of services dating to [redacted].

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 Adult Services Comprehensive Assessment (FIA-324) is the primary tool for determining need for services. The comprehensive assessment will be completed on all open cases, whether a home help payment will be made or not. ASCAP, the automated workload management system provides the format for the comprehensive assessment and all information will 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 customer in his/her place of residence.
- An interview must be conducted with the caregiver, if applicable.
- Observe a copy of the customer's social security card.
- Observe a picture I.D. of the caregiver, if applicable.
- The assessment must be updated as often as necessary, but minimally at the six month review and annual re-determination.
- A release of information must be obtained when requesting documentation from confidential sources and/or sharing information from the agency record.
- Follow specialized rules of confidentiality when ILS cases have companion APS cases.

Functional Assessment

The **Functional Assessment** module of the **ASCAP** comprehensive assessment is the basis for service planning and for the HHS payment.

Conduct a functional assessment to determine the customer's ability to perform the following activities:

Activities of Daily Living (ADL)

- Eating
- Toileting
- Bathing
- Grooming
- Dressing
- Transferring
- Mobility

Instrumental Activities of Daily Living (IADL)

- Taking Medication
- Meal Preparation and Cleanup
- Shopping for food and other necessities of daily living
- Laundry
- Housework

Functional Scale ADL's and IADL's are assessed according to the following five-point scale:

1. Independent

Performs the activity safely with no human assistance.

2. Verbal Assistance
   Performs the activity with verbal assistance such as reminding, guiding or encouraging.

3. Some Human Assistance
   Performs the activity with some direct physical assistance and/or assistive technology.

4. Much Human Assistance
   Performs the activity with a great deal of human assistance and/or assistive technology.

5. Dependent
   Does not perform the activity even with human assistance and/or assistive technology.

Note: HHS payments may only be authorized for needs assessed at the 3 level or greater. Customers must require assistance with at least one qualifying ADL in order to qualify for HHS payments. A qualifying ADL (functionally assessed at Level 3 or greater) would include:

- An ADL functional need authorized by the worker
- An ADL accomplished by equipment or assistive technology and documented by the worker, or
- An ADL functional need performed by someone else, requiring no Medicaid reimbursement, or
- A request authorized as necessary through an exception made by the Department of Community Health, Central Office.

Once an ADL has been determined or exception request has been granted, the customer is then eligible for any ADL or IADL authorized home help service.

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Service Plan Development

Address the following factors in the development of the service plan:

- The specific services to be provided, by whom and at what cost.
- The extent to which the customer does not perform activities essential to caring for self. The intent of the Home Help program is to assist individuals to

function as independently as possible. It is important to work with the recipient and the provider in developing a plan to achieve this goal.

- The kinds and amounts of activities required for the customer's maintenance and functioning in the living environment.
- The availability or ability of a responsible relative or legal dependent of the customer to perform the tasks the customer does not perform. Authorize HHS **only** for those services or times which the responsible relative/legal dependent is unavailable or unable to provide.
- Do **not** authorize HHS payments to a responsible relative or legal dependent of the customer.
- The extent to which others in the home are able and available to provide the needed services. Authorize HHS **only** for the benefit of the customer and **not** for others in the home. If others are living in the home, prorate the IADL's by at least 1/2, more if appropriate.
- The availability of services currently provided free of charge. A written statement by the provider that he is no longer able to furnish the service at no cost is sufficient for payment to be authorized as long as the provider is not a responsible relative of the customer.
- HHS may be authorized when the customer is receiving other home care services if the services are not duplicative (same service for same time period).

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ELIGIBILITY FOR HOME HELP SERVICES

Home help services (HHS) are defined as those, which the Agency is paying for through Title XIX (Medicaid) funds. The customer must be eligible for Medicaid in order to receive these services.

Medicaid/Medical Aid (MA)

Verify the customer's Medicaid/Medical aid status.

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

- All requirements for MA have been met, **or**
- MA spend-down obligation has been met.

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Necessity For Service

> The adult services worker is responsible for determining the necessity and level of need for HHS based on:
>
> - Customer choice.
> - A complete comprehensive assessment and determination of the customer's need for personal care services.
>
> - Verification of the customer's medical need by a Medicaid enrolled medical professional. The customer is responsible for obtaining the medical certification of need. The Medicaid provider identification number must be entered on the form by the medical provider. The Medical Needs form must be signed and dated by one of the following medical professionals:
>
> - Physician
> - Nurse Practitioner
> - Occupational Therapist
> - Physical Therapist
>
> The physician is to certify that the customer's need for service is related to an existing medical condition. The physician does not prescribe or authorize personal care services.
>
> If the Medical Needs form has not been returned, the adult services worker should follow-up with the customer and/or medical professional.
>
> *Adult Services Manual (ASM) 4-1-2004,Pages 9-10 of 27*

In this case the material facts are not in dispute. The Appellant did not have a Home Help Service case open prior to leaving the state, as he was not in need at that time. He left the state due to an emergent medical condition and remained out of state for a lengthy period of time. During this time period he sought payment assistance for Home Help Services. He did not submit an application for services. Although a telephone inquiry had been made on his behalf, no actual application was ever completed. Additionally, while an exception to the policy cited above was sought, none was authorized on behalf of the Appellant. The Appellant now has services effective the date of his application, [redacted]. He seeks services payments back to [redacted] These cannot be authorized under the current policy.

Policy has many requirements which were unable to be met, thus the case was not opened prior to the application date. A DHS 54 medical needs form must be completed and submitted to the Department in conjunction with an application for services. While there is no requirement it be submitted at the time of application, it must eventually be submitted before payment can be authorized. Additionally, a comprehensive assessment must be completed, along with a service plan. The Department was unable to complete an assessment with the Appellant while he was temporarily out of State. While this ALJ took testimony relative to the circumstances that gave rise to the telephone inquiry rather than application and the emergent

nature of the circumstances that gave rise to the need for services and reasons the exception was requested, this ALJ is without equitable jurisdiction. Also, this ALJ took testimony relative to the fact that the medical personnel were ready in [redacted] to provide necessary information to the Department regarding a need for services. The Appellant asserts this would have served sufficiently in place of comprehensive assessment. Again, this ALJ is without equitable jurisdiction. The Policy as written in the Department manual is the controlling authority for this hearing. This ALJ cannot determine if the Department denied an exception request in error, rather, can only determine if the Department correctly applied its own policy. In this case, it did.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the Department correctly denied the Appellant Home Help Services Payments for the time period before the signed application for services, dated [redacted]

IT IS THEREFORE ORDERED that:

The Department's decision is AFFIRMED.

Jennifer Isiogu
Administrative Law Judge
for Janet Olszewski, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 2/26/2009

***** 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.