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

[redacted],

Appellant.
_____/

Docket No. 2011-46545 HHS
Case No. 35854166

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], Appellant's daughter and chore provider, appeared and testified on Appellant's behalf. Appellant also testified on her own behalf. [redacted], Appeals Review Officer, represented the Department of Community Health. [redacted], Adult Services Supervisor at the [redacted] County DHS-[redacted] Office, appeared as a witness for the Department. Following the hearing, the record was left open until [redacted], in order to allow the parties to submit additional evidence.

ISSUE

Did the Department properly deny retroactive 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. On [redacted], Appellant was referred to the Department for HHS. (Exhibit 1, page B).

3. According to the Department's records, Appellant's case was never opened because the required forms were not received. (Exhibit 1, page C).

[1] Appellant's HHS case was held in conjunction with another HHS case, Docket No. 2011-39018 HHS. The appellant in that other case was Appellant's husband and it involved the same representative, some of the same evidence, and the same issue over back payments.

4. According to Appellant's representative's testimony, however, Appellant was approved for HHS and Appellant's representative was entered into the Bridges system as a chore provider on [redacted]. (Testimony of [redacted]).

5. Appellant's representative also testified that Appellant never received a denial letter or notice of her hearing rights. (Testimony of [redacted]).

6. Appellant was subsequently referred for HHS again on [redacted]. (Exhibit 1, page D; Testimony of [redacted]).

7. The Department's records provide that Appellant's second application was deemed withdrawn because Appellant did not make herself available for services. (Exhibit 1, page E).

8. According to Appellant's representative, ASW [redacted] conducted a home visit in [redacted] or [redacted]. (Testimony of [redacted]). Appellant's representative also testified that ASW [redacted] informed her that Appellant had been approved for HHS, but no payment ever came. (Testimony of [redacted]).

9. Appellant's representative further testified that, not only did Appellant not receive notice that his application was deemed withdrawn, but she was actually told that she had been approved for HHS. (Testimony of [redacted]).

10. Appellant then applied for HHS for the third time. (Testimony of [redacted]; Exhibit 1, pages E-G). On [redacted], a home visit letter was sent out and ASW [redacted] subsequently conducted a home visit. (Exhibit 1, pages H-I; Testimony of [redacted]).

11. On [redacted], the Department sent Appellant a Services Payment and Approval Notice. That notice stated that Appellant had been approved for HHS. The start date for the payments was identified as [redacted]. (Exhibit 1, pages H-I).

12. On [redacted], the Department received Appellant's Request for Hearing. In that request, Appellant sought back payments for services her provider performed between [redacted] and [redacted]. (Testimony of [redacted]).

13. Following the hearing, Appellant's representative amended the request

[2] ASW [redacted] is no longer with the Department and was unavailable to testify at the hearing. (Testimony o[redacted]).

and now Appellant only seeks payments from [redacted] to [redacted]. (Exhibit 2, page 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 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.

Timeliness of Appeal

Here, the Department first requested a dismissal based on the untimely filing of a hearing request.

The Social Security Act and the federal regulations which implement the Social Security Act require an opportunity for fair hearing to any recipient who believes the Department may have taken an action erroneously. *See* 42 C.F.R. § 431.200 *et seq.* However, the opportunity for fair hearing is limited by a requirement that the request be made within 90 days of the CMH's negative action. 42 C.F.R. § 431.221(d).

The Department argues that Appellant's appeal is based on the [redacted] and [redacted] denials and that, consequently it clearly exceeds the 90 days time to request a fair hearing. However, following the hearing, Appellant's representative amended the dates Appellant is requesting back payments for (Exhibit 2, page 1) and the [redacted] denial is no longer relevant. Moreover, there is simply no evidence suggesting that Appellant was sent a notice of denial on [redacted]. Nor is there any evidence suggesting that Appellant was notified of her right to appeal any denial that did take place on that date.

Appellant's appeal is based on the [redacted] Services and Payment Approval Notice. According to Appellant, the effective start date in that approval is incorrect as Appellant was previously approved for services effective [redacted] following her [redacted] application. Given the absence of any denial of that application or notice of fair hearing rights with respect to any denial, this Administrative Law Judge finds that there is over jurisdiction over Appellant's request for back payments.

Merits of Appeal

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, Appellant's representative seeks retroactive HHS payments for the period of [redacted] to [redacted] on the basis that the Department, through ASW [redacted], approved Appellant for such services. However, as discussed below, Appellant presents insufficient evidence of such an approval and the Department's records fail to reflect any approval prior to [redacted] (effective date [redacted]). Accordingly, the Department's 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 also note that it is not clear what specific services were performed during the time period in question. Appellant's representative just generally testified that she took care of Appellant and she could not say how many total hours were worked. (Testimony of [redacted]). Additionally, Appellant's representative acknowledged that no provider logs were kept during the disputed time period and, despite the fact that she claimed that HHS had been approved, there was no time and task sheet detailing what HHS had been authorized. (Testimony of [redacted]). That lack of specific testimony makes the

calculation of payment for past services impossible and precludes any award of back payments.

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. Appellant's representative testified that past such services were authorized by ASW [redacted], but there is minimal support for such an assertion outside of her testimony. The primary support for Appellant's claim of approval comes from the provider information, which, Appellant's representative testified and the Department does not dispute, identifies Appellant's representative as a provider since [redacted]. (Testimony of [redacted]). According to Adult Services Supervisor [redacted], the start date for Bridges data with respect to providers is one year prior to the start of HHS and Appellant's representative should have only gotten a provider identification number after services were approved. (Testimony of [redacted]).

Despite that provider information, the Department's records clearly provide that the first and only approval for HHS for Appellant occurred on [redacted], with an effective start date of [redacted]. (Exhibit 1, pages H-I). Those records also clearly provide that the approval occurred with respect to Appellant's third application and that his first two applications were denied or deemed withdrawn. (Exhibit 1, pages B-E). Furthermore, the Department has no record of a home visit taking place in [redacted] or [redacted], as claimed by Appellant's representative. (Exhibit 1, pages B-F).

Similarly, while the record was left open following the hearing in order to allow Appellant to gather evidence, Appellant provided no evidence of any approval or home visit except for a home visit letter from ASW [redacted], dated [redacted] and scheduling a home visit on [redacted]. (Exhibit 2, page 2). However, it is undisputed that such a home visit letter was printed and the question is whether the home visit was actually conducted. With respect to that question, the letter submitted by Appellant's representative provides no support for her argument that the visit did take place as she testified that the visit took place in either [redacted] or [redacted] of [redacted], and not as scheduled in that letter. (Testimony of [redacted]). Additionally, Appellant's representative was unable to provide evidence that would support her argument, such as the provider agreement she testified that she signed on that date or an approval notice.

Moreover, 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 is no record of a functional assessment conducted in order to determine the client's ability to perform the identified activities, ASM 363, pages 2-4 of 24, or a 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 provided 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, the referral information for Appellant's third application states that she attached a 54-A form along with her application on [redacted]. (Exhibit 1, page F). Given the express policy discussed above, no payments could have been authorized prior to that date.

This Administrative Law Judge does not possess equitable powers and, therefore, cannot award benefits or payments as a matter of fairness. Moreover, the burden is on the Appellant to demonstrate by a preponderance of the evidence that the Department erred. Here, given the Department's records and the lack of evidence submitted by Appellant, this Administrative Law Judge finds that Appellant failed to meet that burden. Certain criteria have to be met and specific events have to occur before HHS payments can be authorized. In this case, the only evidence regarding that criteria and events demonstrates that the only approval of HHS was the [redacted] approval of Appellant's third application, with an effective start date of [redacted]. Appellant requests that the Department go even further and authorize even more back payments, but the Department declined to do so and Appellant provides no basis for overturning that action. Accordingly, the Department's decision is affirmed.

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.

[redacted]
Administrative Law Judge
for Olga Dazzo, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 9/15/2011

***** 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.