

**STATE OF MICHIGAN
STATE OFFICE OF ADMINISTRATIVE HEARINGS AND RULES
FOR THE DEPARTMENT OF COMMUNITY HEALTH**

P.O. Box 30763, Lansing, MI 48909
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IN THE MATTER OF:

██████████

Appellant

_____ /

Docket No. 2009-5837 HHS

Case No. ██████████

Load No. ██████████

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 ██████████ ██████████, Appellant's mother/representative, appeared and testified Appellant's behalf. ██████████ ██████████, represented the Department of Community Health (Department).

ISSUE

Did the Department properly determine that Appellant no longer met the eligibility criteria for 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 ██████-year-old Medicaid recipient who was receiving home help services.
2. On or about ██████████, Appellant's doctor completed a Medical Needs form, DHS-54A, indicating that Appellant has a diagnosis of asthma and allergies; and he does not need any assistance with any of his personal care activities. (Department Exhibit 1, p. 7)
3. On ██████████, the Adult Services Worker sent the Appellant an Advance Negative Action Notice, informing him that he was no longer eligible for home help services. (Exhibit 1, p. 4)

4. On [REDACTED], the State Office of Administrative Hearings and Rules received Appellant's hearing request, protesting the denial of 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.

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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.

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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.

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In this case, Appellant's doctor completed a Medical Needs form, indicating that Appellant does not need any assistance with his personal care activities. Department policy states clearly that the Department cannot authorize home help services if the client's doctor fails to certify a need for services. Therefore, the Department's denial of Appellant's request for home help services must be upheld. Appellant has the right to reapply for home help services and submit a completed medical needs form from a


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qualified medical source, nurse practitioner, or physical/occupational therapist, which certifies his need for home help services.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the Department properly determined that Appellant was no longer eligible for home help services.

IT IS THEREFORE ORDERED THAT:

The Department's decision is AFFIRMED.

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

cc:



Date Mailed: 2/24/2009

***** 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.