STATE OF MICHIGAN
STATE OFFICE OF ADMINISTRATIVE HEARINGS AND RULES
FOR THE DEPARTMENT OF COMMUNITY HEALTH
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IN THE MATTER OF:

[redacted],

Appellant
_____/

Docket No. 2010-20580 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.*, upon the Appellant's request for a hearing.

After due notice, a hearing was held on [redacted]. Ms [redacted], mother and chore provider, appeared on the Appellant's behalf. Ms. [redacted], Appeals Review Officer, represented the Department. Ms [redacted], Adult Services Worker, and [redacted], Registered Nurse DCH Home Help Services Program, appeared as witnesses for the Department.

ISSUE

Did the Department properly reduce Home Help Services payments to the Appellant?

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 Medicaid beneficiary.

2. The Appellant is a [redacted] man who has been diagnosed with a spinal cord injury, C-5 quadriplegia. (Exhibit 1, pages 16 and 29)

3. The Appellant is ranked as a level 5 for all activities of daily living and instrumental activities of daily living except respiration, which is ranked at level 1. (Exhibit 1, page 14)

4. On [redacted], a DHS Adult Services Worker (worker) made a visit to the Appellant's home to conduct a Home Help Services assessment. (Exhibit 1, page 11)

5. On [redacted], the worker requested approval for the Appellant's case from the Department of Community Health (DCH) central office noting the tasks had not changed in [redacted] years and the HHS hours have remained the same since [redacted]. (Exhibit 1, page 28)

6. The worker submitted a request for approval of a monthly payment of $[redacted] for approximately [redacted] hours of care. (Exhibit 1, pages 21 and 28)

7. On [redacted], the RN recommended revisions to the time and task schedule resulting in a decreased monthly payment of $[redacted] for [redacted] hours and [redacted] minutes of care. The RN noted that additional information would have answered many of the questions needed to judge the hours needed for each task and requested that if there was additional documentation it should be forwarded to her office within a week. (Exhibit 1, pages 19-20 and 23-26)

8. On [redacted], the Department sent an Advance Negative Action Notice notifying the Appellant that his Home Help Services payments would be reduced to $[redacted] per month, effective [redacted]. (Exhibit 1, pages 8-10)

9. On [redacted], the State Office of Administrative Hearings and Rules received an unsigned Request for Hearing from the Appellant. On [redacted], the Appellant's signed hearing request was received. (Exhibit 1, pages 4-7)

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 Social Welfare Act, 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.

Program requirements are set forth in Adult Services Manual item 362, below:

> **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.
>
> **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 redetermination.
>
> Adult Services Manual (ASM 362) 12-1-2007, Page 3 of 5

Adult Services Manual item 363 addresses program procedures:

> **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 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 redetermination.
- 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.

IADL Maximum Allowable Hours

There are monthly maximum hour limits on all IADLs except medication. The limits are as follows:

- 5 hours/month for shopping
- 6 hours/month for light housework
- 7 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.

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).

REVIEWS

ILS cases must be reviewed every six months. A face-to-face contact is required with the client, in the home. If applicable, the interview must also include the caregiver.

Six Month Review

Requirements for the review contact must include:

- A review of the current comprehensive assessment and service plan.

- A reevaluation of the client's Medicaid eligibility, if home help services are being paid.
- Follow-up collateral contacts with significant others to assess their role in the case plan.
- Review of client satisfaction with the delivery of planned services.

Adult Services Manual (ASM 363) 9-1-2008, Pages 2-6 of 24

The Appellant's case was sent to the central office for review on [redacted]. (Exhibit 1, page 28) In her [redacted] review, the RN noted that the tool to assist with assessing both regular and complex care tasks was not utilized and would have answered many of the questions required to judge the hours needed for each task. (Exhibit 1, page, 25) However, it does not appear that the RN requested additional information to review the case. Instead, she issued recommendations to revise the Appellant's time and task for the worker to review. If the worker had additional documentation to justify additional HHS hours, it was to be forwarded to the RN's office within a week. Otherwise the worker was to implement the revisions to the time and task. (Exhibit 1, page 26) There is no evidence that the worker gathered and submitted additional information to the RN for further review. Instead, the worker proceeded with revising the Appellant's times and task schedule and issued the [redacted] Advance Negative Action Notice.

The times and tasks, as revised by the RN, do not appear to be based upon a comprehensive assessment of the Appellant's needs. For example, the RN eliminated HHS hours for toileting because the Appellant was receiving HHS hours for catheters or leg bags and a bowel program. The elimination of toileting hours was appropriate since HHS hours were being authorized for catheters and the bowel program. However, the times authorized for catheters and the bowel program were not based upon any information specific to this Appellant. The RN recommended [redacted] minutes per day if the Appellant has a catheter in place or [redacted] minutes per day for intermittent catheters to allow for catheterization [redacted] times per day. (Exhibit 1, page 26) The worker revised the time for catheters to [redacted] minutes per day as was recommended for an in place catheter. According to the Appellant's hearing request, intermittent catheters are used [redacted] times per day. (Exhibit 1, pages 5 and 19) The RN testified that no information was available for review of the bowel program so she recommended [redacted] minutes [redacted] days per week as the submitted request for HHS hours for this task indicated [redacted] days per week and this can be normal for some individuals with a spinal cord injury. (See also Exhibit 1, page 26) The Appellant's hearing request indicates that his bowel program is seven days per week. (Exhibit 1, page 5) Regarding the recommendation to only allow HHS hours for repositioning overnight, this can not be supported without information addressing how mobile the Appellant is during the day. The Appellant may require repositioning during the daytime to prevent further skin breakdown unless his daily activities do allow for sufficient transferring or repositioning. Additionally, the RN decreased the HHS hours for transferring by half despite her testimony that she was not clear what type of lift is being used.

Other discrepancies indicate that the way HHS hours are assigned for tasks has not been discussed with the Appellant and chore provider. Dressing and bathing are two separate tasks for which HHS hours can be assigned. However, the Appellant includes dressing time in the discussion of bathing in his hearing request. The Appellant discusses wound care under the category of specialized skin care in his hearing request. The RN only authorized time for turning the Appellant overnight under the task of specialized skin care. (Exhibit 1, pages 5 and 26) Information that the Appellant has pressure sores requiring daily treatment should have been obtained so that HHS hours for wound care could be authorized as this is another complex care task category.

Further, it does not appear that the Department policies regarding proration, and the maximum allowable hours for the tasks of housework, laundry, shopping and meal preparation have been explained to the Appellant based on the discussion of these tasks in his hearing request. However, this ALJ notes that if there was documentation to support an exception, Department policy would allow for a request for expanded hours for these tasks. (Exhibit 1, pages 4-6, 39-41 and 43-44)

Overall, this ALJ is concerned because the information the RN based her revisions on was incomplete. Based on the submitted evidence, the Department failed to conduct a complete case review, including reviewing the comprehensive assessment and service plan review with the Appellant and chore provider. The worker did not obtain and submit documentation to support the requested HHS hours. The RN proceeded with revising the assigned times and tasks without requesting the additional information she noted was missing from the worker's submission. The Department shall complete a new comprehensive assessment, discussing the Appellant's care needs for each task and obtaining the necessary additional documentation to ensure that the authorized HHS hours are appropriate.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, finds that the Department improperly reduced Home Help Services payments to the Appellant.

IT IS THEREFORE ORDERED THAT:

> The Department's decision is REVERSED. The Department is hereby ordered to reinstate the Appellant's HHS payments to the amount authorized prior to the [redacted] Advance Negative Action Notice.

Furthermore, the Department is ordered to conduct a new comprehensive assessment of the Appellant's abilities and assistance needs for each task and obtain the necessary additional documentation to ensure that the authorized HHS hours are appropriate

Colleen Lack
Administrative Law Judge
for Janet Olszewski, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 5/28/2010

***** NOTICE *****

The State Office of Administrative Hearings and Rules March 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 March 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.