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. 2009-33300 HHS
Case 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, an in-person hearing was held on [redacted]. [redacted], Benefits Technician, Community Living Services of [redacted], appeared on behalf of [redacted] (Appellant), who was also present and testified on her own behalf. Also present as a witness for the Appellant was [redacted], Executive Director, Community Living Services.

[redacted], Appeals Review Officer, represented the Department of Community Health. Also appearing as a witness for the Department was [redacted], Adult Services Supervisor, [redacted] of Human Services-[redacted] (DHS).

ISSUE

Did the Department properly terminate the Appellant's adult Home Help Services?

FINDINGS OF FACT

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

1. Appellant is an adult Medicaid beneficiary with physician verified diagnoses of cerebral palsy and quadriplegia. She is wheelchair-bound and exhibits profound communicative difficulties. *(Exhibit 1; p. 14)*

2. On [redacted], the DHS adult service worker sent the Appellant a Services Negative Action Notice informing her that home help services would be terminated, as her provider quit, and because she appeared capable of providing for her own needs.

3. On [redacted], while performing other DHS assessment(s) in the same building in which the Appellant currently resides. She went to the Appellant's apartment after receiving a message from someone claiming the Appellant did not have a provider. The Appellant was in the middle of taking a bath according to the agency worker who answered the door. The DHS worker then learned the Appellant was also receiving personal care services in the form of community living supports through [redacted] Community Mental Health.

4. On [redacted], the DHS worker conducted a face-to-face interview with the Appellant and her mother. At this visit, the DHS worker learned that the Appellant's long-time roommate and provider moved out of the residence, and that her mother was providing supervisory services whenever she could but not regularly because of full time employment. *(Exhibit 1; p. 12)*

5. During the [redacted] visit, the Appellant told the DHS worker that she can go the mall by herself in her power wheelchair, that she can transfer in and out of bed independently, can heat food in the microwave, undress for bed, and knows how to take her medications. *(Exhibit 1; p. 12)*

6. On the basis of information gleaned from the [redacted] interview, the DHS worker issued an Adequate Negative Action Notice informing her that her home help services were being terminated and her case closed because her mother was providing only supervision and monitoring which is not a Medicaid-covered service. *(Exhibit 1; p. 9)*

7. On [redacted], the Appellant filed her request for hearing with the State Office of Administrative Hearings and Rules for the Department of Community Health.

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.

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 client 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 client's maintenance and functioning in the living environment.
- The availability or ability of a responsible relative or legal dependent of the client to perform the tasks the client does not perform.

Authorize HHS **only** for those services or times which the responsible relative/legal dependent is unavailable or unable to provide.

Note: Unavailable means absence from the home, for employment or other legitimate reasons. **Unable** means the responsible person has disabilities of his/her own which prevent caregiving. These disabilities must be documented/verified by a medical professional on the DHS- 54A.

- Do **not** authorize HHS payments to a responsible relative or legal dependent of the client.
- 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 client 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 client.
- HHS may be authorized when the client is receiving other home care services if the services are not duplicative (same service for same time period).

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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 satisfies that burden 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 DHS worker who conducted the [redacted] assessment was not present at the hearing. Testifying in her absence was her supervisor [redacted], who indicated she was familiar with the worker's file regarding this beneficiary and with its contents. [redacted] testified she met with the Appellant's mother after the termination notice was issued, and that the Appellant's mother told her she was primarily supervising the Appellant on a part-time basis because of a full time job, and because the Appellant was receiving personal care services through [redacted].

Community Living Services of [redacted] is the provider contracted to provide Medicaid-funded specialty mental health services to the developmentally disabled Medicaid population. Both witnesses discussed limitations imposed upon the Appellant by her medical diagnoses. However, neither witness offered documentation with regard to how many hours per week the Appellant is receiving services through its agency. It is therefore difficult to ascertain whether the Appellant's adult home help needs are being met.

While it appears that the Appellant's medical conditions require significant care, is also appears she is receiving personal care services, via CLS, through another Medicaid-funded program. Policy is clear----Medicaid dollars may not fund duplicative services.

Because both CLS and adult home help involve some measure of personal care, it is the Appellant's burden to establish adult home help needs remain unsatisfied, despite services she may be receiving through another agency, in this case, [redacted] Community Mental Health. Her failure to carry this burden renders the Department's decision appropriate, because adult home help policy clearly excludes supervision as a covered service.

DECISION AND ORDER

Based on the above findings of fact and conclusions of law, I decide that DHS' termination of Home Help Services in this case is proper.

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

[redacted]
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Decision and Order

cc: [redacted]

Date Mailed: 11/16/2009

***** 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.