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:

[redacted],

Docket No. 2012-33693 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], Appeals Review Officer, represented the Department. [redacted] Adult Services Worker ("ASW"), appeared as a witness for the Department.

ISSUE

Did the Department properly assess the Appellant's Home Help Services ("HHS") case?

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 has been authorized for HHS.

2. The Appellant has been diagnosed with degenerative joint disease, advanced severe asthma, Lupus, chronic low back pain, carpal tunnel syndrome, and non-insulin dependant diabetes mellitus. [redacted]

3. The Appellant had been receiving HHS for assistance with housework, shopping, laundry, and meal preparation. [redacted]

4. The Appellant's [redacted] is her HHS provider. (Appellant Testimony)

5. On [redacted], the Appellant called the ASW requesting an increase in her HHS authorization because she had fallen and hurt her ankle. The ASW requested an updated DHS-54A Medical Needs form prior to scheduling a face-to-face meeting with the Appellant. [redacted]

6. On [redacted] the ASW received a DHS-54A Medical Needs form from the Appellant's doctor documenting open reduction internal fixation surgery on [redacted] for a bimalleolar ankle fracture, certifying a medical need for assistance with transferring, mobility, shopping, and laundry, and indicating an inability to work for approximately 3 months. [redacted]

7. On [redacted], the ASW called the Appellant's doctor's office to clarify and was told the Appellant was able to walk on crutches without the assistance of another and could transfer independently, the doctor had circled transferring thinking it meant transportation. [redacted]

8. On [redacted] the ASW met with the Appellant and her daughter and discussed the request for an increase. The Appellant reported being unable to stand up or walk without her [redacted] assistance after the surgery and that recovery took about 30 days. The ASW also explained that transferring and mobility for the HHS program is not transportation. [redacted]

9. The ASW added HHS hours for toileting for the month of January to the Appellant's HHS authorization to compensate for the 30-day period she needed assistance in [redacted]. Notice of the increase was mailed to the Appellant on [redacted]

10. On [redacted] the Department also sent the Appellant an Advance Negative Action Notice which informed her that that effective [redacted] her HHS case would be reduced back to [redacted]

11. On [redacted] the Appellant's Request for Hearing was received by the Michigan Administrative Hearing System. [redacted]

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 120, 11-1-2011), pages 1-5 of 6 addresses the adult services comprehensive assessment:

> **INTRODUCTION**
>
> The DHS-324, Adult Services Comprehensive Assessment is the primary tool for determining need for services. The comprehensive assessment must be completed on **all open independent living services cases**. ASCAP, the automated workload management system, provides the format for the comprehensive assessment and all information will be entered on the computer program.
>
> **Requirements**
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> Requirements for the comprehensive assessment include, but are not limited to:
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> - 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.
> - The assessment may also include an interview with the individual who will be providing home help services.
> - A new face-to-face assessment is required if there is a request for an increase in services before payment is authorized.
> - A face-to-face assessment is required on all transfer-in cases before a payment is authorized.
> - 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.

    - Use the DHS-26, Authorization to Release Information, when requesting client information from another agency.

    - Use the DHS-1555, Authorization to Release Protected Health Information, if requesting additional medical documentation; see RFF 1555. The form is primarily used for APS cases.

- Follow rules of confidentiality when home help cases have companion APS cases, see SRM 131 Confidentiality.

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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

ADLs and IADLs 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.

HHS payments may only be authorized for needs assessed at the 3 level or greater.

An individual must be assessed with at least one activity of daily living in order to be eligible to receive home help services.

Note: If the assessment determines a need for an ADL at a level 3 or greater but these services are not paid for by the department, the individual would be eligible to receive IADL services.

Example: Ms. Smith is assessed at a level 4 for bathing however she refuses to receive assistance. Ms. Smith would be eligible to receive assistance with IADLs if the assessment determined a need at a level 3 or greater.

See ASM 121, Functional Assessment Definitions and Ranks for a description of the rankings for activities of daily living and instrumental activities of daily living.

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Time and Task

The specialist 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.

An assessment of need, at a ranking of 3 or higher, does not automatically guarantee the maximum allotted time allowed by the reasonable time schedule (RTS). **The specialist must assess each task according to the actual time required for its completion.**

Example: A client needs assistance with cutting up food. The specialist would only pay for the time required to cur the food and not the full amount of time allotted under the RTS for eating.

IADL Maximum Allowable Hours

There are monthly maximum hour limits on all IADLs except medication. The limits are as follows:

- Five hours/month for shopping
- Six hours/month for light housework
- Seven hours/month for laundry
- 25 hours/month for meal preparation

Proration of IADLs

If the client does not require the maximum allowable hours for IADLs, authorize only the amount of time needed for each task. Assessed hour for IADLs (except medications) must be prorated by **one half** in shared living arrangements where other adults reside in the home, as home help services are **only** for the benefit of the client.

Note: This does not include situations where others live in adjoined apartments/flats or in a separate home on shared property and there is no shared, common living area.

In shared living arrangements, where it can be **clearly** documented that IADLs for the eligible client are completed separately from others in the home, hours for IADLs do not need to be prorated.

Example: Client has special dietary needs and meals are prepared separately; client is incontinent of bowel and/or bladder and laundry is completed separately; client's shopping is completed separately due to special dietary needs and food is purchased from specialty stores; etc.

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.

Example: Mrs. Smith is in need of home help services. Her spouse is employed and is out of the home Monday thru Friday from 7a.m. to 7p.m. The specialist would not approve hours for shopping, laundry or house cleaning as Mr. Smith is responsible for these tasks.

Example: Mrs. Jones is in need of home help services. Her spouse's employment takes him out of town Monday thru Saturday. The specialist may approve hours for shopping, laundry or house cleaning.

Legal Dependent

Do **not** approve shopping, laundry, or light housecleaning, when a legal dependent of the client (minors 15-17) resides in the home, **unless** they are unavailable or unable to provide these services.

Adult Services Manual (ASM) 120, 11-1-2011, Pages 1-5 of 6

Adult Services Manual (ASM 150, 11-1-2011), pages 1-4 addresses notification of eligibility determinations:

INTRODUCTION

Individuals who submit an application (DHS-390) for home help services or adult community placement must be given written notification of approval or denial for services. A written notice must be sent within the 45 day standard of promptness.

Clients with active service cases must be provided written notice of any change in their services (increase, reduction, suspension or termination).

Written Notification of Disposition

All notifications are documented under ASCAP contacts when they are generated. This documentation acts as the file copy for the case record. For this purpose, the form letters used are:

- DHS-1210, Services Approval Notice.
- DHS-1212A, Adequate Negative Action Notice.
- DHS-1212, Advance Negative Action Notice.

Each notification letter includes an explanation of the procedures for requesting an administrative hearing.

The adult services specialist **must sign** the bottom of the second page of all notices (DHS-1210, DHS-1212A, DHS-1212) before they are mailed to the client.

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Advance Negative Action Notice (DHS-1212)

The DHS-1212, Advance Negative Action Notice, is used and generated on ASCAP when there is a reduction, suspension or termination of services. Appropriate notations must be entered in the comment section to explain the reason for the negative action.

- Reduced - decrease in payment.
- Suspended - payments stopped but case remains open.
- Terminated - case closure.

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Negative Actions Requiring Ten Day Notice

The effective date of the negative action is ten business days **after** the date the notice is mailed to the client. The effective date must be entered on the negative action notice.

If the client does not request an administrative hearing before the effective date, the adult services specialist must proceed with the proposed action.

If the client requests an administrative hearing before the effective date of the negative action, and the specialist is made aware of the hearing request, continue payments until a hearing decision has been made. If the specialist is made aware of the hearing request **after** payments have ended, payments must be reinstated pending the outcome of the hearing. Offer the client the option of discontinuing payment pending the hearing decision.

Note: When payments are continued pending the outcome of a hearing, the client must repay any overpayments if the department's negative action is upheld. Initiate recoupment procedures by sending the client a Recoupment Letter.

Negative Actions Not Requiring Ten Day Notice

The following situations **do not** require the ten business day notice on negative actions:

- The department has factual confirmation of the death of the client (negative action notice must be mailed to

the guardian or individual acting on the client's behalf) or death of the service provider.

Note: Cases should remain open until all appropriate payments have been issued.

- The department receives a verbal or written statement from the client, stating they no longer want or require services, or that they want services reduced.

Note: This information must be clearly documented in the general narrative of ASCAP. Written notices must be maintained in the paper case file and documented in the general narrative.

- The department receives a verbal or written statement from the client that contains information requiring a negative action. The statement must acknowledge the client is aware the negative action is required **and** they understand the action will occur.

Example: A home help services client informs the specialist that they are engaged and will be married on a specific date. They also acknowledge that their new spouse will be responsible for meeting their personal care needs and they will no longer qualify for home help services.

Note: This information must be clearly documented in the general narrative of ASCAP. Written notices must be maintained in the paper case file and documented in the general narrative.

- The client has been admitted to an institution or setting (for example, hospital, nursing home) where the client no longer qualifies for federal financial participation under the Medicaid State Plan for personal care services in the community.

Note: When a client is admitted to a hospital or nursing home, the facility is reimbursed for the client's care on the day the client is admitted, but not for the day of discharge. The home help provider cannot be reimbursed for the date the client is admitted to the facility but may be paid for the day of discharge.

- The client cannot be located and the department mail directed to the client's last known address has been

returned by the post office indicating the forwarding address is unknown.

Note: In this circumstance, a services payment must be made available if the client is located during the payment period covered by the returned warrant.

- The client has been accepted for services in a new jurisdiction and that fact has been established by the jurisdiction previously providing services.

- The time frame for a services payment, granted for a specific time period, has elapsed. The client was informed, in writing, at the time payments were initiated, that services would automatically terminate at the end of the specified period.

Example: The DHS-1210 clearly states a begin and end date for the services payments.

Adult Services Manual (ASM) 150, 11-1-2011, Pages 1-4

In the present case, the Appellant had been receiving HHS for assistance with housework, shopping, laundry, and meal preparation. [redacted] The Appellant's [redacted] is her HHS provider. [redacted]

On [redacted] the Appellant called the ASW from the emergency room requesting an increase in her HHS authorization because she had fallen and hurt her ankle. The ASW requested an updated DHS-54A Medical Needs form prior to scheduling a face-to-face meeting with the Appellant. The ASW explained that policy requires a new face-to-face assessment before an increase in services can be authorized. [redacted]

On [redacted] the ASW received a DHS-54A Medical Needs form from the Appellant's doctor documenting open reduction internal fixation surgery on [redacted] for a bimalleolar ankle fracture, certifying a medical need for assistance with transferring, mobility, shopping, and laundry, and indicating an inability to work for approximately 3 months. [redacted] the ASW called the Appellant's doctor's office to clarify and was told the Appellant was able to walk on crutches without the assistance of another and could transfer independently, the doctor had circled transferring thinking it meant transportation. [redacted]

On [redacted] the ASW met with the Appellant and her [redacted] and discussed the request for an increase. The Appellant reported being unable to stand up or walk without her [redacted] assistance after the surgery and that recovery took about 30

days. The ASW also explained that transferring and mobility for the HHS program is not transportation. [redacted]

The ASW added HHS hours for toileting for the month of [redacted] to the Appellant's HHS authorization to compensate for the 30-day period she needed assistance in [redacted]. Notice of the increase was mailed to the Appellant on [redacted] On [redacted], the Department also sent the Appellant an Advance Negative Action Notice which informed her that that effective [redacted] her HHS case would be reduced back to [redacted] The ASW testified she would amend the effective date of the reduction to [redacted] to allow for a 10 business day notice of the reduction. [redacted]

The Appellant's hearing request indicates she disagrees with the limited time frame additional HHS hours were approved for and is requesting mobility and transferring for six months. [redacted] The Appellant testified that she also spoke with the doctor's office, who confirmed they told the ASW assistance with mobility was needed. The Appellant explained that the emergency room told her not to walk on her ankle until she saw the orthopedic doctor, and sent her home with crutches and a bed pan. The Appellant stated that her [redacted] helped her once she was home from the emergency room. She also testified that she could not stand up, she just laid in bed. The Appellant stated that a walker was ordered through the orthopedic doctor. The Appellant testified that after the [redacted] surgery, she was still non-weight bearing and had to elevate her leg until some time in February or the beginning of March. [redacted]

The DHS-54A Medical Needs form supports the Appellant's testimony that she was non-weight bearing, but does not support an increase in services for six months. The form indicated the Appellant was last seen on [redacted] was non-ambulatory because she was non-weight bearing, and indicated it would be approximately 3 months before the Appellant could return to work. [redacted] The Appellant's testimony that she was non-weight bearing until some time in February or early March is not supported by the information the doctor's office reported to the ASW on [redacted] specifically that the Appellant could walk on crutches without the assistance of another and transfer independently. [redacted]

The ASW's determination to authorize additional HHS hours for toileting for a 30-day recovery period was reasonable based on the evidence. The Appellant broke her ankle on [redacted] The Appellant's testimony indicates she just laid in bed after being sent home from the [redacted] emergency room visit, and did not utilize her crutches because she was non-weight bearing and could not stand up. Accordingly, she would have needed assistance empting the bed pan, but not mobility or transferring. On [redacted] shortly after the ankle surgery, the doctor's office reported the Appellant was able to walk on crutches without the assistance of another and transfer independently. This supports the ASW's determination to limit the increase in HHS to only 30 days. While it would have been more accurate to add the additional HHS hours for toileting to the month of [redacted], the ASW explained that by the time she

obtained the medical certification and met with the Appellant it was easier to add the time for the month of [redacted]

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, finds that the Department properly assessed the Appellant HHS case.

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: 6-20-2012

***** 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 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.