**STATE OF MICHIGAN**
**MICHIGAN ADMINISTRATIVE HEARING SYSTEM**
**FOR THE DEPARTMENT OF COMMUNITY HEALTH**
P.O. Box 30763, Lansing, MI 48909
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IN THE MATTER OF:

[redacted],

Docket No. 2012-3039 HHS
Case No. [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], the Appellant, appeared on her own behalf. [redacted], daughter and caregiver, appeared as a witness for the Appellant. [redacted], Appeals Review Section Manager, represented the Department. [redacted], Adult Services Worker (ASW), appeared as a witness for the Department.

## ISSUE

Did the Department properly reduce the Appellant's Home Help Services (HHS) authorization?

## 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.

2. The Appellant has multiple medical impairments including diabetic neuropathy, chronic kidney disease stage 3, arthritis, right lower extremity ligamentous laxity and weakness causing gait abnormality, history of stroke with right upper extremity and lower extremity weakness, gait dysfunction with use of assistive device and falls due to previous Achilles tendon injury and rheumatoid arthritis with Sjogren's syndrome, diminished range of motion with previous surgical intervention and reconstruction of right shoulder, history of Cushing's disease with chronic vertigo, chronic parotitis, status post pituitary surgery, history of subtotal thydoidectomy x2, history of hypertension, hyperlipidemia, history of anemia status post transfusions, glaucoma, and hypothyroidism. (Exhibit

1, page 24; Exhibit 2, pages 3-9)

3. The Appellant had been receiving a total of 63 hours and 42 minutes of HHS per month with a monthly care cost of [redacted]. (Exhibit 1, page 36)

4. On [redacted], the ASW made an unannounced visit to the Appellant's home around [redacted]. to conduct a Home Help Services assessment. The ASW made some observations of the Appellant's upper extremity range of motion and ambulation, but did not discuss each of the Activities of Daily Living ("ADLs") and Instrumental Activities of Daily Living ("IADLs") with the Appellant. (Exhibit 1, pages 12-16 and ASW Testimony)

5. As a result of the information gathered, the ASW determined that the Appellant's HHS hours should be reduced. The ASW eliminated the HHS hours authorized for bathing, grooming, dressing, housework, laundry, meal preparation, toileting and transferring, increased the HHS hours authorized for mobility and reduced the HHS hours authorized for medication and shopping. (Exhibit 1, pages 18 and 36)

6. On [redacted], the Department sent an Advance Negative Action Notice to the Appellant indicating that her HHS case would be reduced to [redacted] per month effective [redacted], reflecting the new authorization for mobility, medication, and shopping/errands. (Exhibit 1, page 6)

7. On [redacted], the Appellant's Request for Hearing was received. (Exhibit 1, pages 4-5)

## 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), addresses the comprehensive assessment, functional assessment, time and task authorization, the service, and necessity for services:

**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**

A service plan must be developed for all ILS cases. The service plan is formatted in ASCAP and interacts with the comprehensive assessment.

The service plan directs the movement and progress toward goals identified jointly by the client and specialist.

**Philosophy**

Service planning is person-centered and strength-based.

Areas of concern should be identified as an issue in the comprehensive assessment to properly develop a plan of service.

Participants in the plan should involve not only the client, but also family, significant others, and the provider, if appropriate.

Involvement of the client's support network is based on the best practice principles of adult services and the mission of the Department of Human Services, which focus on:

- Strengthening families and individuals.
- The role of family in case planning.
- Coordinating with all relevant community-based services, and
- Promoting client independence and self-sufficiency.

Service plans are to be completed on all new cases, updated as often as necessary, but minimally at the six month review and annual reassessment.

**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-54-A.

- 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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**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.

*Adult Services Manual (ASM) 363, 9-1-2008,*
Pages 2-9 of 24

The ASW testified that the Appellant's case was new to her at the time of the August 24, 2011, home visit. However, the ASW testified that this was an unscheduled visit, she just called the Appellant from the driveway of the Appellant's home early that morning, around [redacted]. The ASW testimony and notes indicate she observed the Appellant come down stairs, walking, get in and out of a chair, standing and move her upper

extremities showing range of motion. The ASW talked with the Appellant but did not discuss each of the ADL's and IADLs with her, then went upstairs to see the bathroom. The ASW determined the Appellant's HHS case should be reduced based on her observations, the Appellant being able to put on a robe with a tie to come down stairs to talk with the ASW, and a comment the Appellant made about knitting. (ASW Testimony and Exhibit 1, pages 12-16)

The Appellant testified that she was sleeping in the morning the ASW showed up as her daughter had a dentist appointment that morning. The Appellant stated the ASW's testimony and notes were not correct. The Appellant stated her robe has a zipper and does not tie. The Appellant further testified that her son helped with putting her robe on, getting down the stairs, walking into the kitchen and to sit in a chair, she did not do any of this unassisted. (Appellant Testimony) The Appellant also provided a notarized statement from her son, indicating that he helped the Appellant out of bed, put her robe on, down the stairs and to the kitchen chair the morning of the ASW's visit. (Exhibit 2, page 2) The Appellant stated she told the ASW that she used to knit, as in this was an activity she did in the past. The Appellant testified she is no longer able to knit. (Appellant Testimony) The Appellant's testimony indicated she needs assistance with parts or several ADLs and IADLS, including bathing, dressing, meal preparation, and shopping. (Appellant Testimony) Additionally, the Appellant's testimony that she reported additional diagnoses to the previously assigned ASW, which were not shown on the medical certification screen print, is supported in the [redacted] and [redacted] narrative notes. (Exhibit 1, pages 16 and 24)

This ALJ understands the ASW's concerns about the legitimacy of the DHS-54A Medical Needs form received by fax with the transmission line showing it was sent from a bank. However, the ASW did authorize HHS payments for the Appellant when that was the only recent medical verification. Further, the Appellant has since provided another DHS-54A, a letter from her podiatrist, and a Comprehensive Geriatric Assessment, which supports her needs for assistance with ADLs and IADLs. (Exhibit 2, pages 3-9)

The ASW's determination to reduce the Appellant's HHS hours can not be upheld. The ASW gave no explanation for why she showed up unannounced for her first assessment of the Appellant and did not issue the standard home visit letter. The Appellant's daughter, who is the HHS provider, had a dentist appointment that morning. Since no notice of the home visit was sent in advance, neither the Appellant nor her daughter could have contacted the ASW to ask for the visit to be re-scheduled so that the Appellant's daughter could participate. The Department policy indicates that the provider should be involved in the comprehensive assessment and service plan development. Further, the ASW's own testimony indicated that she failed to discuss the specific ADLs and IADLs with the Appellant, which would have given the Appellant an opportunity to report her abilities and needs for assistance with these activities to the ASW. The ASW eliminated the HHS hours authorized for bathing, grooming, dressing, housework, laundry, meal preparation, toileting and transferring, and reduced the HHS

hours authorized for medication and shopping. (Exhibit 1, pages 18 and 36) The ASW testimony and notes indicated these eliminations and reductions were based, at least in part, on her observations of the Appellant's ability to walk, stand, and go down stairs unassisted. Yet the ASW actually doubled the HHS hours authorized for mobility because of the Appellant's need for assistance balancing during ankle strengthening exercises. (Exhibit 1, pages 13, 18 and 36) The ASW did not provide any evidence that she observed or discussed other relevant functional abilities with the Appellant, such as bending, lifting and carrying. The [redacted] home visit was not adequate to make an assessment of the Appellant's HHS case. The reductions to the Appellant's HHS case can not be upheld. The Department shall complete a new assessment to determine the appropriate ongoing HHS authorization for the Appellant's case.

## DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, finds that the Department improperly reduced the Appellant's HHS authorization.

**IT IS THEREFORE ORDERED** THAT:

The Department's decision is REVERSED. The Department is ordered to reinstate the Appellant's HHS payments to the previously authorized times retroactive to the [redacted], effective date and to complete a new assessment to determine the appropriate ongoing HHS authorization.

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

cc: [redacted]

Date Mailed: 1/6/2012

***** 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.