

**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:**

██████████

Appellant

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**Docket No.** 2013-46390 HHS  
**Case No.** ██████████

**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 ██████████ ██████████ daughter, represented the Appellant. ██████████ Appeals Review Officer, represented the Department. ██████████ Adult Services Worker ("ASW"), appeared as a witness for the Department.

**ISSUE**

Did the Department properly deny the Appellant's request for an increase in her Home Help Services ("HHS") hours?

**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 Medicaid beneficiary who has been authorized for HHS since ██████████ (Exhibit 1, page 19)
2. The Appellant has been diagnosed with dementia, anxiety/depression, osteoarthritis, hypertension, muscle weakness and high lipids. (Exhibit 1, pages 10 and 18)
3. The Appellant was receiving a total of ██████ hours and █████ minutes of HHS for assistance with bathing, grooming, dressing, toileting, transferring, eating, mobility, medication, housework, laundry, shopping, and meal preparation, with a total monthly care cost of ██████████. (Exhibit 1, page 17)
4. The Appellant's enrolled HHS providers are her daughter and the ██████████ County Council on Aging ("COA"). (Exhibit 1, pages 17 and 19-21)

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5. Around [REDACTED] a request was made to increase the Appellant's HHS hours. (Exhibit 1, page 14; ASW Testimony)
6. HHS payments of \$550 per month or greater are considered Expanded Home Help Services ("EHHS"). EHHS payments over [REDACTED] per month require approval from the MDCH. (Adult Services Manual (ASM) 140 11-1-2011 page 2)
7. On [REDACTED], the ASW spoke with COA, who reported that beyond the HHS hours for COA and the Appellant's daughter, the Appellant receives additional hours for respite with grant money. The ASW confirmed that the Appellant's needs were being met with the available hours at that time. (Exhibit 1, page 14; ASW Testimony)
8. Based on the available information, the ASW concluded that at that time there was no need for an increase and a EHHS request sent to MDCH in [REDACTED] was withdrawn. (Exhibit 1, page 14; ASW Testimony)
9. The Appellant's needs were being met at the time the ASW spoke with the COA on [REDACTED] with the available HHS and respite hours. (Daughter Testimony)
10. On [REDACTED], the Department sent the Appellant an Adequate Negative Action Notice, which informed her that the request for additional HHS hours is denied. (Exhibit 1, page 5)
11. On [REDACTED], the Appellant's request for hearing was received by the Michigan Administrative Hearing System. (Exhibit 1, pages 4-6)

**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 (ASM) 105, 11-1-11, addresses HHS eligibility requirements:

### **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.

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### **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 IADL's 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.

*Adult Services Manual (ASM) 105,*  
11-1-2011, Pages 1-3 of 3

Adult Services Manual (ASM) 115, 11-1-11, addresses the DHS-54A Medical Needs form:

### **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 medical professional and not the client must complete the form. 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.

*Adult Services Manual (ASM) 115,  
11-1-2011, Pages 1-2 of 3*

Adult Services Manual (ASM) 120, 5-1-12, addresses the comprehensive assessment:

### **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. The form is primarily used for APS cases.
- Follow rules of confidentiality when home help cases have companion APS cases, see SRM 131 Confidentiality.

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### **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 3 level 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 determined 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 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.**

**Example:** A client needs assistance with cutting up food. The specialist would only pay for the time required to cut the food and not the full amount of time allotted under the RTS for eating.

#### 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 adjoining 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.

**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.

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### **Expanded Home Help Services (EHHS)**

Expanded home help services exists if all basic home help services eligibility criteria are met and the assessment indicates the client's needs are so extensive that the cost of care cannot be met within the monthly maximum payment level of \$549.99.

Michigan Department of Community Health Approvals

When the client's cost 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 Requests** 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 documentation (DCH-1785) of approval. A new request **must** be submitted to the Michigan Department of Community Health 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.

*Adult Services Manual (ASM) 120, 5-1-2012,*  
Pages 1-5 of 5

Adult Services Manual (ASM) 101, 11-1-11, addresses services not covered by HHS:

### Services not Covered by Home Help

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

- Supervising, monitoring, reminding, guiding, teaching 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 (such as house cleaning, laundry or shopping).
- Services provided by another resource at the same time (for example, hospitalization, MI-Choice Waiver).
- Transportation - See Bridges Administrative Manual (BAM) 825 for medical transportation policy and procedures.
- Money management such as power of attorney or representative payee.
- Home delivered meals.
- Adult or child day care.
- Recreational activities. (For example, accompanying and/or transporting to the movies, sporting events etc.)

**Note:** The above list is not all inclusive.

*Adult Services Manual (ASM) 101, 11-1-2011,  
Pages 3-4 of 4.*

The Appellant was receiving a total of █████ hours and █████ minutes of HHS for assistance with bathing, grooming, dressing, toileting, transferring, eating, mobility, medication, housework, laundry, shopping, and meal preparation, with a total monthly care cost of █████. The Appellant's enrolled HHS providers are her daughter and the █████ County Council on Aging ("COA"). (Exhibit 1, pages 17 and 19-21)

Around █████, a request was made to increase the Appellant's HHS hours. (Exhibit 1, page 14; ASW Testimony) It is noted that under the above cited policy, HHS payments of █████ per month or greater are considered Expanded Home Help Services ("EHHS"). EHHS payments over █████ per month require approval from the MDCH. (Adult Services Manual (ASM) 140 11-1-2011 page 2)

On █████, the ASW spoke with COA, who reported that beyond the HHS hours for COA and the Appellant's daughter, the Appellant receives additional hours for respite with grant money. The ASW confirmed that the Appellant's needs were being met with the available hours at that time. (Exhibit 1, page 14; ASW Testimony)

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Based on the available information, the ASW concluded that at that time there was no need for an EHHS and the request sent to MDCH in [REDACTED] was withdrawn. (Exhibit 1, page 14; ASW Testimony)

The Appellant's daughter acknowledged that the Appellant's needs were being met at the time the ASW spoke with the COA on [REDACTED] with the available HHS and respite hours. However, on [REDACTED] the respite hours were abruptly cut off. The Appellant's daughter learned of this termination by phone and stated no paperwork was received from the waiver agency stating the hours would be stopped and explaining why. The Appellant's daughter filed a hearing contesting regarding the waiver agency action and stated that at the hearing the ALJ told her to appeal the HHS hours. (Daughter Testimony)

It is also noted that the ASW has since made an EHHS request to Lansing and on [REDACTED] MDCH approved an increase in the Appellant's HHS hours. (Exhibit 2) The Appellant's daughter disagrees with the amount of the increase. (Daughter Testimony)

As discussed during the [REDACTED] hearing proceedings, this hearing is limited to reviewing the [REDACTED] denial of the request for an increase in the Appellant's HHS hours. In this hearing, this ALJ does not have any jurisdiction over waiver agency action(s), what occurred at the prior waiver hearing, or the recent EHHS approval. Based on the information available to the ASW at the time the request for an increase in the Appellant's HHS was made in [REDACTED] the Appellant's needs were being met with the authorized HHS and respite hours. Accordingly, the ASW's determination to deny the request for an increase in the Appellant's HHS hours at that time must be upheld. The Appellant can file a new request for hearing to contest the amount of the recent EHHS approval.

**DECISION AND ORDER**

The Administrative Law Judge, based on the above findings of fact and conclusions of law, finds that the Department properly denied the Appellant's [REDACTED] request for an increase in her HHS hours based on the information available at that time.

**IT IS THEREFORE ORDERED THAT:**


The Department's decision is AFFIRMED.

/s/

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Colleen Lack  
Administrative Law Judge  
for James K. Haveman, Director  
Michigan Department of Community Health

Date Signed: [REDACTED]

Date Mailed: [REDACTED]

  
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**\*\*\* 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.