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. 2010-38600 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]. The Appellant, [redacted], was present. The Appellant's daughter, [redacted], served as the Appellant's representative and translator. [redacted], Appeals Review Officer, represented the Department. [redacted] Adult Services Worker (worker), and [redacted] Adult Services Supervisor, were present as Department witnesses.

ISSUE

Did the Department properly deny the Appellant's Home Help Services (HHS) application?

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 who applied for HHS from the Department of Human Services. (Exhibit 1, page 4; Testimony of Sharpe)

2. The Appellant is [redacted] and suffers from neck pain, arthritis, hypertension, and diabetes. (Exhibit 1, pages 8-9)

3. On [redacted], the Appellant's physician certified on a DHS 54-A medical needs form that the Appellant requires assistance with the

following tasks: transferring, taking medications, meal preparation, shopping, laundry, and housework. (Exhibit 1, page 9)

4. The worker conducted an initial in-home assessment with the Appellant and her daughter on April 26, 2010. (Exhibit 1, page8; Testimony of Sharpe)

5. At the assessment, the worker was able to observe the Appellant use both her hands and legs without difficulty. Indeed, the Appellant was able to walk and stand up from a seated position without any assistance. However, due to a language barrier—the Appellant speaks little, if any, English—the worker was not able to obtain all of the needed information. (Exhibit 1, page 8; Testimony of Sharpe)

6. After the assessment, the worker contacted the Appellant's treating physician to determine why he certified a need for services. At that time, contrary to the medical needs form, the physician advised that the Appellant is fully functional, but she needs assistance with transportation to her appointments, which he assumed was the equivalent of transferring. (Testimony of Sharpe)

7. Based on the Appellant's age and diagnoses, the information gathered from the assessment and the Appellant's physician, and her own observations of the Appellant, the worker determined that the Appellant did not need HHS. (Testimony of Sharpe)

8. On [redacted], the worker sent a Negative Action Notice denying the HHS application. (Exhibit 1, page 5-7)

9. The Appellant requested a formal, administrative hearing [redacted]. (Exhibit 1, page 3)

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.

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.

Adult Services Manual (ASM) 9-1-2008

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.

Adult Services Manual (ASM 363) 9-1-2008, pages 2-5 of 24 addresses the issue of assessment:

> **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.

- 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).

Adult Services Manual (ASM 363) 9-1-2008, Pages 2-5 of 24

The worker testified that at the in-home assessment on [redacted], she observed the Appellant use her hands and legs without difficulty. She stated that the Appellant was able to walk around and rise from a seated position on the couch without any assistance. She acknowledged that there was a language barrier, so she was unable to obtain all of the information that she needed. But based on the Appellant's age, and her own observations of the Appellant, she did not believe that the Appellant was in need of HHS.

The worker further testified that after the assessment, she contacted the Appellant's treating physician to determine why he certified a need for HHS. She stated that the physician advised that the Appellant is functional and that she needs assistance with transportation to her appointments. Apparently, the physician mistakenly believed that transferring was the equivalent of transportation. When asked about the inconsistency between the medical needs form and her conversation with the physician, the worker explained that it happens often—doctors try to do everything they can for their patients.

The Appellant's daughter testified that the Appellant needs HHS because of her back pain. She stated that the Appellant walks very slowly and cannot walk for long distances. The Appellant's daughter testified that the Appellant cannot do laundry, housework, or shopping because of the her back pain. She further stated that the

Appellant is unable to cook for herself, aside from making simple things like tea, because she gets dizzy from her diabetes and hypertension.

The Appellant has the burden of proving, by a preponderance of evidence, that the Department improperly denied her HHS application. The Appellant did not meet that burden. The medical needs form completed by the Appellant's treating physician does not support a diagnosis of back pain, which was cited by the Appellant's daughter as the main reason for her need for HHS. Further, given the inconsistency between the worker's observations of the Appellant and the medical needs form, her telephone call to the Appellant's physician was warranted. And the Appellant's physician's subsequent statement, that the Appellant is fully functional and only needs assistance with transportation to her appointments, supports the denial in this case.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, finds that the Department properly denied the Appellant's application for HHS.

IT IS THEREFORE ORDERED that:

The Department's decision is AFFIRMED.

Kristin M. Heyse
Administrative Law Judge
for Janet Olszewski, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 8/26/2010

***** 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.