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

[redacted],

Docket No. 2012-3036 HHS
Case No. [redacted]

Appellant
_____/

DECISION AND ORDER

This matter is before the undersigned Administrative Law Judge (ALJ) 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 [redacted], the Appellant, appeared on her own behalf. [redacted], Appeals Review Officer, represented the Department. [redacted], Supervisor, appeared as a witness for the Department.

ISSUE

Did the Department properly deny the Appellant's Home Help Services ("HHS") application?

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 [redacted] year old Medicaid beneficiary who underwent a translumbar interbody fusion surgery. (Exhibit 1, page 9)

2. In [redacted], the Appellant applied for the HHS program. (Exhibit 1, page 8, Appellant Testimony)

3. Eligibility requirements include a need for service based in part on a comprehensive assessment as well as a DHS-54A Medical Needs form completed by a Medicaid enrolled physician, nurse practitioner, occupational therapist, or physical therapist certifying a medical need for personal care services. *Adult Services Manual (ASM) 362 pages 1-2 of 5, 12-1-2007.*

4. No comprehensive assessment was completed between [redacted] and [redacted] to determine the Appellant's need for services at that time. (Supervisor Testimony)

5. On [redacted], the Department mailed out forms for the Appellant's HHS referral. (Exhibit 1, pages 5-7)

6. On [redacted], the Appellant's physician completed a DHS 54-A Medical Needs Form, but only certified a medical need for assistance with the specified personal care activities from [redacted] through [redacted] (Exhibit 1, page 9)

7. On [redacted], the Department issued an Adequate Negative Action Notice to the Appellant indicating her HHS application was denied because her doctor did not certify a medical need for services after [redacted] (Exhibit 1, pages 5-7)

8. The Appellant requested a formal, administrative hearing contesting the denial on [redacted]. (Exhibit 1, page 4)

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 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 362) 12-1-2007, pages 1-2 of 5 addresses the issue of eligibility for HHS:

- The client must be eligible for Medicaid.
- Have a scope of coverage code of:
    - 1F or 2F.
    - 1D or 1K, (Freedom to Work), **or**
    - 1T (Healthy Kids Expansion).

- The client must have a need for service, based on
    - Client Choice, **and**

- Comprehensive Assessment (DHS-324) indicating a functional limitation of level 3 or greater in ADL or IADL.

- Medical Needs (DHS 54A) form signed and dated by a medical professional certifying a medical need for personal care services. The medical professional must by and enrolled Medicaid provider and hold one of the following professional licenses:

  - Physician.
  - Nurse practitioner.
  - Occupational therapist.
  - Physical therapist.

Adult Services Manual (ASM 362) 12-1-2007,
Page 2 of 5
(Exhibit 1, page 15)

Adult Services Manual (ASM 363) 9-1-2008, pages 7-9 of 24 also addresses the issue of eligibility for HHS:

ELIGIBILITY FOR HOME HELP SERVICES
Home help services (HHS) are defined as those which the department is paying for through Title XIX (Medicaid) funds. The client must be eligible for Medicaid in order to receive these services.

Medicaid/Medical Aid(MA)
Verify the client's Medicaid/Medical aid status.

The client may be eligible for MA under one of the following:
- All requirements for MA have been met, **or**
- MA deductible obligation has been met.

The client must have a scope of coverage of:
- 1F or 2F, **or**
- 1D or 1K (Freedom to Work), **or**
- 1T (Healthy Kids Expansion).

Clients with eligibility status 07 (Income scale 2-Non MA) and scope of coverage 20 or 2B are **not** eligible for Medicaid until they have met their MA deductible obligation.

An ILS case may be opened (service program 9) to assist the client in becoming MA eligible. However, do **not** authorize HHS payment prior to the MA eligibility date. The payment must be prorated if the eligibility period is less than the full month. To prorate, divide the monthly care cost by the number of days in the month. Then, multiple that daily rates by the number of eligible days.

Note: A change in the scope of coverage by the eligibility specialist (ES) will generate a DHS-5S for cases active to services programs 1, 7, and 9.

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.
>
> Adult Services Manual (ASM 363) 9-1-2008,
> Pages 7-9 of 24

Adult Services Manual (ASM 363, 9-1-08), pages 2-5 of 24 also addresses the comprehensive assessment and service plan:

> **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. When hours exceed the RTS rationale must be provided.

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.

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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 not duplicative (same service for same time period).

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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

In order to authorize Home Help Services, the Adult Services Manual requires verification of medical need for assistance by a Medicaid enrolled provider and a comprehensive assessment. The evidence shows that the Department received a referral for the Appellant for the HHS program on [redacted]. (Exhibit 1, page 9) The Supervisor explained that due to a backlog for the HHS program, the forms were not sent out in the Appellant's case until [redacted]. (Supervisor Testimony)

The Department received the medical verification from the Appellant's doctor on [redacted]. However, the Appellant's physician only certified a medical need for assistance with the specified personal care activities from [redacted] through [redacted]. (Exhibit 1, page 9) The Supervisor testified that this verification could not be used to open a HHS case for the Appellant in [redacted] as the Appellant no longer had a need for services. (Supervisor Testimony)

The Appellant disagrees with the HHS denial and testified that she applied in [redacted]. The Appellant stated that she attempted to follow up with the Department regarding her HHS application and was told they would get to her case as soon as possible. The Appellant testified that she owes her caregivers for the assistance they provided. (Appellant Testimony)

In this case, it is clear the Department did not respond to the Appellant's HHS referral in a timely manner. However, submission of a referral or even an application for the HHS program is not sufficient to open an HHS case, nor to commit the Department to paying for assistance with personal care activities. Department policy requires both the certification of medical necessity by a Medicaid enrolled provider and for the Department to complete a comprehensive assessment to determine a need for

services. Only then can the functional assessment and rankings be assigned resulting in any time and task authorizations. The medical certification documents that the Appellant only had a medical need fro assistance with personal care services between [redacted] and [redacted]. Through no fault of the Appellant, the Department was unable to complete the required comprehensive assessment during that time period. Accordingly, the Department was unable to authorize HHS for the Appellant during that time period and there was no longer a certified need for HHS when the Department reviewed the Appellant's case in [redacted].

Additionally, no enrollment of a HHS provider was completed. Department policy states that the client has the right to choose her own HHS provider(s) but payment can only be made to qualified providers. The policy sets out the minimum provider criteria and requires the ASW to complete a face to face interview with the provider. Adult Services Manual (ASM) 363, 9-1-2008, Pages 15-16 of 24. Policy also requires HHS providers to be enrolled in the system prior to payment authorization. Adult Services Manual (ASM) 363, 9-1-2008, Page 18 of 24.

While the delay in reviewing the Appellant's request for HHS was clearly not the Appellant's fault, this ALJ does not have the authority to order the relief the Appellant seeks, or any form of equitable relief, including payment for personal care services provided to the Appellant by caregiver(s) who were not enrolled as HHS providers during the time period the Appellant's HHS referral or application was pending.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, finds the Department properly denied HHS for the Appellant in [redacted].

IT IS THEREFORE ORDERED that:

The Department's decision is AFFIRMED.

Colleen Lack
Administrative Law Judge
for Olga Dazzo, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 1/5/2012

***** 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.