

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:

██████████

Appellant

_____ /

Docket No. 2009-34373 HHS
Case 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.*, following the Appellant's request for a hearing.

After due notice, a hearing was held on ██████████. ██████████ (Appellant) appeared and testified on her own behalf.

██████████ Appeals Review Officer, represented the Department of Community Health. Also appearing as witnesses for the Department was ██████████ Adult Services Worker, ██████████

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 a Medicaid beneficiary with physician-verified diagnoses of Tenosynovitis and arthritis of the back. She also has a history of right rotator cuff repair. (*Exhibit 1; p. 12*)
2. On ██████████, the adult services worker sent the Appellant a Services Negative Action Notice informing her that home help services would be terminated based on a recent re-assessment of her home help service needs, and a new medical needs form received from the Appellant's physician.

3. Prior to the re-assessment, the Appellant was receiving assistance with bathing, housework, laundry and shopping. On [REDACTED], the adult services worker conducted the re-assessment during which time she observed the Appellant to be moving around her residence freely with no mobility issues.
4. The chore provider was not present during the [REDACTED] re-assessment. Therefore, on [REDACTED], the adult services worker's supervisor interviewed the provider. During the interview, the provider provided vague responses to the supervisor, which led the supervisor to believe the chore services were not being provided. For example, the provider told the supervisor that she "occasionally" assisted the Appellant, if she was otherwise not well enough to do for herself. The provider also indicated that the Appellant was otherwise capable of caring for her own needs. (*Exhibit 1; p. 10*)
5. During the [REDACTED] re-assessment, the Appellant was dressed, groomed and appeared to be functioning independently in her home. When questioned about tasks with which she needed assistance, the Appellant provided vague responses, other than to indicate that she has good and bad days and that sometimes she simply "shuts down" from pain. (*Exhibit 1; p. 10*)
6. 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).

*STATE OF MICHIGAN
ADULT SERVICES MANUAL (ASM) 363; PAGES 3 through 9 of 24
INDEPENDENT LIVING SERVICES PROGRAM PROCEDURES
DEPARTMENT OF HUMAN SERVICES
ASB 2008-002
9-1-2008*

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).

[REDACTED]
Docket No. 2009-34373 HHS
Decision and Order

The Appellant testified only that she never knows when she will have good and bad days. She also indicated she suffers from stiffness in her arms and legs and, at times, has difficulty climbing stairs or attending to other personal care tasks.

While it appears that the Appellant's medical conditions may justify assistance on bad days, policy is clear. Medicaid policy provides for adult home help services when a beneficiary's medical condition(s) require care on a permanent basis, and at the level 3 or higher. The Appellant bears the burden of proof, and has failed to carry that burden in this proceeding.

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

cc:

[REDACTED]

Date Mailed: 11/18/2009

***** 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.