STATE OF MICHIGAN
STATE OFFICE OF ADMINISTRATIVE HEARINGS AND RULES
FOR THE DEPARTMENT OF COMMUNITY HEALTH
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(877) 833-0870; Fax: (517) 334-9505

IN THE MATTER OF:

[redacted]

Appellant
_____/

Docket No. 2009-5044 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], the Appellant's mother and caretaker, appeared and testified at the hearing. [redacted], represented the Department. [redacted] testified on behalf of the Department.

ISSUE

Did the Department properly determine the payment for the Appellant' Expanded Home Help case?

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 [redacted] year-old Medicaid recipient who receives Expanded Home Help Services.

2. The Appellant is wheelchair dependent, with spastic quadriplegic cerebral palsy. She requires assistance at a rank of 3 or above for every aspect of personal care and chore services with the exception of respiration, which is ranked at a 1.

3. The Appellant's Home Help Services provider is her mother.

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

5. Following the assessment, the Adult Services Worker increased the

amount of payment assistance for in home care due to adding time for specialized skin care and range of motion exercises.

6. The Adult Services Worker sent a Notice [redacted] informing the Appellant of the payment amount.

7. The Appellant is dissatisfied with the amount of service payment authorized, thus appealed the 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.

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 PROGRAMPROCEDURES ASB 2004-006 10-1-2004

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.

The Appellant is authorized for Expanded Home Help Services. Adult Services Manual (ASM 363) addresses expanded home help:

Expanded Home Help Services (EHHS)

EHHS may be authorized if **all** of the following criteria are met:

- The customer is eligible for HHS.
- The customer has functional limitations so severe that the care cost cannot be met safely within the monthly maximum payment.
- The local office director/supervisory designee has approved the payment (EHHS $334 - $999) **or** the Department of Community Health (DCH) has approved the payment (EHHS over $1000).

All EHHS requests for approval must contain:

- Medical documentation of need, e.g., FIA-54A, **and**
- An updated FIA-324 **and** written plan of care which indicates:
  - How EHHS will meet the customer's care needs **and**
  - How the payment amount was determined.

Note: See Adult Services Home Page for Expanded Home Help Services Procedure Guideline, developed by the Department of Community

Health.

At the outset of the hearing the Department representative requested a dismissal because no negative action had been taken or proposed. There had been no reduction, suspension or termination of services proposed by the Department. This ALJ denied the request for dismissal on the record, indicating while the Department's position is appreciated as literally true, to grant a dismissal in that circumstance would not allow a recipient to contest the amount of assistance determined by the Department, so long as it was not a decrease from a prior amount. This would not provide a meaningful way to contest Department determinations, such as approving payment in the mount of $5.00 at case opening because it was not technically a reduction, termination or suspension. Following denial of the requested dismissal, testimony was taken from the Department's witness regarding the comprehensive assessment conducted [redacted]

The Department witness testified he went to the assessment and had asked if there had been any changes. He added time for special skin care needs and range of motion exercises and saw no other way to increase the payments made to the Appellant. This ALJ reviewed the documents entered into evidence by the Department, which included, at page 17 of Department exhibit A, the rank for each task the worker had assessed. The Appellant was ranked a 3 for grooming. The worker was asked by this ALJ which tasks the Appellant was able to complete without assistance, specifically related to grooming. He did not have an answer for that question. He was specifically asked if she was able to brush her own hair. He did not know. He was asked if he had sought to learn the answer to that question at the assessment. He had not. The Department witness lacked knowledge of the toileting procedures undertaken 4 or 5 times per day, which includes use of a special lift, catheterizing and even occasional but regular use of suppositories. The Department's worker had her ranked as a 1 regarding continence. She is on a bowel program, using suppositories regularly. She must be cleaned by her caregiver/mother every day, several times per day due to unavoidable accidents. The Department witness testified about the assessment that had been completed regarding transferring. He stated time assessed for transferring did not include time for assistance moving from her bed to her chair, chair to other furniture, or back to her bed. Policy regarding how to assess for transferring needs includes transfers that take place inside the home, such as those specifically stated above. The unrefuted testimony from the Appellant regarding transferring is that she undertakes several per day, only being able to remain in her chair for up to 6 hours, on a good day. She is transferred between her bed and chair and several times per day.

Testimony taken from the Department witness and the credible, unrefuted testimony from the Appellant and her mother establishes that an inadequate assessment was completed on [redacted] The ranks reflect the inaccurate determination that the Appellant is not incontinent, and is able to participate in more grooming than she actually can. Additionally, time for transferring is inadequate to compensate her caregiver for the time involved in actually accomplishing the task. The Department's payment determination is based upon erroneous assumptions and an inadequate assessment of this particular case. Complex care cases require a high level of detailed information be obtained in order to ascertain what is appropriate for the client's needs. The assessment must be done again in order to obtain the necessary information.

DECISION AND ORDER

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

IT IS THEREFORE ORDERED that:

The Department's decision is NOT UPHELD.

The Department is hereby ordered to return to the Appellant's home to complete a new comprehensive assessment reflecting the issues addressed herein, including but not limited to: transferring, incontinence and bowel program. The new payment amount is to be effective dating back to the effective date of the [redacted] assessment.

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

cc: [redacted]

Date Mailed: 2/17/2009

***** 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.