STATE OF MICHIGAN
STATE OFFICE OF ADMINISTRATIVE HEARINGS AND RULES
FOR THE DEPARTMENT OF COMMUNITY HEALTH
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(877) 833-0870; Fax: (517) 334-9505

IN THE MATTER OF:

[redacted]

Appellant
_____/

Docket No. 2010-51280 HHS
Case No. 90571479

DECISION AND ORDER

This matter is before the undersigned Administrative Law Judge (ALJ) 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 [redacted]. [redacted], [redacted], appeared on the Appellant's behalf. [redacted] appeared and testified. [redacted], appeared as a witness for the Appellant. [redacted], represented the Department. [redacted], appeared as a Department witness.

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 [redacted] Medicaid beneficiary who applied for Home Help Services.

2. The Appellant has been diagnosed with COPD, hypertension, insomnia, depression, and chronic right elbow pain with deformity. (Exhibit 1, pages 11-12; Exhibit 3)

3. On [redacted], a resident treating the Appellant completed a DHS 54-A Medical Needs Form certifying a medical need for assistance with personal care activities. The resident did not mark any specific personal

care activities and the Medical Needs Form was also signed by the attending physician. (Exhibit 1, page 11; Exhibit 2)

4. On [redacted], the Department received an altered copy of the [redacted] DHS 54-A Medical Needs Form. (Exhibit 1, page 12)

5. On [redacted] an Adult Services Worker (ASW) made a visit to the Appellant's home to conduct a Home Help Services assessment. (Exhibit 1, page 9)

6. On [redacted], the ASW spoke with a nurse at the Appellant's doctor's office, [redacted]. The nurse faxed the ASW the copy of the [redacted] DHS 54-A Medical Needs Form they had on file. (Exhibit 1, pages 8 and 11; Exhibit 2)

7. On [redacted], the Department sent an Adequate Negative Action Notice to the Appellant indicating that her Home Help Services application was denied based on the diagnosed medical needs, completed Medical 54-A form(s), conversation with [redacted], and the face to face home assessment. (Exhibit 1, pages 5-7)

8. On [redacted], a different resident saw the Appellant and amended the DHS 54-A Medical Needs Form completed [redacted]. This resident indicated that the Appellant has a medical need for assistance with grooming, dressing, meal preparation, and housework. The amendments were also signed by the attending physician. (Exhibits 2 and 3)

9. The Appellant requested a formal, administrative hearing contesting the denial on [redacted]. (Exhibit 1, pages 3-4)

10. The Appellant has subsequently re-applied and been approved for the HHS program. (Uncontested)

11. The Appellant lives with [redacted]. This [redacted] is the Appellant's chore provider. (Appellant Testimony)

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.
Adult Services Manual (ASM 363, 9-1-08), 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**
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> 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).

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:

- o Physician.
- o Nurse practitioner.
- o Occupational therapist.
- o 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.

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.

Adult Services Manual (ASM) 363,
9-1-2008, Pages 2-15 of 24

The Adult Services Worker (ASW) who processed the Home Help Services (HHS) application at issue in this case has retired. The Appellant presented evidence that indicates the retired ASW's case notes are not accurate. Specifically an affidavit from the nurse the retired ASW spoke to on [redacted] and the Appellant's testimony regarding the [redacted] home visit. (Exhibit 2) While it is still unclear who altered the Medical Needs Form received by the Department on [redacted] the original unaltered copy faxed from the Appellant's doctors office did certify a medical need for assistance with personal care activities. (Exhibit 1, page 11) This need was re-certified on [redacted] and four specific activities were marked, grooming, dressing, meal preparation, and housework. (Exhibit 3)

The Appellant's testimony indicated she is not totally dependant on others for tasks, but does need some hands on assistance. The Appellant has limited use of her left arm and gets short of breath. She explained that she can dress herself, but she wears big shirts because it is hard to put a shirt on overhead. The Appellant can not do her own hair, but can take her own medication if the tops are not on. The Appellant lives with her [redacted], who has been providing the needed assistance to the Appellant. It is uncontested that the Appellant's subsequent HHS application was approved, and that the Appellant's [redacted] has been enrolled as the chore provider.

The evidence does not support the retired ASW's denial of the Appellant's HHS application. HHS hours will be authorized for the four activities indicated by the Appellant's physician on the [redacted] Medical Needs Form, grooming, dressing, meal preparation, and housework as appropriate for a functional ranking at level 3, and the household composition. The current ASW was unable to determine the date of the application at issue. Department policy states that HHS hours can not be authorized prior to the date of the medical professional signature on the Medical Needs Form. (Adult Services Manual (ASM) 363, 9-1-2008, Page 9 of 24) Therefore, this authorization of HHS hours for these four activities will be retroactive to [redacted] the physician's signature date on the original Medical Needs Form certifying that the Appellant has a medical need for assistance with personal care activities.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, finds the Department did not properly deny the Appellant's Home Help Services application based on the available information.

IT IS THEREFORE ORDERED that:

The Department's decision is REVERSED. HHS hours shall be authorized retroactive to [redacted] for the activities of grooming, dressing, meal preparation, and housework as appropriate for a functional level of 3 and the Appellant's household composition.

Colleen Lack
Administrative Law Judge
for Olga Dazzo, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 1/28/2011

***** 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.