STATE OF MICHIGAN
STATE OFFICE OF ADMINISTRATIVE HEARINGS AND RULES
FOR THE DEPARTMENT OF COMMUNITY HEALTH
P.O. Box 30763, Lansing, MI 48909
(877) 833-0870; Fax: (517) 334-9505

IN THE MATTER OF:

[redacted]

Appellant
_____/

Docket No. 2009-11885 HHS
Case No. [redacted]
Load No. [redacted]

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 [redacted]. [redacted] (Appellant) appeared and testified on his own behalf. [redacted] represented the Department. [redacted], appeared and testified as a witness for the Department.

ISSUE

Did the Department properly reduce Appellant's Home Help Services?

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 Medicaid recipient who receives Home Help Services.

2. Appellant was diagnosed with a herniated lumbar disc and chronic obstructive pulmonary disease (COPD). (Exhibit 1, p. 15)

3. Appellant had been receiving Home Help Services for assistance with bathing, transferring, mobility, medication, housework, laundry, shopping for food/meds, and meal preparation.

4. The Department received a Personal Care Services Provider Log,

signed by Appellant and his provider on [redacted], indicating that for the months of [redacted] through [redacted], Claimant did not receive any physical assistance with transferring or mobility. (ALJ I)

5. On [redacted], the Adult Services Worker went to Appellant's home to reassess his eligibility for Home Help Services.

6. After the Home Help Services reassessment in [redacted], the Adult Services Worker determined that: Appellant's mobility appears to have improved over the last year, and Appellant stated that he is no longer on oxygen; and during the home call visit, the worker witnessed Appellant ambulating without assistance, and when the worker was leaving, Appellant "escorted worker to the door and out on the porch." (Exhibit 1, p. 8)

7. The Adult Services Worker determined that Appellant no longer needed assistance with transferring and mobility. (Exhibit 1, p. 10)

8. On [redacted], the Adult Services Worker sent Appellant an Advance Negative Action Notice, informing him that his Home Help Services payment would be reduced to [redacted] from [redacted]. (Exhibit 1, p. 2)

9. On [redacted] the State Office of Administrative Hearings and Rules received Appellant's hearing request, protesting the reduction of his Home Help Services.

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.

ASM 363; INDEPENDENT LIVING SERVICES PROGRAM PROCEDURES
ASB 2004-006 10-1-2004

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).

ASM 363; INDEPENDENT LIVING SERVICES PROGRAM PROCEDURES
ASB 2004-006 10-1-2004

Services not Covered by Home Help Services

Do **not** authorize HHS payment for the following:

• Supervising, monitoring, reminding, guiding or encouraging (functional assessment rank 2);

• Services provided for the benefit of others;

• Services for which a responsible relative is able and available to provide;

• Services provided free of charge;

• Services provided by another resource at the same time;

• Transportation - See Program Administrative Manual (PAM) 825 for medical transportation policy and procedures.

• Money management, e.g., power of attorney, representative payee;

• Medical services;

ASM 363; pages 9 or 26; 10 of 26 and 15 of 26; INDEPENDENT LIVING SERVICES PROGRAM PROCEDURES ASB 2004-006 10-1-2004

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.

ASM 363; page; INDEPENDENT LIVING SERVICES PROGRAM PROCEDURES ASB 2004-006 10-1-2004

In this case, Appellant requested a hearing, protesting the reduction of his Home Help Services. In [redacted] the Adult Services Worker completed a comprehensive Home Help Services reassessment of Appellant. During the reassessment, the Adult Services Worker determined that Appellant no longer needed assistance with transferring and mobility. The worker testified that no other changes were made. Appellant's Home Help Services payment was reduced because Appellant was determined no longer eligible to receive a payment for assistance with transferring and mobility.

According to ASM 365, the functional assessment definitions for transferring and mobility are as follows:

Transferring- Moving from one sitting or lying position to another sitting or lying position; e.g., from bed to or from a wheelchair or sofa, coming to a standing position and/or repositioning to prevent skin breakdown.

Mobility- Walking or moving around inside the living area, changing locations in a room, moving from room to room, does respond adequately if he/she stumbles or trips. Does step over or maneuver around pets or obstacles, including uneven floor surfaces. Does climb or descends stairs. Does not refer to transfers, or to abilities or needs once destination is reached.

A client is ineligible for a payment for assistance with any ADL or IADL that does not require hands-on or physical assistance. (ASM 365) In this case, the Department established that it properly determined that Appellant was no longer eligible for a Home Help Services payment for assistance with transferring and mobility. The Adult Services Worker completed a reassessment of Appellant's eligibility for services in accordance with the applicable policy. The worker noted

that: Appellant's mobility appears to have improved over the last year; Appellant stated that he is no longer on oxygen; and during the home call visit, the worker witnessed Appellant ambulating without assistance, and when the worker was leaving, Appellant escorted the worker to the door and out on the porch. The worker testified at the hearing that during the home call visit, he uses his cane only once in a while, and Appellant had no problems transferring during the home visit. Appellant testified that he needs some human assistance with transferring to the bathroom and from one room to the other. However, Appellant failed to provide the necessary evidence to substantiate his testimony of a continued need for physical assistance with transferring and mobility. This Administrative Law Judge observed Appellant walking in and out of the hearings room with his cane, but he did not require any physical assistance. Further, the Department received a Personal Care Services Provider Log, signed by Appellant and his provider, which indicates that for the months of October through [redacted] the provider did not assist Appellant with transferring and mobility even though she was being paid to do so. (ALJ I) The Home Help Services policy states clearly that the Adult Services Worker is responsible for determining the necessity and level of need for Home Help Services. Although the client's physician must certify that the client's need for services is related to an existing medical condition, the physician does not prescribe or authorize personal care services.

In conclusion, Appellant failed to provide the necessary evidence to refute the Department's Home Help Services eligibility determination. Accordingly, the reduction of his Home Help Services must be upheld.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the Department properly reduced Appellant's Home Help Services.

IT IS THEREFORE ORDERED that:

The Department's decision is AFFIRMED.

_____

Marya Nelson-Davis
Administrative Law Judge
for Janet Olszewski, Director
Michigan Department of Community Health

[redacted]
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Decision and Order

cc: [redacted]

Date Mailed: 4/30/2009

***** 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.