

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

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IN THE MATTER OF:

Docket No. 2012-3911 HHS

██████████,

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 ██████████ was present at hearing. She brought a translator. The translator's name was ██████████

██████████, Appeals and Review Officer, represented the Department of Community Health. ██████████, Adult Services Worker, appeared as a witness on behalf of the Department.

ISSUE

Did the Department properly deny the Home Help Services (HHS) application of the Appellant?

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 ██████ year old Medicaid beneficiary who applied for Home Help Services.
2. The Appellant has care provided to her by her daughter for the last 7 years. (uncontested testimony of the Appellant)
3. The Appellant's doctor completed a 54-A Medical Needs form in conjunction with the Appellant's HHS application. (Exhibit B)
4. The doctor who completed the 54-A stated that the Appellant did not have a medical need for assistance with any of the personal care activities listed on the form.

5. The Department denied the Appellant's HHS application and sent her a Notice of denial in [REDACTED].
6. The Appellant requested a formal, administrative hearing [REDACTED]
[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 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.

Program requirements are set forth in Adult Services Manual item 362, below:

GENERAL SERVICES REQUIREMENTS The client must sign an Adult Services Application (DHS-390) to receive ILS. An authorized representative or other person acting for the client may sign the DHS-390 if the client:

- Is incapacitated, **or**
- Has been determined incompetent, **or**
- Has an emergency. A client unable to write may sign with an "X", witnessed by one other person (e.g., relative or department staff). Adult services workers must not sign the services application (DHS-390) for the client. Eligibility must be determined within 45 days of the signature date on the DHS-390.

Note: ASSIST (Automated Social Services Information and Support) requires a disposition within 30 days of the registered request. See ASSIST User Manual (AUM) 150-7/8. The DHS-390 is valid indefinitely unless the case is closed for more than 90 days.

ELIGIBILITY CRITERIA

Independent Living Services The following **nonpayment** related independent living services are available to any person upon request **regardless** of income or resources:

- Counseling.
- Education and training.
- Employment.
- Family planning.
- Health related.
- Homemaking.
- Housing.
- Information and referral.
- Money management.
- Protection (For adults in need of a conservator or a guardian, but who are not in any immediate need for protective service intervention.)

Home Help Services (HHS) Payment related independent living services are available if the client meets HHS eligibility requirements. Clients who may have a need for HHS should be assisted in applying for Medicaid (MA). Refer the client to an eligibility specialist. Cases pending MA determination may be opened to program 9 (ILS). HHS eligibility requirements include all of the following:

- The client must be eligible for Medicaid.
- Have a scope of coverage 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 an 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 be an enrolled Medicaid provider and hold one of the following professional licenses:
 - Physician.
 - Nurse practitioner.
 - Occupational therapist.
 - Physical therapist.

ASM 362, 12-1-2007

Manual Item 363 addresses what a comprehensive assessment consists of, as well as other program procedures.

COMPREHENSIVE ASSESSMENT

The Adult Services Comprehensive Assessment (DHS-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 customer in his/her place of residence.
- An interview must be conducted with the caregiver, if applicable.
- Observe a copy of the customer'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 re-determination.
- 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 customer'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
- 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 the 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:

- Five hours/month for shopping
- Six hours/month for light housework
- Seven 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.

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 caregiver, if applicable.

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 the 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 the same time period).

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 rate 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.

Payment for Medical Exams:

The Medicaid card is to be used to pay for medical professional charges for examinations or tests to certify the client's need for services and for completing the DHS-54A for MA recipients. Use the Examination Authorization/Invoice for Services (DHS-93) to pay for professional charges for non-MA clients. Payment is limited

to the medical procedures and tests necessary to certify the client's need for home help services. See SRM 234, Diagnostic Fee Schedule.

Medical Review Team (MRT)

If the client refuses to see a physician, or the physician refuses to complete a DHS-54A, forward medical and case information to the Medical Review Team (MRT) through the local office medical contact worker and/or the local office's designated person responsible for reviewing medical information. Attach a cover memo explaining the reason a MRT evaluation is needed. The local office designee will forward the packet to the regional Disability Determination Services (DDS) MRT. The MRT will make a determination and return the forms. See L-letter 00-130, June 20, 2000. The MRT may also be used if the client's physician does not certify a need for personal care services, but services appear to be justified.

Expanded Home Help Services (EHHS)

EHHS may be authorized if **all** of the following criteria are met:

- The client is eligible for HHS.
- The client has functional limitations so severe that the care cost cannot be met safely within the monthly maximum payment.
- The local office director/supervisory designee has approved the payment (EHHS \$550-\$1299.99) **or** the Department of Community Health (DCH) has approved the payment (EHHS \$1300 or over). All EHHS requests for approval must contain:
 - Medical documentation of need, e.g., DHS-54A, **and**
 - An updated DHS-324 **and** written plan of care which indicates:
 - How EHHS will meet the client's care needs **and**
 - How the payment amount was determined.

Note: See adult services home page for Expanded Home Help Services Procedure Guideline under Training Materials/Job Aids, developed by the Department of Community Health. **Service Animal** Payment for maintenance costs of a service animal may be authorized if **all** of the following conditions are met:

- The client is eligible for HHS.

- The client is certified as disabled due to a specific condition such as arthritis, blindness, cerebral palsy, polio, multiple sclerosis, deafness, stroke or spinal cord injury.
- The service animal is certified as professionally trained by a recognized agency to meet specific needs of the client.
- The HHS plan documents that the service animal will be used primarily to meet specific client personal care needs.

Service animal maintenance may be authorized for a client in an alternative care setting (AFC or HA). Authorize payment for maintenance costs of a service animal if the client meets **all** eligibility criteria.

COORDINATION OF HHS WITH OTHER SERVICES

Coordinate available home care services with HHS in developing a services plan to address the full range of client needs. Do **not** authorize HHS if another resource is providing the same service at the same time.

Supported Independent Living Programs (SIP)

Clients in supported independent living program homes (SIP) may be eligible for HHS payments. See L-Letter 97-278.

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.

Note: If it appears the client's primary need is for adult foster care (AFC) or foster care is being provided without a license, the case should be referred to the local AFC licensing consultant.

ASM 363, 9-1-2008

At hearing, the Appellant stated her doctor did not perform tests on her and had a problem with language. She further indicated she was surprised when the doctor did not certify a need for services. She said she is getting worse and has only her daughter to rely on. She asserted her daughter is bathing her, dressing her and she cannot prepare food even. She said her daughter has been doing this for 7 years. She asserted she is getting worse and worse. She presented a prescription from her doctor dated ██████████. This ALJ declined to admit into the evidentiary record, explaining it was after the Department's determination, thus was not material to the disposition necessary at this hearing. It was further explained that she could re-apply for services at any time. This ALJ does not find a prescription from the doctor dated ██████████, could be used to determine what the Department did in this case on ██████████ was error.

The Department witness stated the 54-A Medical Needs form indicated the doctor did not certify a need for assistance. This form was relied on to deny the HHS application. Additional testimony confirming the DHS policy that does not allow a HHS case to be opened if the needed services are being provided free of charge was elicited by this ALJ.

This ALJ must follow the DHS policy as published. There is no authority to make an exception or disregard it. The determination made by the DHS on ██████████, pertaining to the HHS application was proper.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, finds that the Department's denial of the Appellant's Home Help Services application was proper.

IT IS THEREFORE ORDERED that:

The Department's decision is AFFIRMED.

Jennifer Isiogu
Administrative Law Judge
for Olga Dazzo, Director
Michigan Department of Community Health

Docket No. 2012-3911 HHS
Decision and Order

cc:



Date Mailed: 12/22/2011

***** 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.