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

Docket No. 2013-11969 HHS

[redacted],

Appellant.
_____/

DECISION AND ORDER

This matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9 and 42 C.F.R. § 431.200 *et seq.*, upon the Appellant's request for a hearing.

After due notice, a hearing was held on [redacted] Appellant's representative, appeared and testified on Appellant's behalf. Appellant also testified on her own behalf. [redacted], Appeals Review Officer, represented the Department of Community Health. [redacted] Adult Services Worker (ASW), from the Wayne County DHS Office appeared as a witness for the Department. [redacted], Adult Services Supervisor was also present but did not testify.

ISSUE

Did the Department properly reduce Appellant's Home Help Services (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. Appellant is a [redacted]-year-old Medicaid beneficiary (DOB [redacted]) who has been receiving HHS. (Testimony).

2. Appellant has been diagnosed by a physician with fibromyalgia, peripheral neuropathy, CVA in [redacted] and [redacted], and Rheumatoid arthritis. (Exhibit A, p. 22).

3. On [redacted] completed a DHS 54A Medical needs form. [redacted] certified a medical need for assistance with a number of personal care items, including eating, toileting, bathing, grooming, transferring mobility, shopping, laundry, and housework.

4. On [redacted], Appellant provided DHS a copy of the DHS 54A that included a statement indicating the Appellant would need wound care for three months. A medical packet submitted along with the DHS 54A indicated for wound care that the appellant needed to leave the dressing on for two days, and then she could remove it and take a shower. Thereafter, Appellant was to keep the wound clean with peroxide and water. (Exhibit A, p. 26, Exhibit B, p. 3).

5. On [redacted], [redacted] ASW, received a DHS 54A from Appellant's doctor, [redacted] that was different than the one obtained from the Appellant. It appeared that the one from the Appellant had been altered adding the need for three months of wound care. (Exhibit B, pp. 1, 2-3).

6. On [redacted], the ASW spoke with [redacted] to clarify Appellant's need for wound care so she could authorize additional HHS to cover the wound care. [redacted] told the ASW he did not write the "3 months for wound care" on the medical needs form. The ASW stated [redacted] did not indicate that any wound care was needed, but did indicate the Appellant needed one month of physical therapy three times per week, and he was going to give her a prescription for physical therapy. The ASW further stated [redacted] told her the Appellant was ambulatory and could walk without an assistive device as he saw her walking at her last doctor's visit. [redacted] stated there was no need for assistance with mobility, transferring, and range of motion (the range of motion would be addressed with the physical therapy). The ASW reported [redacted] stated he felt the Appellant could do more for herself than she indicated to him. [redacted] further stated he just marked on the medical needs form what the Appellant told him, (bathing, eating, toileting, grooming, meal prep, and housework); although he felt she could do these things for herself. (Exhibit A, p. 24 and testimony).

7. On [redacted], the Department issued an Advance Action Notice to Appellant notifying her that her HHS would be reduced to a total of [redacted] hours and [redacted] minutes of HHS per month for a total monthly care cost of [redacted], effective [redacted] The reduction resulted from an elimination of assistance for range of motion exercises, transferring and mobility. (Exhibit A, pp. 17-21, Exhibit C, pp. 3-4 and testimony).

8. On [redacted], MAHS received Appellant's Request for Hearing. (Exhibit A, p. 4-9).

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 101 (11-1-2011) (hereinafter "ASM 101") and Adult Services Manual 120 (11-1-2011) (hereinafter "ASM 120") address the issues of what services are included in Home Help Services and how such services are assessed:

> **Home Help Payment Services**
>
> Home help services are non-specialized personal care service activities provided under the independent living services program to persons who meet eligibility requirements.
>
> Home help services are provided to enable individuals with functional limitation(s), resulting from a medical or physical disability or cognitive impairment to live independently and receive care in the least restrictive, preferred settings.
>
> Home help services are defined as those tasks which the department is paying for through Title XIX (Medicaid) funds. These services are furnished to individuals who are **not** currently residing in a hospital, nursing facility, licensed foster care home/home for the aged, intermediate care facility (ICF) for persons with developmental disabilities or institution for mental illness.
>
> These activities must be certified by a Medicaid enrolled medical professional and may be provided by individuals or by private or public agencies. **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.
>
> Personal care services which are eligible for Title XIX funding are limited to:
>
> Activities of Daily Living (ADL)
>
> • Eating.
> • Toileting.
> • Bathing.

• Grooming.
• Dressing.
• Transferring.
• Mobility.

Instrumental Activities of Daily Living (IADL)

• Taking medication.
• Meal preparation/cleanup.
• Shopping for food and other necessities of daily living.
• Laundry.
• Housework.

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 IADL's if the assessment determines a need at a level 3 or greater. [ASM 101, pages 1-2 of 4].

Services not Covered by Home Help Services

Home help services must **not** be approved for the following:

- Supervising, monitoring, reminding, guiding or encouraging (functional assessment rank 2); [ASM 101, page 3 of 4].

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 RFF 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.

* * *

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

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.

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 Needs 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 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**.

IADL Maximum Allowable Hours

There are monthly maximum hour limits on all Instrumental Activities of Daily Living 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 hours 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.

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. [ASM 120, pp. 1-5].

Adult Services Manual 115 (11-1-2011) (hereinafter "ASM 115") sets forth the requirements relating to the medical needs for. ASM 115 states in 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 provider 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 disabled adult children (DAC). All other Medicaid recipients must have a DHS-54A completed at the initial opening and annually thereafter.
>
> The client is responsible for obtaining the medical certification of need but the form must be completed by the medical professional and not the client. The National 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. [p. 1 of 3, emphasis added].

Appellant's ASW [redacted] stated the Appellant had some surgery near the end of [redacted]. The ASW stated she had information that the Appellant

may be in need of some additional services for wound care and she attempted to confirm this with the Appellant's doctor, [redacted]

On [redacted], the ASW spoke with [redacted] to clarify Appellant's need for wound care. [redacted] told the ASW he did not write the "3 months for wound care" on the medical needs form. The ASW stated [redacted] did not indicate that any wound care was needed, but did indicate the Appellant needed one month of physical therapy three times per week, and he was going to give her a prescription for physical therapy.

The ASW further stated [redacted] told her the Appellant was ambulatory and could walk without an assistive device as he saw her walking at her last doctor's visit. [redacted] stated there was no need for assistance with mobility, transferring, and range of motion (the range of motion would be addressed with the physical therapy). The ASW reported [redacted] stated he felt the Appellant could do more for herself than she indicated to him. [redacted] further stated he just marked on the medical needs form what the Appellant told him, (bathing, eating, toileting, grooming, meal prep, and housework); although he felt she could do these things for herself.

Based upon her conversation with [redacted] the ASW [redacted] determined that the Appellant's condition had improved and she had a lesser need for assistance with her ADLs (she eliminated transferring, mobility, and range of motion exercises), and she reduced the Appellant's HHS to a total of [redacted] hours and [redacted] minutes of HHS per month for a total monthly care cost of [redacted]. The ASW stated she had not received the doctor's prescriptions for physical therapy prior to the time the negative action notice was sent out. The ASW stated that she believed the negative action in this case was appropriate based on the statement's she received from the Appellant's doctor, [redacted].

During the hearing, the Appellant submitted two multiple page exhibits, (Exhibit 1, pp. 1-39 and Exhibit 2, pp. 1-27), the exhibits contained mostly medical records from her various doctors for medical procedures and doctor's visits which occurred after DHS sent out the Negative Action notice reducing her HHS on [redacted] None of the medical records for treatments and procedures that occurred after the DHS sent out their Negative action notice would have any bearing on the previous decision to reduce HHS, and I find that they are not relevant to the prior decision to reduce services, or a determination of whether the decision to reduce services on [redacted] was proper.

Appellant testified that she saw [redacted] for Rheumatoid arthritis, but he also was aware that she had neuropathy. Appellant made reference to the physical therapy prescriptions and the daily therapy note contained in Exhibit A at pp. 12, 14, 15, and testified that they were given to DHS and faxed to them prior to the [redacted], but the documents appeared to have been received by fax on [redacted] and again on [redacted] There is no evidence showing the documents were received by DHS prior to [redacted] Appellant also denied

altering the medical needs form that she submitted from [redacted]. She testified that she wrote the information on the medical needs form and then [redacted] signed the form. The Appellant indicated she was not aware that according to the Adult Services Manual, the medical needs form was supposed to be filled out by the doctor.

Appellant's provider also testified at the hearing. He described all the services he provides for the Appellant. Appellant's provider testified he did all the cooking, washes the clothes, bathes her, feeds her, gets her groceries, does her shopping, gets her medications for her, transfers her to her wheel chair which she uses to get around, and assists her with range of motion exercises. Appellant's provider stated he takes care of all her daily needs. He stated he started as the Appellant's provider in [redacted] of [redacted]. Appellant asked him to indicate how much time it took him to complete certain task for her, in an attempt to show that the total amount of time that was authorized for home help services was not sufficient. However, the Respondent objected, pointing out that the negative action being appealed from only eliminated services for mobility, transferring, and range of motion exercises. The times for the other services were not reduced, and were not properly the subject of this appeal.

The Department presented credible evidence to show that at the time the Appellant's HHS was reduced, the information provided by Appellant's doctor, [redacted] supported the reduction in the Appellant's HHS. Appellant's witnesses failed to discredit the ASW's testimony concerning the Appellant's reduced need for assistance with her ADL's. The policy quoted above dictates that the needed services are determined by the comprehensive assessment conducted by the adult services specialist. The preponderance of the evidence shows that the ASW properly determined the needed services based upon the information she had at the time of her assessment. Accordingly, the Department's decision must be sustained.

DECISION AND ORDER

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

IT IS THEREFORE ORDERED THAT:

The Department's decision is AFFIRMED.

William D Bond

William D. Bond
Administrative Law Judge
for James K. Haveman, Director
Michigan Department of Community Health

Date Signed: [redacted]
Date Mailed: [redacted]

[redacted]
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WDB/db

cc: [redacted]

***** 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.