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]

Appellants
_____/

Docket Nos. 2009-14202 HHS
2009-14205 HHS
Case Nos. [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's representative/provider/daughter, appeared and testified on the Appellants' behalf. [redacted] (Appellant-husband) and [redacted] (Appellant-wife) appeared at the hearing. [redacted] represented the Department of Community Health (Department). [redacted], testified as a witness for the Department.

ISSUE

Did the Department properly determine Appellants' eligibility 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. Appellants are Medicaid recipients who were determined eligible to receive HHS.

2. Appellants are married and live together.

3. At the time relevant to this matter, [redacted], received notice from Appellants' daughter/provider that Appellant-husband needed additional HHS due to have surgery for prostate cancer.

4. [redacted] sent a DHS-54-A, Medical Needs form to Appellant-husband's surgeon, [redacted], the medical doctor who performed the surgery.

5. On [redacted] completed and signed the Medical Needs form, which indicated that Appellant-husband was diagnosed with prostate cancer and incontinence, and he does not need any assistance with his personal care activities. (Appellant-husband's Exhibit 1, p. 8)

6. Appellant-wife was diagnosed with hypertension, degenerative joint disease, chronic back pain, breast cancer, inguinal hernia, and a hip fracture; and she had been receiving HHS. (Appellant-wife Exhibit 1, pp. 8-11)

7. On [redacted], the Adult Services Worker sent an Advance Negative Action Notice to both Appellants, informing them that they were no longer eligible for HHS.

8. On [redacted], the State Office of Administrative Hearings and Rules received Appellants' hearing request, protesting the HHS eligibility determination.

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.

Adult Services Manual (ASM) 362

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.

Adult Services Manual (ASM) 362

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) 362

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;
INDEPENDENT LIVING SERVICES PROGRAM PROCEDURES

ASB 2008-002; 9-1-2008

RESPONSIBLE RELATIVE

A person's spouse.
A parent of an unmarried child under age 18

ASM 361;
INDEPENDENT LIVING SERVICES PROGRAM OVERVIEW
ASB 2008-002; 9-1-2008

In this case, Appellant's representative argued that the Adult Services Worker sent the Medical Needs form to the wrong doctor; and Appellant-husband needs HHS and is unable to assist Appellant-wife with her personal care activities due to his severe physical impairment. The representative of Appellants testified that [redacted] made a mistake when he indicated that Appellant-husband does not need assistance with his personal care activities.

The Adult Services Worker testified credibly and established by a preponderance of evidence that Appellant-husband was diagnosed with prostate cancer for which he had to undergo surgery. The worker testified credibly that at the request of Appellant's representative/daughter, she sent the Medical Needs form to the doctor who performed the surgery.

Appellant-husband stated in his hearing request that he had prostate surgery, recently, and it is hard to perform his daily activities. Based on the evidence on the record, there was a change in Appellant-husband's medical condition, "prostate surgery" after a diagnosis of prostate cancer, which required additional HHS. Therefore, this Administrative Law Judge finds that the worker acted properly in sending the Medical needs form to the doctor who performed the surgery. The doctor completed the Medical Needs form, indicating that Appellant-husband was given a diagnosis of prostate cancer and incontinence, and he does not need any assistance with his personal care activities. (Appellant-husband's Exhibit 1, p. 8) Department policy states clearly that the Department cannot authorize HHS if the client's doctor fails to certify a need for services. Therefore, the Department's determination that Appellant-husband was no longer eligible for HHS must be upheld. Appellant's representative was advised that Appellant-husband has a right to submit additional documentation, including a completed Medical Needs form(s), certifying his need for HHS.

The evidence on the record fails to establish Appellant-wife's eligibility for HHS. Since Appellant-husband failed to provide the required certification of medical need for HHS, and the evidence on the record fails to establish that he is unable or unavailable to assist Appellant-wife with her ADLs, he would be considered a **responsible relative** of Appellant-wife. A client is not eligible for HHS if a **responsible relative** is able and available to provide the services that the client needs. Although there is no dispute that Appellant-wife needs physical assistance with her personal care activities, she cannot

be approved for HHS as long as her spouse is considered a responsible relative who is able and available to provide the services that she needs.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the Department did properly determine Appellants' eligibility for HHS.

IT IS THEREFORE ORDERED THAT:

The Department's approval of Appellants' application for HHS is AFFIRMED.

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

cc: [redacted]

Date Mailed: 5/11/2009

***** 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.