

**STATE OF MICHIGAN
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
FOR THE DEPARTMENT OF COMMUNITY HEALTH**

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IN THE MATTER OF:

Docket No. 2012-21702 HHS
Case No. [REDACTED]

[REDACTED],

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 [REDACTED]. [REDACTED] appeared and testified. [REDACTED], Manager, Appeals Section, represented the Department. [REDACTED], Adult Services Worker, testified for the Department.

ISSUE

Did the Department properly determine the effective date of the Appellant's Home Help Services (HHS)?

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 Medicaid beneficiary who resides with her spouse and two sons in her [REDACTED] home.
2. The Appellant has been diagnosed with syncope, asthma, closed head injury, hypoglycemia, hypertension and spinal stenosis.
3. In [REDACTED], the Appellant submitted an application for HHS to the Department of Human Services (DHS). Subsequently, the application was not processed and the Appellant did not submit the documentation required.
4. A new DHS Adult Services Worker was assigned to the case and the new worker discovered that the DHS data base indicated that the Appellant and her spouse were residing at the same address. The DHS worker sent the Appellant a DHS-54A Medical Needs form and instructed the Appellant that her spouse's physician needed to complete the form to verify if the Appellant's spouse was physically able to provide care to the Appellant.

Docket No. 2012-21702 HHS
Decision and Order

5. On [REDACTED], DHS sent the Appellant an Adequate Action Notice in which she was informed that her pending HHS application was denied.
6. On [REDACTED], DHS sent the Appellant an Adequate Action Notice in which it informed the Appellant that her HHS application had been denied because the Appellant had not provided a DHS-54A Medical Needs form for the Appellant's spouse.
7. On [REDACTED], DHS received a Medical Needs form completed by the Appellant's spouse's physician.
8. On [REDACTED], the Appellant's Adult Services Worker, [REDACTED] approved the Appellant for [REDACTED] per month with an effective date of [REDACTED]. HHS Services were prorated to reflect a shared household.
9. On [REDACTED], the Michigan Administrative Hearing System received the Appellant's request for hearing.
10. The Appellant requested a hearing to contest the [REDACTED], effective date for her approved HHS. The Appellant believes that HHS should have been approved retroactive to [REDACTED], the date of her initial HHS application.

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.

On ██████████, the Appellant's Adult Services Worker, Ms. Williams, approved the Appellant for ██████████ of HHS. On ██████████, the Michigan Administrative Hearing System received the Appellant's request for hearing. The Appellant testified that she appealed the HHS service authorization because she believes that HHS should have been approved effective ██████████.

██████████ testified that after she was assigned to the Appellant's case she reviewed the Appellant's case file and application and discovered that the Appellant and her spouse resided at the same address. ██████████ testified that DHS HHS policy prohibits the authorization of HHS in cases where a responsible relative (which includes a spouse) is available to provide care. ██████████ testified that if her spouse is unable to provide care to the Appellant then HHS could be approved. In response, ██████████ sent the Appellant a DHS-54A Medical Needs form so that the Appellant's physician could indicate on the form whether the Appellant's spouse was capable of providing care to the Appellant. ██████████ testified that she received the completed form on or about ██████████, she reviewed the form and then approved HHS effective ██████████.

DHS policy at ASM 363 now AASM 120 provides in pertinent part:

Responsible Relatives

Activities of daily living may be approved when the responsible relative is **unavailable** or **unable** to provide these services.

Note: Unavailable means absence from the home for an extended period due to employment, school or other legitimate reasons. The responsible relative must provide a work or school schedule to verify they are unavailable to provide care. **Unable** means the responsible person has

disabilities of their own which prevent them from providing care. These disabilities must be documented/verified by a medical professional on the DHS-54A, Medical Needs form. Do **not** approve shopping, laundry, or light housecleaning, when a responsible relative of the client resides in the home, **unless** they are unavailable or unable to provide these services. Document findings in the general narrative in ASCAP.

Adult Services Manual 120, pp 4-5

[REDACTED] testified that the earliest date that she could approve the Appellant's HHS was [REDACTED], because that is the date on which the Appellant's spouse submitted his [REDACTED], DHS-54A.

DHS policy at ASM 363 now ASM 115 provides in pertinent part:

MEDICAL NEEDS FORM (DHS-54A)

The DHS-54A, Medical Needs form must be 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:

- M.D. or D.O.
- Nurse practitioner.
- Occupational therapist
- Physical therapist.

Note: A physician assistant (PA) is not an enrolled Medicaid provider and **cannot** sign the DHS-54A.

The medical needs form is only required at the initial opening for SSI recipients and disabled adult children (DAC). All other Medicaid recipients must have a DHS-54A completed at the initial opening and annually thereafter.

The client is responsible for obtaining the medical certification of need but the form must be completed by the medical professional and not the client. The National Provider Identifier (NPI) number must be entered on the form by the medical provider and the medical professional must indicate whether they are a Medicaid enrolled provider.

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.** Needed services are determined

by the comprehensive assessment conducted by the adult services specialist.

If the medical needs form has not been returned, the adult services specialist should follow-up with the client and/or medical professional.

Do **not** authorize home help services prior to the date of the medical professional signature on the DHS-54A.

The medical needs form does not serve as the application for services. If the signature date on the DHS-54 is **before** the date on the DHS-390, payment for home help services must begin on the date of the application.

Example: The local office adult services unit receives a DHS-54A signed on 1/18/2011 but a referral for home help was never made. The adult services staff enters a referral on ASCAP and mails an application to the client. The application is returned to the office with a signature date of 2/16/2011. Payment cannot begin until 2/16/2011, or later, if the provider was not working during this time period.

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.

Veteran's Administration (VA)
The Michigan Department of Community Health (MDCH) will accept a DHS-54A completed by a Veteran's Administration physician or the VA medical form in lieu of the medical needs form.

DHS policy at ASM 362 now ASM 105 provides the eligibility criteria for HHS.

Requirements

Home help eligibility requirements include **all** of the following:

- Medicaid eligibility.
- Certification of medical need.
- Need for service, based on a complete comprehensive assessment (DHS-324) indicating a functional limitation of level 3 or greater for activities of daily living (ADL).
- Appropriate Level of Care (LOC) status

The Appellant testified that she applied for HHS well before [REDACTED] and feels that her providers (her two sons) should be paid for the services provided from [REDACTED] through [REDACTED].

The undisputed facts show that the Appellant's spouse's physician submitted a [REDACTED], Medical Needs form and the submission of that form completed the Appellant's HHS file and allowed [REDACTED] to open the Appellant's case and approve payments for [REDACTED] and [REDACTED]. DHS HHS policy eligibility criteria does not permit the authorization of HHS payments prior to the date of the Appellant's spouse's DHS-54A. Therefore, the Appellant's Adult Service Worker had no choice but to approve HHS payments retroactive to [REDACTED].

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, finds that the Department properly determined the effective date of the Appellant's Home Help Services.

IT IS THEREFORE ORDERED THAT:

The Department's decision is AFFIRMED.

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

cc:

[REDACTED]

Date Mailed: 3/8/2012

***** 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.