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) 373-4147

IN THE MATTER OF:

[redacted],

Docket No. 2013-35615 HHS
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]. The Appellant appeared and testified. He was represented by [redacted]. [redacted], Appeals Review Officer, represented the Department. Her witnesses were [redacted], ASW and [redacted], ASW supervisor.

PRELIMINARY MATTER

The Department motion to dismiss for lack of jurisdiction owing to late appeal could not be supported as they had no evidence that the Appellant's petition was actually received late.

ISSUE

Did the Department properly assess the Appellant for 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. The Appellant is a [redacted]-year-old Medicaid beneficiary. (Appellant's Exhibit #1)

2. The Appellant is afflicted with arteriosclerosis, scoliosis, OA, chronic pain (back) and gait abnormality. (Department's Exhibit A, pp. 15 and 20)

3. The Department witness testified that an in-home assessment was conducted on [redacted] from a new case referral entered on [redacted]. (*See* Testimony)

4. On [redacted] the Department sent the Appellant a DHS 1210-A Services and Payment Approval Notice authorizing payments and services in the amount of $[redacted] back dated for the effective start date of [redacted]. (*See* Testimony and Department's Exhibit A, pp. 7 and 8)

5. The Appellant claimed he sent his application materials in on [redacted]. (*But see* Testimony and Department's Exhibit A, pp. 22)

6. The Department's witness said that the referral for HHS was received and assigned for follow-up on [redacted] – this would later become the effective date, post in-home assessment. (Department's Exhibit A, p. 13 and *See* Testimony)

7. The Department's representative said that the Appellant was assessed and services were prorated - as he did not live alone. (*See* Testimony)

8. The crux of the Appellant's petition and testimony was that he needed more time for his ADLs than was assigned by the ASW. (*See* Testimony)

9. The request for hearing on the instant appeal was received by the Michigan Administrative Hearings System (MAHS) for the Department of Community Health on [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.

COMPREHENSIVE ASSESSMENT

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 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.

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Adult Service Manual (ASM), §120, page 1 of 5, 5-1-2012.

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 Service Requirements.

ASM §105, page 2 of 3, November 1, 2011

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ADULT SERVICES REQUIREMENTS - 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.

….

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.

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.

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(Emphasis supplied by ALJ) ASM 115, pages 1 and 2 of 3, *Supra*

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The Department witness testified that they approved HHS in the above stated amount as the ASW assessed the Appellant and found him to need HHS assistance at a ranking of three (3) or greater in the activities of daily living (ADLs) for bathing, grooming and dressing. The Instrumental Activities of Daily Living (IADLs) were assigned various times (below) and were subject to mandatory proration.

The Appellant and his representative testified on the need for greater assistance – particularly in the areas of bathing and grooming.

The following item summarizes the ADL assessment and the ALJ's observation:

- Bathing was correctly assessed at 7 minutes, 7 days a week based on the ASW observations at the in-home assessment. The Appellant's testimony that he now required a daily bath (versus an assisted shower) because he now eliminates on himself was not part of the in-home assessment conducted on [redacted]. There was no medical evidence to support this dramatic erosion in bowel/bladder control. Bathing was properly established at 3:31 per month.

- Grooming was properly established at 5 minutes a day, twice a week. The items of shaving and nail cutting were properly assessed at a ranking of three (3). The testimony from the Appellant that the addition of combing hair was not supported in the record. Furthermore, transportation to a barber is not a covered service under the HHS program. Grooming was properly established at 43 minutes per month.

- Dressing was properly established at 7 minutes a day, 7 days a week as a daily activity which coincided with the bathing function – a daily activity. The Appellant established that putting on his socks, pants and tying his shoes were his most difficult dressing tasks. These assignments were more than accounted for in the [redacted] assessment. The was no evidence that the Appellant required more frequent dressing owing to bowel or bladder accidents. Dressing was properly established at 3:31 per month.

- There was no dispute from the Appellant or his representative concerning the adequacy of the IADLs.

On review of the testimony and the evidence the Administrative Law Judge finds that the comprehensive assessment was properly drawn. There was no evidence that the Appellant's condition had worsened since the date of the assessment, nor was there any persuasive evidence that the in-home assessment (conducted on [redacted]) was improperly drawn.

The Appellant's argument that he needed his chore provider to do more for him "in the shower" by way of stabilization "…at the waist" did not preponderate his burden of proof. The Appellant's representative emphasized that the residuals of the Appellant's scoliosis were very painful and debilitating – however there was no new medical evidence to support alleged developments or changes in condition.

At best the Appellant has suggested a change in condition which, in order to merit reassessment, must be communicated to the department via his ASW. If the Appellant has new evidence to support those claims that should be shared with the ASW.

Accordingly, the Appellant has failed to preponderate his burden of proof that the Department erred in conducting its assessment on [redacted] – the times and tasks were properly identified and structured for time and payment - according to policy.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the Department properly assessed the Appellant's HHS on December 5, 2012.

IT IS THEREFORE ORDERED that:

The Department's decision is AFFIRMED.

\s_____
Dale Malewska
Administrative Law Judge
for James K. Haveman, Director
Michigan Department of Community Health

[redacted]

[redacted]
Docket No. 2013-35615 HHS
Hearing Decision & Order

cc: [redacted]

Date Signed: 6/21/2013

Date Mailed: 6/21/2013

***** 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.