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

Docket No. 2012-40671 HHS

[redacted] 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] represented the Appellant. [redacted] of [redacted] testified for the [redacted] testified for the Appellant.

ISSUE

Did the Department of Human Services properly deny the Appellant's Home Help Services application (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 in a [redacted].
2. On [redacted] the [redacted]) Adult Services received a referral and Home Help Services application from [redacted] for Home Help Services for the behalf of the Appellant.
3. Subsequently, [redacted] assigned an [redacted] who began processing the Appellant's application.
4. On [redacted] and [redacted] attempted a home call to complete a comprehensive [redacted] assessment. [redacted] was not able to complete the assessment because there was no person present at the home.

5. The Appellant's address was cor rectly entered in t he [redacted] data base and the address has not been edited since t he Appellant's [redacted] referral.

6. On [redacted] sent the Appellant a Ne gative Action Notice in which he informed that A ppellant that she must respond by [redacted] or her [redacted] application would be denied.

7. On [redacted] s ent the Appellant a Negative Action Notice which informed the Appellant that her [redacted] app lication would be denied if she did not respond.

8. On [redacted] sent the Appella nt a Negative Action notic e which informed the Appellant that her application for [redacted] was denied.

9. On [redacted] received the Appellant's request for hearing.

CONCLUSIONS OF LAW

The Medic al Ass istance Program is established purs uant to Title XIX of t he Soc ial Security Act and is implemented by Title 42 of the Code of Federal Regulations (CFR) . It is admi nistered in accordance with stat e statute, the Soci al Welfare Act, the Administrative Code, and the St ate Plan under Title XIX of the Social Security Act Medical Assistance Program.

[redacted] are provided to enable functionally limited individuals to live independently and receive car e in the least restrictive, preferred setti ngs. These activities must be certified by a physic ian 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 asses sment will be complet ed on a ll open cases, whether a home help pa yment will be made or not. ASCAP, t he autom ated work load management syste m provides the format for the comprehensive assessment and all information will be entered on the computer program.
>
> Requirements for the compr ehensive assessment include , but are not limited to:

- A comprehensive assessment will be completed on all new cases.
- A face-to-face contac t is required with the client in his/her place of residence.
- An interview must be conduc ted with the ca regiver, 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 minim ally at the six-month r eview and annual redetermination.
- A release of information must be obtained when requesting document ation 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 c lient'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 ass essed acc ording 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.

<u>Service Plan Development</u>

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 [redacted] received a referral for HHS for the Appellant. The Appellant resides in a [redacted] home. Following the referral the Appellant's representative submitted a [redacted] application and DHS 54-A Medical Needs Form. Subsequently the [redacted] attempted two home calls and no HHS assessment was completed. On [redacted] sent the Appellant a notice which informed her that her application for [redacted] was denied because he was not able to complete a [redacted] assessment. The Appellant's representative filed the Appellant's appeal because she feels that [redacted] mistakenly attempted home calls at the incorrect address and his mistake lead to the application denial. The Appellant's representative believes that the Appellant and her provider should be approved for [redacted] and is seeking approval of the Appellant's [redacted] application with retroactive payments.

[redacted] Adult Services and Adult Protective Services Worker, testified that the information contained in the Appellant's [redacted] files show that a [redacted] referral was received on [redacted] and that [redacted] attempted home calls on [redacted] testified that the information in the file also shows that [redacted] sent notices to the Appellant on [redacted] which included information that the Appellant's application would be denied if she failed to contact his office. [redacted] testified that on [redacted] sent the Appellant a written notices that her [redacted] application was denied because no assessment could be completed. [redacted] testified that the [redacted] data based ASCAP shows that the Appellant's correct current address was entered in the data base and there was no change made to that address since the Appellant's [redacted] HHS application.

[redacted] the Appellant's representative, testified that the Appellant's correct address is the [redacted] address and she believes that [redacted] went to a vacant home that [redacted] owns located on [redacted] testified that [redacted] was not able to complete the [redacted] assessment in [redacted] because he went to the wrong address. [redacted] testified that since she filed that Appellant's [redacted] application she has attempted to contact [redacted] on numerous occasions and each time he would not respond to her telephone calls. [redacted] testified she was not aware that there was a problem with the [redacted] HHS application and assessment until [redacted] sent the [redacted] denial notice. [redacted] testified that after she became aware of the notice she filed a second HHS application. [redacted] testified that [redacted] has been providing [redacted] services to the Appellant since

[redacted] and s hould be paid fo r the [redacted] provided. [redacted] testified that [redacted] actions resulted in a denial of the [redacted] application and [redacted] payments should be approved effective [redacted]

In response to [redacted] testimony [redacted] testified that no [redacted] assessment had been completed and that the information in the Appellant's HHS files indicates that two home calls were attempted and failed result ing in the [redacted] applic ation denia l notice. [redacted] testifi ed that [redacted] payments may not be aut horized until an [redacted] in-home assessment is completed which show s that the Appellant has a medical ne ed for HHS.

[redacted] testified that the Ap pellant's application was filed in [redacted] went to the wrong home and [redacted] inaction led to the application denial. [redacted] testified that [redacted] should be pa id for the [redacted] she prov ided to the Appellant since [redacted]

[redacted] testified that she b egan prov iding [redacted] to the App ellant in [redacted] and was t old that when the Appellant's [redacted] applicati on was approved she would be paid. [redacted] testifi ed that she has paid out of her poc ket for her time and expenses and she should not be denied payment because [redacted] did do what he was supposed to do.

[redacted] 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 pr ovider 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 disabl ed adult children (DAC). All other Medicaid rec ipients must have a DHS-54A com pleted at the initial opening and annually thereafter.
> The client is responsible for obtaining the medical certification of need but the form must be c ompleted by the medical professional and not the client. The Nationa l 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 asses sment (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 in [redacted] received a [redacted] referral and subsequently the Appellant submitted a [redacted] application and [redacted]-54A Medical Needs form. The evidence also shows that the [redacted] the [redacted] r, after two failed home visits, did not complete a HHS assess ment and on [redacted] denied that Appe llant's [redacted] application. [redacted] policy pr ovides that [redacted] pay ments may not be aut horized until a comprehens ive [redacted] assessment is completed which s hows that the Appellant has a medical need for HHS. There is no dispute that no [redacted] assessment was completed as of [redacted] The issues raised by the Appellant's representat ive regarding the effective date of the Appellant's [redacted] may only be addres sed after an [redacted] assessm ent is completed whic h shows the Appellant has a medical need for [redacted] Therefore [redacted] correctly applied [redacted]S policy when he denied the Appellant's [redacted] because no assessment was completed.

DECISION AND ORDER

The Administrative Law Judge, based on the abov e findings of fact and conclusions of law, finds that the Department properly denied the Appellant's application for 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: _____

***** 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.