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:

Docket No. 2011-51793 HHS
Case No.

,

Appellant
______________________/

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 , Appellant, appeared and testified. , Appeals Review Officer, represented the Department. , Adult Services Worker, appeared as a witness for the Department.

ISSUE

Did the Department properly terminate the Appellant's Home Help Services (HHS) payments?

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 a year-old Medicaid beneficiary.

2. The Appellant has been diagnosed with Osteoarthritis, pelvis fracture, seizures, multiple orthopedic traumas, and post traumatic arthritis right knee. (Exhibit 1, page 12)

3. The Appellant resides in her home.

4. On , the Appellant's treating physician, M.D. completed a DHS 54-A Medical Needs form. indicated on the form that the Appellant did not have a medical need for HHS.

5. On went to the Appellant's home and completed a face to face assessment. The Appellant's HHS provider, , the Appellant's sister was present. During the assessment the Appellant informed that the Appellant was in an auto accident in and suffered a pelvic fracture. The Appellant also

indicated that she has osteoarthritis in her shoulder, had a seizure disorder and panic attacks. The Appellant was able to walk around on her own unassisted.

6. On [redacted] sent the Appellant an Advance Action Notice which informed the Appellant that effective [redacted], the Appellant's HHS would be terminated because the Appellant did not have a medical need for HHS.

7. On [redacted] the Appellant's treating physician, [redacted] completed a DHS 54-A Medical Needs form. [redacted] indicated on the form that the Appellant had a medical need for HHS.

8. On [redacted], the Michigan Administrative Hearing System received the Appellant's request for hearing.

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

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).

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 evidence presented shows that on , the Appellant's Adult Services Worker, went to the Appellant's home and completed a face to face HHS assessment. The Appellant's sister and HHS provider, was present. During the assessment the Appellant was physically able to ambulate unassisted throughout her home. The Appellant told that she needed assistance with all of her Instrumental Activities of Daily Living (IADLs) due to arthritis in her shoulder.

The evidence also shows that subsequently completed her assessment and determined that the Appellant did not require hands on assistance in any Activity of Daily Living or Instrumental Activity of Daily Living at a ranking of 3 or higher. also reviewed the DHS 54-A submitted by the Appellant's physician. indicated on this form that the Appellant had no medical need for HHS. Based on the information available at that time, concluded that the Appellant no longer had a medical need for HHS. On sent the Appellant an Advance Action Notice which informed the Appellant that her HHS services would be terminated because the Appellant no longer had a medical need for HHS. Subsequently, on , the Appellant submitted a request for hearing and a DHS 54-A dated , from indicated on this form that the Appellant had a medical need for HHS.

The Appellant testified that her HHS was terminated despite the Appellant's continuing medical need for HHS. There is a dispute between the Appellant's treating physicians regarding the Appellant's medical need for HHS. The Appellant testified that is her treating pain management physician while is the Appellant's general practice and long term treating physician. The Appellant testified that she believes that is more familiar with the Appellant's medical condition and opinion should be given greater weight than opinion. It should be noted that Medical Needs form was completed after and not before the Appellant received written notice that her services would be terminated.

The Appellant believes that certification of the Appellant's medical need controls. The medical information provided by and is informative,

but is not controlling. Department policy at ASM 363 provides that a "…medical professional certifies that the client's need for services is related to an existing medical condition. The medical profession does not prescribe or authorize personal care services." See ASM 363, p. 9 of 24. Department policy also provides that "the adult services worker is responsible for determining the necessity and level of need for HHS based on client choice, a completed comprehensive assessment and determination of the client's need for personal care services and verification of the clients medical needs by a Medicaid enrolled medical professional." See ASM 363, p. 9 of 24. If based her decision solely on determination that the Appellant had no medical need for HHS then determination that the Appellant does have a medical need would have more weight and HHS would be required. However, given the conflict between the Appellant's treating physician's opinions, correctly proceeded, and pursuant to DHS policy, completed a face to face comprehensive HHS assessment. opinion regarding the Appellant's need for HHS is only advisory. According to DHS policy the Appellant Adult Services Worker's assessment is controlling.

, the Appellant's Adult Services Worker, testified that on , she completed a comprehensive assessment of the Appellant's need for HHS and determined that the Appellant had no medical need for HHS. testified that when completing the assessment she considered the Appellant's diagnosed medical conditions and related physical limitations and considered the information obtained from the Appellant and her provider. , also during the in home assessment, made observations of the Appellant's ability to ambulate, lift, and carry items, and perform simple tasks. testified that she determined that the Appellant did not require hands on assistance in any ADL or IADL at a ranking of 3 or higher. I agree.

The Appellant testified that she believes that , in her assessment, incorrectly did not consider the Appellant's physical limitations. During the hearing the Appellant was asked to review the list of ADL and IADLs listed on page 13 of the Department's Exhibit and explain which tasks she felt were inadequately considered in the assessment. In response the Appellant provided a very general and vague statement which essentially was that she needed her services. The Appellant did not provide evidence to support her conclusion. The Appellant did not provide credible evidence regarding why she needed additional time for each task considered by Ms. Young. The Appellant testified that she does not agree with the entire assessment because her medical condition and limitations, as documented by her medical records, require more HHS hours in all tasks.

The evidence shows, that despite the Appellant's medical condition, the Appellant failed to submit credible evidence that assessment failed to properly assess the Appellant's medical need for HHS.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, finds that the Department properly determined in its , assessment that

the Appellant did not have a medical need for HHS and properly terminated the Appellant's HHS.

IT IS THEREFORE ORDERED THAT:

The Department's decision is AFFIRMED.

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Martin D. Snider
Administrative Law Judge
for Olga Dazzo, Director
Michigan Department of Community Health

cc:

Date Mailed: __10/18/2011____

***** 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 March 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.