STATE OF MICHIGAN
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
FOR THE DEPARTMENT OF COMMUNITY HEALTH
P.O. Box 30763, Lansing, MI 48909
(877) 833-0870; Fax: (517) 334-9505

IN THE MATTER OF:

[redacted],

Docket No. 2011-43240 HHS
Case No. 67934950

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] from the Welfare Rights Organization of [redacted] County appeared and testified on Appellant's behalf. [redacted], Appellant's chore provider, and [redacted], a social worker from North Oakland Home Health Care, Inc., also testified on Appellant's behalf. [redacted], Appeals Review Officer, represented the Department of Community Health. [redacted], Services Program Manager, and [redacted], Adult Services Specialist, from the [redacted] County HHS 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. (Exhibit 1, page 10).

2. Appellant has been diagnosed by a physician with hyperthyroidism, degenerative joint disease, and hypertension. Appellant also reported to the Department that she suffered a hip fracture in the past. (Exhibit 1, page 13).

3. According to [redacted] testimony and notes, she referred Appellant to the Department for HHS on [redacted]. [redacted] also testified that she referred Appellant's case by telephoning the Department and leaving

a message on its general voicemail. (Exhibit 2, page 2; Testimony of [redacted]).

4. The Department has no record of the message and Appellant never received a response with respect to that referral. (Testimony of [redacted]; Testimony of [redacted]).

5. On [redacted], chore provider [redacted] telephoned [redacted], an Adult Services Worker (ASW) and referred Appellant for HHS. (Exhibit 1, page 11; Testimony of [redacted]). [redacted] testified that she called ASW [redacted] because she knew ASW [redacted] from working with other clients and Appellant had never heard back from the Department. (Testimony of [redacted]).

6. According to the Department's records, Appellant's case was first referred on that day. (Exhibit 1, page 11).

7. The DHS 54-A Medical Needs Form Appellant subsequently submitted as part of her application for HHS was signed by Appellant's doctor on [redacted]. (Exhibit 1, page 13; Testimony of [redacted]).

8. On [redacted], ASW [redacted] conducted a home visit. Appellant and [redacted] were present during the visit. (Exhibit 1, page 10; Testimony of [redacted]).

9. On [redacted], the Department 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 [redacted]. (Exhibit 1, pages 6-7).

10. On [redacted], the Department sent Appellant another Services Payment and Approval Notice. That notice changed the start date for the payments to [redacted]. (Exhibit 1, pages 8-9). [redacted] testified that she made that change in an effort to placate Appellant and, in doing so, that she violated policy by approving payments prior to the date of the medical professional's signature on the medical needs form. (Testimony o[redacted]).

11. On [redacted], the Department received Appellant's Request for Hearing. In that request, Appellant seeks back payments for services her provider has not been paid for. (Exhibit 1, pages 4-5).

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 362 (12-1-07) (hereinafter "ASM 362") and Adult Services Manual 363 (9-1-08) (hereinafter "ASM 363") address how HHS payments are assessed and authorized:

> **Home Help Services (HHS)**
>
> Payment related independent living services are available if the client meets HHS eligibility requirements. Clients who may have a need for HHS should be assisted in applying for Medicaid (MA). Refer the client to an eligibility specialist. Cases pending MA determination may be opened to program 9 (ILS). HHS eligibility requirements include all of the following:
>
> ***
>
> - Medical Needs (DHS-54-A) form signed and dated by a medical professional certifying a medical need for personal care services. The medical professional must be an enrolled Medicaid provider and hold one of the following professional licenses:
>
>   •• Physician.
>   •• Nurse practitioner.
>   •• Occupational therapist.
>   •• Physical therapist.
>
> (ASM 362, page 2 of 5)
>
> **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.

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.

(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 Appellant may have been referred for HHS on [redacted], the Department never recorded or responded to the message left by [redacted]. Therefore, nothing was done until chore provider [redacted] contacted ASW [redacted] on [redacted] and the Department recorded the referral. Following that referral, the Department received a completed medical needs form, signed on [redacted], and conducted a home visit on [redacted]. The Department also approved HHS on [redacted] and made that approval retroactive to [redacted].

Appellant now seeks HHS payments for the period of [redacted] to [redacted] on the basis that it was the Department's fault that her referral was not recorded sooner. However, even if the Department delayed the processing of Appellant's referral, 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.

Even if the amount of past services during the disputed time period could be determined, this Administrative Law Judge cannot award payments for them in this case. 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. With respect to the disputed time period, however, 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 should happen before HHS payments can be made. Moreover, 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, ASM 362 and ASM 363 provide that the Department must have verification of medical need from a Medicaid enrolled provider in order to authorize HHS. Specifically, the applicable policy expressly states "Do **not** authorize HHS prior to the date of the medical professional signature on the DHS-54A." ASM 363, page 9 of 24. Here, it is undisputed that Appellant did not provide a signed medical needs form prior to [redacted]. Given the express policy, no payments should have been authorized prior to that date and, by authorizing payments from [redacted], the Department violated policy.

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. Here, the Department went against policy by authorizing payments from [redacted] and, to the extent it did so, it was generous in favor of Appellant. Appellant requests that the Department go even further and authorize even more back payments, but the Department declined to do so and there is no basis for doing so. Accordingly, the Department's decision is affirmed.

[redacted]
Docket No. 2011-43240
Hearing Decision & Order

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: **9/9/2011**

***** 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.