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

[redacted],

Docket No. 2013-29425 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.*, and upon the Appellant's request for a hearing.

After due notice, a hearing was held on [redacted]. Appellant's son [redacted] appeared and testified on Appellant's behalf. Appellant's daughter and caregiver [redacted] was also present but did not testify. [redacted], Appeals Review Officer, represented the Department of Community Health. [redacted], Adult Services Worker (ASW), from the [redacted], testified for the Department. [redacted], Adult Services Supervisor was present but did not testify.

ISSUE

Did the Department properly deny Home Help Services (HHS) payments for the time period of [redacted] to [redacted]?

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 who has been diagnosed with ischemic brain infarct with right spastic hemiparesis & expressive aphasia, and systemic lupus. (Respondent's Exhibit A, pp. 10, 12 and testimony).

2. On [redacted], Appellant filed an application for HHS. (Testimony).

3. At that time, Appellant also submitted a medical needs form completed by her doctor and dated [redacted]. Neither the form nor the attached discharge plan of care listed Appellant's diagnoses. (Respondent's Exhibit A, pp. 6-8 and testimony).

4. On [redacted], the Department sent Appellant an Adequate Action notice informing her that HHS would be denied effective [redacted], as there was no diagnosis on her medical needs form. Appellant was advised to have her doctor correct the form or complete a new one. (Exhibit A, pp. 2, 13-16 and testimony).

5. On [redacted], an initial assessment was completed by the ASW to determine the Appellant's needs for home help services. Thereafter on [redacted], a second copy of the medical needs form that was submitted by the Appellant on [redacted], was received by DHS. This time Section B-Diagnosis contained the following: "Stroke Complications, Physical and Cognitive Impairments, See Attached Post Discharge Plan of Care, Medication Wound Care Therapy". (Exhibit A, pp. 2, 9, 26-27).

6. On [redacted], after the ASW and her supervisor determined that the second copy of the medical needs form was not sufficient, a second Adequate Action notice was sent to the Appellant informing her that HHS would be denied effective [redacted], because Section B of her medical needs form was not completed with a written diagnosis by her doctor. A new form was sent to Appellant for completion by her doctor. (Exhibit A, pp. 2, 17-21 and testimony).

7. On [redacted], the new medical needs form signed by her doctor on [redacted] was received containing medical diagnoses of ischemic brain infarct with right spastic hemiparesis & expressive aphasia, and systemic lupus. (Exhibit A, pp. 2, 10, 26 and testimony).

8. On [redacted], a Services and Payment Approval Notice was sent to the Appellant in the amount of $[redacted] for 133 hours and 19 minutes per month with an effective start date of [redacted]. (Exhibit A, pp. 2, 22-23 and testimony).

9. On [redacted], MAHS received a Request for Hearing from Appellant. In that request, Appellant claims that the start date for her HHS should have been [redacted], the date she came home from the nursing home, and that and her provider should receive payments for the time period between [redacted] and [redacted]. (Exhibit A, p. 4).

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 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") addressed the issue of payment services for Home Help at the time of the denial in this case:

> **Payment Services for Home Help**
>
> 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.
- Light Housecleaning.

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.]

Regarding the assessment discussed above, Adult Services Manual 120 (11-1-2011) (hereinafter "ASM 120") provided:

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 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 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.

HHS payments may only be authorized for needs assessed at the 3 level 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.
>
> * * *
>
> **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. When hours exceed the RTS, rationale **must** be provided. [ASM 120, pages 2-4 of 6.]

Moreover, with respect to the authorization of payments, Adult Services Manual 140 (11-1-2011) (hereinafter "ASM 140") states:

> **ADULT SERVICES AUTHORIZED PAYMENTS (ASAP)**
>
> The Adult Services Authorized Payments (ASAP) is the Michigan Department of Community Health payment system that processes adult services authorizations. The adult services specialist enters the payment authorizations using the **Payments** module of the **ASCAP** system.
>
> *No payment can be made unless the provider has been enrolled in Bridges*. Adult foster care, homes for the aged and home help agency providers must also be registered with Vendor Registration; see ASM 136, Agency Providers.
>
> **Note:** The adult services home page provides a link to the provider enrollment instructions located on the Office of Training and Staff Development web site.

Home help services payments to providers must be:

- *Authorized for a specific period of time and payment amount.* The task is determined by the comprehensive assessment in ASCAP and will automatically include tasks that are a level three or higher.

- Authorized **only** to the person or agency actually providing the hands-on services.

  Note: An entity acting in the capacity of the client's fiscal intermediary is not considered the provider of home help and must not be enrolled as a home help provider; see ASM 135, Home Help Providers.

- Made payable jointly to the client and the provider.

Exception: Authorizations to home help agency providers are payable to the provider only. There are circumstances where payment authorizations to the provider only are appropriate, for example, client is physically or mentally unable to endorse the warrant. All single party authorizations must be approved by the supervisor.

- Prorate the authorization if the MA eligibility period is less than the full month. [ASM 140, page 1 of 3 (italics added).]

The Reference Forms & Publications Manual, State of Michigan, Department Of Human Services**,** RFF 54A p. 3 of 3, DHS-54A, Medical Needs, RFB 2010-007**,** 10-1-2010 further provides in part:

INSTRUCTIONS FOR ADULT SERVICES

Client information in the upper right hand corner is generated from the ASCAP system.

Obtain client/representative signature and date.

Worker signs and dates the form.

All Adult Services cases require a Medicaid enrolled medical professional to complete the following:

- Item B-Diagnosis
- Item C-Chronic illness

- Item E-Estimated months of treatment
- Item I-Certification of need for personal care services. Medical professional must check **Yes** or **No** and sign and date the form.

A Medicaid enrolled physician, nurse practitioner, physical or occupational therapist, completes the information at the bottom and signs and dates the form. The Medicaid provider ID number **must** be provided.

In this case, while Appellant provided a complete application and medical needs form on [redacted]. Unfortunately the Appellant's doctor failed to complete article B-Diagnosis on the medical needs form. On [redacted], the Department sent Appellant an Adequate Action notice informing her that HHS would be denied effective [redacted], as there was no diagnosis on her medical needs form. Appellant was advised to have her doctor correct the form or complete a new one.

On [redacted], an initial assessment was completed by the ASW to determine the Appellant's needs for home help services. Thereafter on [redacted], a second copy of the medical needs form that was submitted by the Appellant on [redacted], was received by DHS. This time Section B-Diagnosis contained the following: "Stroke Complications, Physical and Cognitive Impairments, See Attached Post discharge Plan of Care, Medication Wound Care Therapy". However, after the ASW and her supervisor determined that the second copy of the medical needs form was not sufficient, on [redacted] a second Adequate Action notice was sent to the Appellant informing her that HHS would be denied effective [redacted], because Section B of her medical needs form was not completed with a written diagnosis by her doctor. A new form was sent to Appellant for completion by her doctor.

Finally, on [redacted], the new medical needs form signed by her doctor on [redacted] was received containing medical diagnoses of ischemic brain infarct with right spastic hemiparesis & expressive aphasia, and systemic lupus. Accordingly, on [redacted], a Services and Payment Approval Notice was sent to the Appellant in the amount of $[redacted] for 133 hours and 19 minutes per month with an effective start date of [redacted].

At the hearing Appellant's representative presented evidence to show that he attempted to fax the corrected medical needs form that DHS eventually received on [redacted], back on [redacted]. Unfortunately the fax number he used, which was published on the DHS web site, was not the correct number. The ASW acknowledged at the hearing that the Adequate Action notice they sent out on [redacted] did not contain the fax number for returning the corrected form.

As a preliminary matter, this Administrative Law Judge would note that it is not clear what specific services were performed during the time period in question. Appellant's representative just generally testified that his little sister the Appellant's caregiver was taking care of their mother after she came home from the nursing facility, he did not say

how many total hours were worked, and he admitted that no provider logs were kept during the disputed time period. The lack of specific testimony makes the calculation of payment for past services impossible and precludes any award of back payments. The provider is only entitled to payment for assistance actually performed and there is simply no basis for authorizing such a payment on this record.

Even if the amount of past services could be determined, this Administrative Law Judge cannot award payments for them in this case. HHS payments to providers must be authorized for a specific type of service, period of time and payment amount (ASM 140, page 1 of 3), but no such specific authorization was made in this case for the disputed time period. Similarly, with respect to the disputed time period, there was no functional assessment conducted in order to determine the client's ability to perform the identified activities (ASM 120, pages 2-4 of 6), no service plan developed to address the specific services to be provided, by whom and at what cost (ASM 130, pages 1-2 of 2), and no provider was enrolled (ASM 140, page 1 of 3). All of those things have to happen before HHS payments can be made.

This Administrative Law Judge does not possess equitable powers and, therefore, cannot award benefits or payments as a matter of fairness. Certain criteria have to be met and specific events have to occur before HHS payments can be authorized. The assessment process was not completed and the provider was not enrolled in this case until [redacted]. Consequently, any services provided between [redacted] and [redacted] was unauthorized and the Department cannot pay for them.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the Department properly denied payments for Home Help Services for the time period of [redacted] and [redacted].

IT IS THEREFORE ORDERED THAT:

The Department's decision is **AFFIRMED**.

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

cc: [redacted]

[redacted]
Docket No. 2013-29425 HHS
Decision and Order

Date Mailed: _4/12/2013____

***** 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.