

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

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IN THE MATTER OF:

██████████

Appellant

Docket No. 2012-21795 HHS

██████████

██████████

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 and testified on her own behalf. ██████████ was present on her behalf and testified.

██████████, 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 a diagnosis of left breast cancer and has had surgery related to her medical condition.
3. The Appellant's doctor was given a DHS-54 Medical Needs form to complete as part of the application process.
4. The Appellant's doctor indicated the Appellant had a medical need for assistance on the first form she completed. It was dated ██████████. She

did not specify which of the listed personal care and/or household tasks the Appellant requested assistance with.

5. The ASW telephoned the doctor after receiving the partially completed DHS-54 in order to ascertain which tasks the doctor was certifying a need for assistance with. She spoke with the doctor, who informed her the Appellant needed assistance with transportation only
6. The doctor was informed the HHS program does not provide for medical or other transportation. The doctor then re-submitted a DHS-54 Medical Needs form indicating the Appellant did not have a medical need for any of the tasks listed on the form. The resubmitted form was dated [REDACTED]
7. The Department denied the Appellant's HHS application and sent her a Notice of Denial in [REDACTED].
8. The Appellant requested a formal, administrative hearing [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.

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.

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. (emphasis added by ALJ)

ASM 363, 9-1-2008

At hearing, the Appellant stated the doctor who completed the form was not the one who performed surgery or the one who sees her regularly. She said she is the chemotherapy specialist. She said she had surgery under her left breast and is unable to use her left arm for anything. She testified she experiences a lot of pain. She further testified she takes nerve pills for her pain and has restrictions. The restrictions were read into the record. The Appellant specifically testified she cannot stand to do chores or cook.

The Appellant's witness testified he is available to her █ days per week. He stated he is not a doctor so he could not speak to her medical needs specifically but could say she requires assistance. He reiterated he assists her with haircuts, cooks food and cleans. He further stated she has children who require care and she is unable to do their care without assistance.

The Department witness explained that the doctor re-submitted the form after the telephone call to her office to ask which tasks the Appellant requires assistance with. The doctor stated only transportation. She was informed transportation is not provided through this program and the doctor re-submitted the Medical Needs form, having changed her answer from yes to no. The re-submitted form was relied on to deny the HHS application.

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 pertaining to the HHS application was proper. The Appellant is free to re-apply at any time.

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.


Docket No. 2012-21795 HHS
Decision and Order

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

cc:



Date Mailed: _____3-27-12_____

***** 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.