**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. 2010-46418 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.*, upon the Appellant's request for a hearing.

After due notice, a hearing was held on . The Appellant appeared without representation. He had no witnesses. , appeals review officer, represented the Department. Her witness was

PRELIMINARY MATTER

Appellant's proposed Exhibit #2, taken under advisement at hearing on objection from the Department, is not admitted for lack of relevance. A copy of that exhibit is returned to the Appellant by U.S. Mail for use in the proper forum. This ALJ has no jurisdiction concerning Medicaid eligibility.

## ISSUE

Did the Department properly establish the Appellant's start date for HHS as

## FINDINGS OF FACT

The Administrative Law Judge, based upon the competent, material and substantial evidence on the whole record, finds as material fact:

1. At the time of hearing, the Appellant is a Medicaid beneficiary.
2. The Appellant is afflicted with arthritis, HIV, high cholesterol, HTN , heart condition, ulcer, sinus and hernia. (Department's Exhibit A, pp. 7, 8)

3. The Appellant disputes the start date of HHS as an inaccurate, albeit unintentional error, which should have reflected the original date of his application to the "Michigan Department of Social Services" of . (*See* Testimony o

4. On , the ASW conducted an opening visit/assessment of Appellant. (Department's Exhibit A, p. 7)

5. The ASW found the Appellant eligible for HHS and recommended payment for the certain serves in the amount of per month. Those services are not in dispute. (*See* Testimony and Appellant's Exhibit #1)

6. The , assessment was approved retroactive to . (Department's Exhibit A, pp. 4, 7)

7. On or about the first of , the office suffered a flood and the temporary closing of facilities and services. During this period the Appellant's in home visit was missed through no fault of the parties. (*See* Testimony and E-mail alert dated )

8. The parties missed an earlier face-to-face meeting when the Appellant had to attend an important meeting with his attorney. (*See* Testimony of )

9. The instant request for hearing was received by SOAHR on . (Appellant's Exhibit #1)

**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 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
- 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.

**<u>Necessity For Service</u>**

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. <u>The client is responsible for obtaining the medical certification of need</u>. 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.

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Do not authorize HHS prior to the date of the medical professional signature on the DHS-54A. (Emphasis supplied)

Adult Service Manual (ASM), §363,
pp. 2, 3, 9 of 24, 9-1-2008.

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The Department witness testified that the Appellant's HHS services were approved and mirrored the recommendation of his physican [on submission of DHS54A which was received on or about ] and his face-to-face assessment.

The Appellant testified that on application and approval for Medicaid a DHS representative ] told him he could hire an aide to assist him at home. However, according to he was never informed of the need to contact for HHS assessment - until several weeks had lapsed.

Once the Appellant was before the HHS program – there were some missed calls between the parties to which the ALJ assigns no error as unforeseen circumstances worked against both the Appellant and the ASW.

On review, the Department properly assessed the Appellant and awarded him HHS benefits. His award was properly applied - retroactive to . While I found the Appellant to be a credible witness on his own behalf his evidence supported an incorrect or incomplete instruction from DHS personnel on application for Medicaid. Since this Tribunal has no jurisdiction concerning eligibility for Medicaid his remedy – if he has one – is before that body/DHS.

On proof of the need for greater or lesser assistance with HHS the Appellant and the ASW may revisit that initial assessment. However, today the Appellant has failed to preponderate his burden of proof that the Department's start date of HHS was in error.

A comprehensive assessment and the assignment of a start date is the responsibility of the ASW and I find that it was properly measured and applied to this Appellant.

**DECISION AND ORDER**

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the Department properly established Appellant's HHS payment and start date.

**IT IS THEREFORE ORDERED** that:

The Department's decision is AFFIRMED.

Dale Malewska
Administrative Law Judge
for Janet Olszewski, Director
Michigan Department of Community Health

cc:

Date Mailed: 11/4/2010

***** 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.