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. 2012-24701 HHS

[redacted] [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] represented the Appellant. [redacted] Appeals Review Officer, represented the Department, [redacted], Adult Services Worker, testified for the Department. [redacted] testified for the Appellant.

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 husband in her [redacted]

2. On [redacted], the Department of Human Services Adult Services received a referral and Home Help Services application from [redacted] [redacted] for the behalf of the Appellant.

3. Subsequently, DHS assigned an Adult Services Worker, [redacted] who began processing the Appellant's application.

4. On [redacted], [redacted] completed a comprehensive HHS assessment.

5. Subsequently [redacted] approved the Appellant for HHS and authorized HHS payments retroactive to [redacted]

6. 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.

On [redacted] the Department of Human Services Adult Services received a referral and Home Help Services application from [redacted] for the behalf of the Appellant. The Appellant is an [redacted]-year-old female who resides in her [redacted], Michigan home with her husband. The Appellant's representative while provided authorized HHS to the Appellant's husband became

aware of the Appellant's apparent need for HHS. On [redacted], the Appellant's representative filed a HHS application with DHS. Subsequently the Appellant's Adult Services Worker, [redacted], completed a HHS assessment and approved the Appellant for HHS retroactive to [redacted].The Appellant's representative disagrees with the [redacted] HHS start date and believes that HHS should have been approved effective [redacted]

[redacted] testified that DHS received only the [redacted], HHS application and had no record of any earlier application. Mr. Vernier testified that after the [redacted] application was received he was assigned at the Adult Services Worker. Mr. Vernier testified that he completed a HHS assessment on [redacted] and approved the Appellant for HHS effective [redacted] [redacted] testified that he was not able to locate an HHS application filed before [redacted]. [redacted] testified that the [redacted] date was the earliest date that he could authorization the Appellant's HHS.

[redacted]iams testified that the Appellant was released from the nursing home to her home without regard to the Appellant's need for in home care. [redacted] testified that her company was providing the Appellant's spouse with HHS and in the process discovered that the Appellant needed services. [redacted] testified that she and [redacted] submitted HHS applications and DHS 54-A Medical Needs form with DHS on [redacted] [redacted] testified that she and [redacted] were subsequently told that the Appellant's Medicaid was not active. [redacted] testified DHS did not provide a denial of the [redacted] application. [redacted] testified that in [redacted] DHS staff informed her and [redacted] that the Appellant's Medicaid was active so another HHS application was filed. [redacted] testified that three HHS applications were filed. [redacted] states that the [redacted] Notice of Case Action provided by the Appellant shows that the Appellant's Medicaid was active effective [redacted] and as a result all HHS applications including the [redacted] application should have been processed. [redacted] testified that her company provided HHS to the Appellant in [redacted] and should be paid for the services provided. [redacted]ams testified that she attempted to get the Appellant's HHS approved in [redacted] and [redacted] but DHS lost the application and provided inaccurate information regarding the Appellant's Medicaid eligibility.

[redacted] confirmed in her testimony the facts provided in [redacted] testimony

In response to [redacted] and [redacted] testimony [redacted] restated his position DHS has a record of only the [redacted], HHS application. [redacted] testified that neither DHS nor the Appellant's representative has a date stamped HHS application with a date before [redacted] [redacted] testified that HHS policy at ASM 115 provides that HHS payments may not be authorized before the date of the DHS 54-A and that DHS 54-A is not an HHS application. If the DHS 54-A date is before the date of the HHS application then HHS payments may only be authorized to the date of the HHS application. [redacted] testified that he authorized that Appellant's HHS

effective [redacted] even though the Appellant provided a DHS 54-A with an [redacted] date.

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.
>
> Adult Services Manual 105, page 1

The evidence presented shows that DHS received a referral and HHS application on [redacted]. Neither the Appellant nor her representative provided a HHS application with a DHS date stamped receive date before [redacted]. The evidence shows that [redacted] and [redacted] contacted DHS numerous times regarding the Appellant's HHS and obtained a DHS 54-A from the Appellant's physician; but despite those contacts the Appellant's representative cannot provide a date stamped application with a date in [redacted] correctly applied HHS policy when he approved the Appellant's HHS 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 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: 4-11-12

***** 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.