STATE OF MICHIGAN
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
FOR THE DEPARTMENT OF COMMUNITY HEALTH
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IN THE MATTER OF:

[redacted],

Docket No. 2011-42119 HHS
Case No. 89155199

Appellant.
_____/

DECISION AND ORDER

This matter is before the undersigned Administrative Law Judge (ALJ), pursuant to M.C.L. § 400.9 and 42 C.F.R. § 431.200 *et seq.*, upon the Appellant's request for a hearing.

After due notice, a hearing was held on [redacted]. [redacted], Appellant's chore provider, appeared and testified on her behalf. Appellant also testified on her own behalf. [redacted], Appeals Review Officer, represented the Department of Community Health. [redacted], Adult Services Supervisor, and [redacted], Adult Services Worker (ASW), from the [redacted] County-District [redacted] DHS Office appeared as witnesses for the Department.

ISSUE

Did the Department properly deny Home Help Services (HHS) payments for the period of [redacted] to [redacted]?

FINDINGS OF FACT

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

1. Appellant is a [redacted] year-old Medicaid beneficiary.

2. Appellant has been diagnosed by a physician with hypertension, osteoarthritis, a total right knee replacement, and degenerative disc disease. (Exhibit 1, page 11).

3. On [redacted], Appellant was referred to the Department for HHS. (Exhibit 1, page 13).

4. On [redacted], the Department sent Appellant an ILS Intro Letter. (Exhibit 1, page 5; Testimony of ASW [redacted]).

5. On [redacted], ASW [redacted], the worker assigned to Appellant's case, sent Appellant a Home Visit Letter. However, that visit never took place. According to the Department's records, the home visit never took place because, on [redacted], Appellant called in and asked that the home visit be rescheduled. (Exhibit 1, page 5). According to Appellant's representative, the home visit was erroneously scheduled for a Saturday and no worker from the Department showed up. (Testimony of [redacted].

6. ASW [redacted] retired in [redacted]. However, Appellant's case was not immediately reassigned and the home visit was not promptly rescheduled. (Testimony of AS Supervisor [redacted]).

7. Appellant's representative testified that, over the next few months, he provided Appellant with care services and frequently called in about her application. (Testimony of [redacted]). AS Supervisor [redacted] testified that she spoke with [redacted] during that time period, but she does not recall which of his clients was discussed. (Testimony of AS Supervisor [redacted]).

8. On [redacted], Appellant's case was reassigned to ASW [redacted]. (Exhibit 1, pages 5, 10).

9. ASW [redacted] called Appellant that same day and scheduled a home visit. (Exhibit 1, pages 5, 10).

10. On [redacted], ASW [redacted] conducted a home visit. Appellant, her son, and a representative from Unlimited Home Care were present during the visit. (Exhibit 1, page 10).

11. On [redacted], ASW [redacted] sent Appellant a Services Payment and Approval Notice. That notice stated that Appellant had been approved for payments of $[redacted] per month. The start date for the payments was identified as January 6, 2011. (Exhibit 1, pages 7-8).

12. According to Appellant's representative, however, ASW [redacted] previously told him that payments would go back to [redacted]. (Testimony of [redacted]).

13. On [redacted], the Department received Appellant's Request for Hearing. In that request, Appellant seeks back payments for the services her provider has not been paid for. (Exhibit 1, page 4).

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 agencies.

Adult Services Manual 363 (9-1-08) (hereinafter "ASM 363") addresses how HHS payments are assessed and authorized:

> **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 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.

(ASM 363, pages 2-3 of 24)

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 no duplicative (same service for same time period).

Good Practices

Service plan development practices will include the use of the following skills:

- **Listen actively** to the client.

- Encourage clients to **explore options** and select the appropriate services and supports.

- Monitor for **congruency** between case assessment and service plan.

- Provide the necessary supports to **assist** clients **in applying for resources**.

- Continually **reassess** case planning.

- Enhance/preserve the client's **quality of life**.

- **Monitor and document** the status of all **referrals** to waiver programs and other community resources **to ensure quality outcomes**.

(ASM 363, pages 4-6 of 24)

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.

(ASM 363, page 9 of 24)

PAYMENT AUTHORIZATION

Payment Authorization System

Enter home help provider enrollments and payment authorizations on the Model Payment System (MPS) using the Payments module of the ASCAP system.

No payment can be made unless the provider has been enrolled on the MPS provider database. See the ASCAP user guide on the adult services home page.

HHS payments to providers must be:

- Authorized for a specific type of service, period of time and payment amount.
- Authorized to the person actually providing the service.
- Made payable jointly to the client and the provider.

Any payment authorization that does not meet the above criteria must have the reason fully documented in the Payments module, exception rationale box, in ASCAP. The supervisor will document through the electronic approval process.

(ASM 363, pages 19-20 of 24)

In this case, while the Department promptly responded to the initial referral and quickly acted after the case was reassigned to ASW [redacted], Appellant's application did languish for months after ASW [redacted] retirement. Therefore, through no fault of Appellant's, her needs and HHS were not assessed until [redacted]. However, while the Department may have been inattentive in responding to Appellant application for a few months, it did authorize payments starting on [redacted] and its decision not to award payments for any additional services provided between [redacted] and [redacted] must be affirmed.

As a preliminary matter, this Administrative Law Judge would note that it is not clear what specific services were performed during the time period in question. [redacted] just generally testified that Appellant's provider took care of Appellant and he could not say how many total hours were worked. (Testimony of [redacted]). Additionally, [redacted] acknowledged that no provider logs were kept during the disputed time period. (Testimony of [redacted]). That lack of specific testimony makes the calculation of payment for past services impossible and precludes any award of back payments.

[redacted] did testify that, regardless of the services were actually performed during the disputed time period, he would be willing to settle for the monthly hours of HHS that were eventually authorized. (Testimony of [redacted]). However, the provider is only entitled to payment for assistance actually performed and there is simply no basis for authorizing such a payment here.

Even if the amount of past services could be determined, this Administrative Law Judge cannot award payments for them in this case. HHS payments to providers must be authorized for a specific type of service, period of time and payment amount, ASM 363, pages 19-20 of 24, but no such specific authorization was made in this case for the disputed time period. Similarly, with respect to the disputed time period, there was no functional assessment conducted in order to determine the client's ability to perform the identified activities, ASM 363, pages 2-4 of 24, or service plan developed to address the specific services to be provided, by whom and at what cost, ASM 363, pages 4-6 of 24. All of those things have to happen before HHS payments can be made. Appellant's representative testified that ASW [redacted] promised him that payments would go back to [redacted], but he could provide no proof of such a promise (Testimony of [redacted]) and such a promise would go against policy.

Appellant's application, and the documents she submitted along with that application, was necessary and an important step in the process, but the ASW is responsible for determining the necessity and level of need for HHS based on a number of factors, ASM 363, page 9 of 24. Here, ASW [redacted] did not make that determination or any other assessment of Appellant's specific needs until [redacted]. The Department cannot make payments for services made prior to that assessment date.

This Administrative Law Judge does not possess equitable powers and, therefore, cannot award benefits or payments as a matter of fairness. Certain criteria have to be met and specific events have to occur before HHS payments can be authorized. The assessment process was not completed in this case until [redacted] and, consequently, any prior services provided between [redacted] and [redacted], were unauthorized and the Department cannot pay for them.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the Department properly denied back payments for Home Help Services.

IT IS THEREFORE ORDERED THAT:

The Department's decision is AFFIRMED.

Steven Kibit
Administrative Law Judge
for Olga Dazzo, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 9/8/2011

***** NOTICE *****

The Michigan Administrative Hearing System 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 Michigan Administrative Hearing System 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.