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. 2009-17340 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.,* following the Appellant's request for a hearing.

After due notice, hearings were held on [redacted] and [redacted]. The hearing set for [redacted] was adjourned at the request of the Appellant.

At the [redacted], hearing [redacted] appeared, claiming she was the Appellant's court-appointed guardian. However, because the hearing file reflected no such documentation, [redacted] was directed to supply this office with a copy of the court-appointed guardianship documentation, and the hearing was adjourned. [redacted] never supplied this office with a copy of the guardianship documentation.

At the [redacted], hearing, the Appellant appeared and testified on her own behalf. Also appearing as witnesses for the Appellant were her [redacted], [redacted], [redacted], and [redacted].

[redacted] represented the Department of Community Health (Department) at both hearings. Also appearing as a witness for the Department at both hearings was [redacted] (DHS).

ISSUE

Did the Department properly determine the Appellant's Adult Home Help Services award?

FINDINGS OF FACT

Based upon the competent, material and substantial evidence presented, I find, as material fact:

1. Appellant is a Medicaid beneficiary with physician-verified medical diagnoses of dementia, hypertension and osteoarthritis. The Appellant also reports a medical history of incontinence, skin rash, breast cancer, kidney problems and congestive heart failure. *(Exhibit 1, p. 10)*

2. On [redacted], an [redacted] DHS adult services worker issued to the Appellant a Services and Payment Approval Notice informing her that adult Home Help Services were approved in the amount of [redacted] per month. The adult services worker's conclusions are based on a [redacted], home visit.

3. During the [redacted], home visit, the adult services worker interviewed the Appellant, the Appellant's provider and others residing in the home. There are four individuals residing in the Appellant's home. All instrumental activities of daily living, with the exception of laundry, were prorated by four. *(Testimony of adult services worker)*

4. On [redacted], the Appellant filed her request for hearing with the State Office of Administrative Hearings and Rules for the Department of Community Health, asserting that the amount awarded is insufficient to account for her medical problems and associated needs.

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 (DHS-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 client in his/her place of residence.
• An interview must be conducted with the caregiver, if applicable.
• Observe a copy of the client'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 department 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 client'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.
• Laundry.
• Light 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.

Time and Task The worker will allocate time for each task assessed a rank of 3 or higher, based on interviews with the client and provider, observation of the client's abilities and use of the reasonable time schedule (RTS) as a guide. The RTS can be found in **ASCAP** under the **Payment** module, Time and Task screen. When hours exceed the RTS rationale must be provided.

IADL Maximum Allowable Hours

There are monthly maximum hour limits on all IADLs except medication.

The limits are as follows:

- Five hours/month for shopping.
- Six hours/month for light housework.
- Seven hours/month for laundry.
- 25 hours/month for meal preparation.

These are **maximums**; as always, if the client needs fewer hours, that is what must be authorized. Hours should continue to be prorated in shared living arrangements If there is a need for expanded hours, a request should be submitted to:

MDCH
Attn: Long Term Care, Systems Development Section
Capitol Commons, 6th Floor, Lansing, MI 48909

Necessity For Service

The adult services worker is responsible for determining the necessity and level of need for HHS based on:

- Client choice.

- A complete comprehensive assessment and determination of the client's need for personal care services.

• Verification of the client's medical need by a Medicaid enrolled medical professional. The client 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.

Exception: DCH will accept a DHS-54A completed by a VA physician or the VA medical form in lieu of the medical needs form.

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. If the medical needs form has not been returned, the adult services worker should follow-up with the client and/or medical professional. 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.

Do **not** authorize HHS prior to the date of the medical professional signature on the DHS-54A.

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A Medicaid beneficiary bears the burden of proving he or she was denied a medically necessary and appropriate service. See, e.g., *J.K By and Through R.K. v Dillenberg*, 836 F Supp 694, 700 (Ariz, 1993). Whether the Appellant satisfied that burden here must be determined in accord with the preponderance of the evidence standard. See, e.g., *Aquilina v General Motors Corp*, 403 Mich 206, 210; 267 NW2d 923 (1978).

Regarding an appeal filed with the State Office of Administrative Hearing and Rules for the Department of Community Health, the Administrative Law Judge is given ultimate discretion to determine the weight and credibility of the evidence presented. *Wiley v Henry Ford Cottage Hosp*, 257 Mich App 488, 491; 668 NW2d 402 (2003); *Zeeland Farm Services, Inc v JBL Enterprises, Inc*, 219 Mich App 190, 195; 555 NW2d 733 (1996) (the fact finder is provided with the unique opportunity to observe or listen to witnesses; and, it is the fact finder's responsibility to

determine the credibility and weight of the testimony and other evidence provided).

The adult services worker testified that the amount, scope and duration of the Appellant's home help service award was based on information gleaned during the [redacted], home call assessment. He further testified that the information obtained during the assessment is the result of his personal observations, as well as information provided him by the Appellant, her chore provider(s) and others who were present during the meeting. I find the adult services worker's testimony to be credible.

In contrast, the Appellant testified she needs assistance due to her health conditions. The Appellant's witnesses testified they work full-time jobs and are unavailable to provide 24-hour care for the Appellant.

Although the evidence supports a conclusion the Appellant needs personal care assistance due to a variety of medical ailments, she failed to provide specific evidence, supported by medical documentation, that would otherwise contradict the adult services worker's determination regarding the amount, scope and duration of her home help service award.

The preponderance of the evidence presented supports a conclusion the adult services worker appropriately determined the amount, scope and duration of the Appellant's home help services award, based on the [redacted], assessment.

DECISION AND ORDER

Based on the above findings of fact and conclusions of law, I decide that the Department properly determined the amount, scope and duration of the Appellant's home help services.

IT IS THEREFORE ORDERED that:

The Department's decision is AFFIRMED.

Stephen B. Goldstein
Administrative Law Judge
for Janet Olszewski, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 7/13/2009

***** NOTICE *****

The State Office of Administrative Hearings and Rules for the Department of Community Health 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 for the Department of Community Health 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 60 days of the mailing date of the Decision and Order or, if a timely request for rehearing was made, within 60 days of the mailing date of the rehearing decision.