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] Case

Docket No. 2012-49447 HHS
No. 68681411

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 [redacted]. The Appellant was represented by her [redacted] represented the Department. [redacted] and [redacted] appeared as witnesses for the Department.

ISSUE

Did the Department properly deny the Appellant's [redacted] 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] Medicaid beneficiary who has been receiving [redacted].
2. The Appellant is [redacted] with aid of a [redacted] and supervision to guard against falls.
3. The Appellant has suffered a [redacted]. She reports [redacted] and [redacted], [redacted] and a [redacted].
4. The Appellant's medical history was last updated in Department records in [redacted].
5. The Appellant requires assistance with transferring, mobility, bathing, toileting, eating, grooming, dressing, laundry, housework, shopping, medication administration and meal preparation.

6. Documentation submitted into evidence includes a handwritten note indicating the Appellant is having issues with continence.

7. The [redacted] went to the Appellant's home [redacted] to complete a home call in conjunction with an annual review

8. The [redacted] spoke with the Appellant and her provider about her case.

9. The [redacted] made notes in the functional assessment justification section, included as [redacted] page 13. They indicate the Appellant is experiencing more issues due to general aging process. She is reliant on a walker for support and has issues with balance.

10. The [redacted] did not assess the Appellant's need for assistance with grooming at the home call of [redacted].

11. Narrative notes entered by the [redacted] following her home call of [redacted] indicate the Appellant only requires supervision with toileting and that time for dressing, bathing, eating and mobility will be reduced. No reasons are provided in the notes. Additional narrative notes state the Appellant experiences dizziness and has been falling more often.

12. The [redacted] is not aware of the Appellant's cognitive status.

13. The [redacted] sent notice of large reduction in payment authorization [redacted] effective [redacted] The payment was reduced from $[redacted] per month.

14. The [redacted] reduced the time authorized for eating from 22 hours and 4 minutes to 5 hours 1 minute per month. Time for dressing was reduced from 9 hours and 2 minutes to 7 hours and 1 minute. Time for bathing was reduced from 10 hours and 2 minutes to 4 hours and 1 minute per month. Mobility was reduced from 12 hours 32 minutes per month to 5 hours and 1 minute pr month. Transferring was increased slightly from 3 hours and 1 minute per month to 4 hours and 1 minute per month. Medication administration was increased slightly from 1 hour per month to 1 hour and 30 minutes per month.

15. The Appellant requires food to be cut up for her. She will drop her utensils and require someone to get her more. She must drink from a paper cup due to limited strength in her hands.

16. The Appellant requires assistance with transfers several times per day. She also requires assistance up and down the stairs each day.

17. The Appellant requires assistance on and off the toilet at least occasionally, despite having grab bars next to the toilet.

18. The Appellant requires assistance washing her hair and cutting her nails. She also requires assistance with having her legs washed.

19. The Appellant contested the reductions in home help authorizations by requesting a hearing.

20. On [redacted] the Appellant's Request for Hearing was received.

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. The Adult Services Manual (ASM) sets forth eligibility criteria, program mission and goals. The current, updated policy states:

> **ELIGIBILITY CRITERIA**
>
> **GENERAL**
>
> Home help services are available if the client meets all eligibility requirements. An independent living services case may be opened to supportive services to assist the client in applying for Medicaid.
>
> Home help services payments cannot be authorized prior to establishing Medicaid eligibility and a face-to-face assessment completed with the client. Once MA eligibility has been established, the case service methodology **must** be changed to case management.
>
> **Requirements**
>
> Home help eligibility requirements include **all** of the following:
>
> - Medicaid eligibility.
> - Certification of medical need.
> - Need for service, based on a complete comprehensive assessment (DHS-324) indicating a

functional limitation of level 3 or greater for activities of daily living (ADL).

- Appropriate Level of Care (LOC) status.

Medicaid/Medical Aid (MA)

The client may be eligible for MA under one of the following:

- All requirements for Medicaid have been met.
- MA deductible obligation has been met.

The client must have a scope of coverage of either:

- 1F or 2F.
- 1D or 1K (Freedom to Work).
- 1T (Healthy Kids Expansion).

Clients with a scope of coverage 20, 2C or 2B are **not** eligible for Medicaid until they have met their MA deductible obligation.

Note: A change in the scope of coverage in Bridges will generate a system tickler in ASCAP for active services cases.

Medicaid Personal Care Option

Clients in need of home help personal care services may become eligible for MA under the Medicaid personal care option.

Discuss this option with the client and coordinate implementation with the eligibility specialist.

Conditions of eligibility:

- The client meets all Medicaid eligibility factors except income.
- An independent living services case is open.
- The client is eligible for home help services.
- The cost of personal care services is **more** than the MA excess income amount.

If **all** the above conditions have been satisfied, the client has met MA deductible requirements. The adult services specialist can apply the personal care option in [redacted]. The

deductible amount is entered on the **MA History** tab of the Bridges **Eligibility** module in ASCAP.

Use the DHS-1210, Services Approval Notice to notify the client of home help services approval when MA eligibility is met through this option. The notice must inform the client that the home help payment will be affected by the deductible amount, and that the client is responsible for paying the provider the MA deductible amount each month.

Do **not** close a case eligible for MA based on this policy option if the client does not pay the provider. It has already been ensured that MA funds will not be used to pay the client's deductible liability. The payment for these expenses is the responsibility of the client.

Changes in the client's deductible amount will generate a system tickler from Bridges.

MA eligibility under this option **cannot** continue if the cost of personal care becomes **equal to or less than** the MA excess income amount.

Note: See Bridges Eligibility Manual (BEM) 545, Exhibit II, regarding the Medicaid Personal Care Option.

Medical Need Certification

Medical needs are certified utilizing the DHS-54A, Medical Needs form and must be completed by a Medicaid enrolled medical professional. A completed DHS-54A or veterans administration medical form are acceptable for individual treated by a VA physician; see ASM 115, Adult Services Requirements.

Necessity For Service

The adult services specialist is responsible for determining the necessity and level of need for home help services based on:

- Client choice.
- A completed DHS-324, Adult Services Comprehensive Assessment. An individual must be assessed with at least one activity of daily living (ADL) 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 determines a need at a level 3 or greater.

- Verification of the client's medical need by a Medicaid enrolled medical professional via the DHS-54A. The client is responsible for obtaining the medical certification of need; see ASM 115, Adult Services Requirements.

Appropriate Level of Care Status

Verify client's level of care to avoid duplication of services. The level of care will determine if the client is enrolled in other programs. The level of care information can be found in ASCAP under the **Bridges Search** or **Bridges Eligibility**

module, **MA History** tab; see ASM 125 Coordination With Other Services for a list of level of care codes.

Adult Services Manual 105
Effective November 1, 2011

Adult Services Manual 115:

APPLICATION FOR SERVICES (DHS-390)

The client must complete and sign a DHS 390, Adult Services Application to receive independent living services. An authorized representative or other person acting for the client may sign the DHS-390 if the client either:

- Is incapacitated.
- Has a court-appointed guardian.

A client unable to write may sign with an X, witnessed by one other person (for example, relative or department staff). The adult services specialist **must not** sign the DHS-390 on behalf of the client.

The DHS-390 remains valid unless the case record is closed for more than 90 days.

MEDICAL NEEDS FORM (DHS-54A)

The DHS- 54A, Medical Needs form must be signed and dated by a medical professional certifying a medic al need for personal care services. The medical professional must be an enrolled Medicaid pr ovider and hold one of the following professional licenses:

- Physician (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 National Provider Identifier (NPI) number must be entered on the form by the medical prov ider and t he medical professional must indicate whether they are a Medicaid enrolled provider.

The medic al professional c ertifies that the client's need for service is related to an existing medical condition. **The medical professional does n ot prescribe or authorize personal care services** . Needed services are determined by the comprehensive assessment conducted by the adult services specialist.

If the medi cal needs f orm has not been returned, the adult services specialist should follow-up with the client and/or medical professional.

Do **not** authorize home help serv ices prior to the date of the medical professional signature on the DHS-54A.

The medic al needs form does not serve as the applicatio n for services. If the signat ure date on the DHS-54 is **before** the date on the DHS-390, pay ment for home help services must begin on the date of the application.

Example: The local office adult services unit receiv es 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.

COMPREHENSIVE ASSESSMENT (DHS-324)

Conduct a face-to-face interview with the client in their home to assess the personal care needs. Complete the DHS-324, Adult Services Comprehensive Assessment which is generated from the Adult Services Comprehensive Assessment Program (ASCAP); see ASM 120, Adult Services Comprehensive Assessment.

SERVICE PLAN

Develop a service plan with the client and/or the client's representative. Determine the method of service delivery and any use of home help services with other types of services to meet the assessed needs of the client. The ILS service plan is developed whenever an issue is identified in the comprehensive assessment; see ASM 130, Service Plan.

CONTACTS

The specialist must, at a minimum, have a face-to-face interview with the client, prior to case opening, then every six months in the client's home, at review and redetermination.

An initial face-to-face interview must be completed with the home help provider in the client's home or local DHS office. A face-to-face or phone contact must be made with the provider at the next review or redetermination to verify services are being furnished.

Note: If contact is made by phone, the provider must offer identifying information such as da te of birth and the las t four digits of their social security number. A face-to-face interview in the clien t's home or local DH S office must take place at the next review or redetermination.

ADULT SERVICES REQUIREMENTS § 115

The [redacted] provides the following instru ction to the worker in implementing the policy:

PERSON CENTERED PLANNING

The adult services specialist views each client as an individual with specific and uni que circumstances, and will approach case planning holistically, from a person-centered, strength-based perspective.

Person-centered, strength-based case pl anning focuses on the following:

- Client as **decision-maker** in determining needs and case planning.
- Client **strengths and successes,** rather than problems.
- Client as their **own best resource.**
- Client **empowerment.**
- The adult services specialist's role includes **being an advocate** for th e client. **As advo cate, the specialist will:**
  - ••Assist the client to become a self-advocate.
  - ••Assist the client in securing necessary resources.
  - ••Inform the client of options and educate him/her on how to make the best possible use of available resources.
  - ••Promote services for client s in the least r estrictive environment. Participate in c ommunity forums, town meetings, hearings, etc. for the purpose of information gathering and sharing.
  - ••Ensure that community programming balanc es client choice with safety and security.

••Advocate for protection of the frail, disabled and elderly.

••Promote employment counseling and training services for developmentally disabled persons to ensure **inclusion** in the range of career opportunities available in the community.

PARTNERSHIPS

Work cooperatively with other agencies to ensure effective coordination of services; see ASM 125, Coordination With Other Services.

Previous policy included different eligibility criteria. It was initially changed with an Interim Policy Bulletin issued and a effective October 1, 2011.

Adult Services Manual (ASM)
115 11-1-2012

[redacted] 120) addresses the issues of assessment and service plan development.

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 must be entered on the computer program.

Requirements

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.

•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-27, 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 RF 1555. This form is primarily used for APS cases.

•Follow rules of confidentiality when home help cases have companion adult protective services cases; see SRM 131, Confidentiality.

Bridges Eligibility Module

The **Bridges Eligibility** module in **ASCAP** contains information pertaining to the client's type of assistance (TOA) eligibility, scope of coverage and level of care.

Medical Module

The **Medical** module in **ASCAP** contains information regarding the physician(s), diagnosis, other health issues, adaptive equipment, medical treatments and medications. The medical needs certification date is entered on the diagnosis tab, at initial certification and annually thereafter, if applicable; see ASM 115, Adult Services Requirements.

Functional Assessment

The **Functional Assessment** module of the **ASCAP** comprehensive assessment is the basis for service planning and for the home help services 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.

Home help payments may only be authorized for needs assessed at the level 3 ranking 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 IADL's if the assessment determines 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.

Complex Care Needs

Complex care refers to conditions requiring intervention with special techniques and/or knowledge. These complex care tasks are performed on client's whose diagnoses or conditions require more management. The conditions may also require special treatment and equipment for which specific instructions by a health professional or client may be required in order to perform.

- Eating and feeding.
- Catheters or legs bags.
- Colostomy care.
- Bowel program.
- Suctioning.
- Specialized skin care.
- Range of motion exercises.
- Peritoneal dialysis.
- Wound care.
- Respiratory treatment.
- Ventilators.
- Injections.

When assessing a client with complex care needs, refer to the complex care guidelines on the adult services home page.

Time and Task

The specialist will allocate time for each task assessed a rank of 3 or higher, based on in terviews wit h the client and provider, observation of the clie nt's abilities and use of the reasonable time schedule (RT S) as a **guide**. The RT S can be found in ASCAP under the Payment m odule, Time and Task screen. When hours exc eed 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 it's completion.**

Example: A client needs assis tance with cutting up food. The specialist would only pay for the time required to c ut the food and not the full amount of time allotted under the RT S for eating.

IADL Maximum Allowable Hours

There are monthly maximum hour limits on all instrumental activities of daily living except medication. T he 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 [redacted], authorize only the amount of time needed for each task. Assessed hours for [redacted] (exc ept medications) must be prorated by **one half** in shared liv ing 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 s ituations where others live in adjoined apartments/flat s or in a separate home on s hared property and there is no shared, common living area.

In shared living arrangements , where it can be **clearly** documented that [redacted] for the e ligible clie nt are completed separately from others in th e home, hours for [redacted] 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.

Expanded Home Help Services (EHHS)

Expanded home help services exis ts if all basic home help services eligibility criteria are met and the assess ment indicates the client's needs are so extensive that the cost of care cannot be met within t he monthly maximum payment level of $549.99.

Michigan Department of Community Health Approvals

When the client's cos t of care exceeds $1299.99 for **any** reason, the adult services specialist must submit a written request for approval to the Michigan Department of Community Health (MDCH).

Follow the **Procedures for Submitting Expanded Home Help Req uests** found on the Adult Services Home Page. Submit the request with all required documentation to:

Michigan Department of Community Health
Long Term Care Services Policy Section
Capital Commons Building, 6th Floor
P.O. Box 30479
Lansing, MI 48909

MDCH will provide written do cumentation (DCH-17 85) of approval. A new request **must** be submitted to the Michigan Department of Community Heal th whenever there is an increase in the cost of care amount. A new request is **not** require if the cost of care decreases below the approved amount set by MDCH.

Note: If an expanded home help case closes and reopens within 90 days and the care cost remains the same, a new MDCH approval is **not** required.

	ASM 115-125
Version:	Nov.1, 2011-May1, 2012

SERVICE PLAN

INTRODUCTION

A service plan must be devel oped for all independent living services 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.
- 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 client and the provider, if appropriate, in developing a plan to achieve this goal.

- The kinds and amounts of activities required for the client's maintenance and functioning in their 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 home help **only** for those services or times which the responsible relative

or legal dependent is **unavailable** or **unable** to provide; see ASM 120, Adult Services Comprehensive Assessment.

Example: Client's spouse is unavailable to provide care due to employment. Their work schedule is Monday-Friday, 7:00 a.m. to 6:00 p.m. The client's spouse would be responsible for house cleaning, shopping and laundry (possibly dinner) during those times they are available.

•Home help services may be approved when the client is receiving other home care services **if** the services are not duplicative (same service for the same time period); see ASM 125, Coordination With Other Services.

Good Practices

Service plan development practices will include the use of the following skills:

•**Listen actively** to the client.

•Encourage clients to **explore options** and select the appropriate services and supports.

•Monitor for **congruency** between case assessment and service plan.

•Provide the necessary supports to **assist** clients **in applying for resources**.

•Continually **reassess** case planning.

•Enhance/preserve the client's **quality of life**.

Monitor and document the status of all **referrals** to waiver programs and other community resources **to ensure quality outcomes**.

ASM 130
Version: Nov.1, 2011

In this case there is no dispute the Appellant requires physical assistance with her activities of daily living. The time authorized to complete the care tasks is at issue. The worker completed the home call and became concerned her case was out of compliance because she learned the Appellant was able to feed herself after her food was cut for her. She saw a large authorization for eating assistance that was

unnecessary and she reduced it. She kept some limited assistance for eating in t he authorization, 10 minutes per day. She reduced it from the previous level of 44 minutes per day. This ALJ agrees this reduction was proper in order f or the case to be more congruent with the Appellant's actual need.

The worker made other reductions that ar e not supported by a s ound comprehensiv e assessment and polic y. This is evident for a number of reasons. Following the reductions the worker received a teleph one call from the provider and agreed t o increase (slightly) some of t he authorizations. The total au thorization wa s originally reduced from over $700.00 per month to less than $400.00 per month. Thereafter it was increased back to just slightly over $400.00 per month. H er narrative notes and need to adj ust the authorization upwards is consistent with a det ermination by this ALJ that the comprehensive assess ment comple ted in [redacted] was inadequate t o determine the Appellant's ac tual needs . This then result ed in an inadequate authorization. The worker had not a ssessed the Appellant's need for grooming assistance, thus it remained at a functional rank of 1, despite needing help with nails and hair. The worker did not take into acc ount the length of time it takes t o assist the Appellant, given her fragile state and slow movem ents. This contribut ed to the inadequate authorization for bathing, dressing and mobility. The worker's notes indicate the Appellant requires assi stance getting on and off the toilet even though she has grab bars. The worker removed assistance for toi leting despite what her notes state. This is incorrect because the Appellant still require s some physical ass istance with the task. It is also incongruent wit h her m edical status, lack of report of improved functional status and need for assistance getting on and off the furnit ure. The end result of the worker's assessment and authorization are incongr uent and not supported by policy. The attempt to resolve the issues at hearing did not yield a complete reso lution although the Department sought to restore payment authorization for some tasks retroactive to [redacted] This ALJ did not get a voluntary wit hdraw from the Appellant, thus is issuing a Decision and Order.

The testimony from the Appellant's care provider/daughter is found credible. She states her mother does drop her eatin g utensil and she must get it for her. She must drink from a paper cup due to strengt h limitations wither hands. No payment authorization is made for the mere fact that so meone must drink from a paper cup. It is relevant and material here as useful when ass essing for congruency. The pro vider credible testifie d she must wash her mother's legs for her w hen bathing due to balanc e iss ues. This is congruent with her documented medical s tatus and notes entered from the worker indicating she has increased frequency of fa lls due to dizziness and balance issues. The reduction for bathing bas ed upon a belief the Appellant me rely required as sistance getting in and out of the tub is incongruent with her known m edical status. Furthermore, the provider credibly t estified her mother is slow mov ing and that it takes a lot of time to traverse the stairs. Additionally she mu st be guided when s he walks, ag ain due t o increased falls and dizziness. The worker mu st seek to determi ne how much time is spent physically assis ting with transferring daily , as well as mobility. This is required due to the Appe llant's uncontested medica l fragility, increased falls and overall medical status. There is no report of improved condition or increased functional status, thus the large reduction for mobility should be reexamined carefully.

Based upon the evidence of record, this ALJ finds the Department did not complete an adequate comprehensive assessment at the [redacted] home call. The credible evidence of record demonstrates an inadequate amount of time was authorized for the tasks of bathing, dressing, mobility, transferring, toileting and grooming.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, finds that the Department improperly determined that the proper authorization for home help services on behalf of the Appellant at the most recent assessment.

IT IS THEREFORE ORDERED THAT:

The Department's decision is PARTIALLY AFFIRMED AND PARTIALLY REVERSED. The reduction for eating is **affirmed.** The Appellant's time for toileting, bathing, dressing, mobility, transferring and grooming shall be reassessed and adjusted consistent with the stated intention of the Department at hearing and with this decision. The adjustments ordered herein are to be made retroactive to [redacted]

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

cc: [redacted]

Date Signed: _____

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.