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. 2009-16093 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, a hearing was held on [redacted]. [redacted] (Appellant) appeared and testified. Also appearing as a witness for the Appellant was her daughter (and chore provider), [redacted].

[redacted], represented the Department of Community Health. Also appearing as a witness for the Department was [redacted].

ISSUE

Did the Department properly deny the Appellant's request for adult Home Help Services?

FINDINGS OF FACT

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

1. Appellant is a Medicaid beneficiary, with medical conditions including back pain, neck pain, and fibromyalgia. *(Exhibit 1, p. 6)*

2. On [redacted], a services negative action notice was issued to the Appellant informing her that her request for adult Home Help Services was denied, because the required application and medical needs form (FIA 54A) were not returned.

3. 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** If the client appears eligible for independent living services, conduct a face-to face interview with the client in their home to assess the personal care needs. Complete the comprehensive assessment (DHS-324) which is generated from the Adult Services Comprehensive Assessment Program (ASCAP).
>
> **SERVICE PLAN** Develop a service plan with the client and/or the client's representative. Determine the method of service delivery and any use of home help services with other types of services to meet the assessed needs of the client.
>
> The ILS service plan is developed whenever an issue is identified in the comprehensive assessment.
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> ***Michigan Department of Human Services, Independent Living Services Program Requirements, Adult Services Manual (ASM) 362, pages 3 of 4 Adult Services Bulletin (ASB 2007-003); 6-1-2007***
>
> **CONTACTS** The worker must, at a minimum, have a face to face interview with the client **and** care provider, prior to case opening, then every six months, in the client's home, at review and re-determination.
>
> **TERMINATION OF HHS PAYMENTS** Suspend and/or terminate payments for HHS in **any** of the following circumstances:
>
> • The client fails to meet any of the eligibility requirements.
> • The client no longer wishes to receive HHS.
> • The client's provider fails to meet qualification criteria.

When HHS are terminated or reduced for any reason, send a DHS-1212 to the client advising of the negative action and explaining the reason. Continue the payment during the negative action period. Following the negative action period, complete a payment authorization on ASCAP to terminate payments.

If the client requests a hearing before the effective date of the negative action, continue the payment until a hearing decision has been made. If the hearing decision upholds the negative action, complete the payment authorization on ASCAP to terminate payments effective the date of the original negative action. See Program Administrative Manual (PAM) 600 regarding interim benefits pending hearings and Services Requirements Manual (SRM) 181, Recoupment regarding following upheld hearing decisions.

REINSTATEMENT OF HHS PAYMENTS When HHS payments have been terminated and subsequently reopened within 90 days, they may be reinstated without completing a new DHS-390 if the client meets eligibility criteria.

Home Help Payment Services

Home help services (HHS, or personal care services) are non-specialized personal care service activities provided under ILS to persons who meet eligibility requirements.

HHS is 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.

Personal care services which are eligible for Title XIX funding are limited to:

Activities of Daily Living (ADL)
- Eating.
- Toileting.
- Bathing.
- Grooming.
- Dressing.
- Transferring.
- Mobility.

Instrumental Activities of Daily Living (IADL)
- Taking medication.
- Meal preparation/cleanup.
- Shopping for food and other necessities of daily living.
- Laundry.
- Housework.

Expanded Home Help Services (EHHS) can be authorized for individuals who have severe functional limitations which require such extensive care that the services cannot be purchased within the maximum monthly payment rate.

BEST PRACTICE PRINCIPLES Independent living services will adhere to the following principles:

- Case planning will be person-centered and strength-based.
- Clients will be given a wide range of options to enable informed decision making.
- Client choice will be encouraged and respected; choices will be balanced with safety and security needs.
- All ILS clients will become self-advocates and will participate in case planning.
- Monitor client satisfaction by actively involving clients in evaluating the quality of services delivered to them.
- Monitor service delivered by caregivers to ensure client needs are properly met.
- Monitor caseloads to ensure consistency of service delivery.
- Service plans will be built on the principle of continuous quality improvement.
- Services should be least intrusive, least disruptive and least restrictive.
- Services must recognize the role of the family, directing resources toward the family in their role as caregiver. **However**, if the interest of the family and the client compete, the client's interest is primary.
- A broad range of social work practices will be employed, focused on person-centered services planning.

Michigan Department of Human Services, Independent Living Services Overview, Adult Services Manual (ASM) 361, pages 3 and 4 of 5
Adult Services Bulletin (ASB) 2007-003; 6-1-2007

PROGRAM GOALS Independent living services are directed toward the following goals:

- To encourage and support the client's right and responsibility to make informed choices.
- To ensure the necessary supports are offered to assist client to live independently and with dignity.
- To recognize and encourage the client's natural support system.
- To ensure flexibility in service planning, respecting the client's right to determine what services are necessary.
- To provide the necessary tools to enable client self-advocacy.

Client Service Supports: as a client's functionality declines, progressively increased service supports will be offered to enable living in the least restrictive setting.

Client Satisfaction: all clients will express satisfaction with quality of life and services received through the Independent Living Services Program.

Michigan Department of Human Services, Independent Living Services Overview, Adult Services Manual (ASM) 361, page 5 of 5 Adult Services Bulletin (ASB) 2007-003; 6-1-2007

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.

Michigan Department of Human Services, Independent Living Services Procedures, Adult Services Manual (ASM) 363, page2 of 23 Adult Services Bulletin (ASB) 2007-003; 6-1-2007

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.

Michigan Department of Human Services, Independent Living Services Procedures, Adult Services Manual (ASM) 363, page 2 and 3 of 23 Adult Services Bulletin (ASB) 2007-003; 6-1-2007

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).

Michigan Department of Human Services, Independent Living Services Procedures, Adult Services Manual (ASM) 363, pages 4 and 5 of 23 Adult Services Bulletin (ASB) 2007-003; 6-1-2007

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.*

(Emphasis supplied by ALJ)

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.

Michigan Department of Human Services, Independent Living Services Procedures, Adult Services Manual (ASM) 363, pages 8 and 9 of 23 Adult Services Bulletin (ASB) 2007-003; 6-1-2007

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;

- Home delivered meals;
- Adult day care.

Michigan Department of Human Services, Independent Living Services Procedures, Adult Services Manual (ASM) 363, page 14 of 23 Adult Services Bulletin (ASB) 2007-003; 6-1-2007

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).

Proof by a preponderance of the evidence requires that the fact finder believe that the evidence supporting the existence of the contested fact outweighs the evidence supporting its nonexistence. See, e.g., *Martucci v Detroit Police Comm'r*, 322 Mich 270, 274; 33 NW2d 789 (1948).

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).

It is the province of the Administrative Law Judge to adjudge the credibility and weight to be afforded the evidence presented. *Maloy v. Stuttgart Memorial Hosp.*, 316 Ark. 447, 872 S.W.2d 401 (1994).

The Appellant claims she sent DHS both her application for Home Help Services, and the medical needs form, but did not make copies of either document. She failed to present any proof she had done so.

Current policy is clear. Home Help Services cannot be approved unless a physician or other health care provider certifies a need for such services, and a written application for services is filed with the DHS office located in the county in which the beneficiary resides.

According to a preponderance of evidence presented, neither the application for services, nor a medical needs form was filed with or received by the DHS office, rendering appropriate its decision denying services.

DECISION AND ORDER

Based on the above findings of fact and conclusions of law, I decide that DHS' denial 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

cc: [redacted]

Date Mailed: 5/26/2009

***** 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.