

**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

Docket No. 2013-49072 HHS

██████████

██████████

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 ██████████, the Appellant, appeared on his own behalf. ██████████ Appeals Review Officer, represented the Department. ██████████, Adult Services Worker ("ASW"), ██████████ General Services Program Manager, and ██████████ RN Michigan Department of Community Health ("MDCH") Home Help Services Program, appeared as witnesses for the Department.

ISSUE

Did the Department properly reduce the Appellant's Expanded Home Help Services ("EHHS") case?

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 EHHS since ██████████. (Exhibit 2, page 2)
2. Home Help Services payments of ██████████ per month or greater are considered EHHS. EHHS payments over ██████████ per month require approval from the MDCH. (Adult Services Manual (ASM) 140 11-1-2011 page 2)
3. The Appellant has been diagnosed with C4 complete ASIA-B spinal cord injury and quadriplegia. (Exhibit 1, page 9)
4. The Appellant lives with his parents. (Exhibit 3, page 1)

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5. The Appellant's three enrolled HHS providers are his mother, his father and [REDACTED]. (Exhibit 1, page 32)
6. The Appellant had been authorized for EHHS with a total monthly care cost of [REDACTED] since [REDACTED]. (Exhibit 2, page 2)
7. On [REDACTED], the ASW wrote a request for an increase in the Appellant's EHHS authorization to MDCH noting that the Appellant had entered the hospital and would be needing more care when he returns home. The ASW requested an increase in the monthly EHHS authorization to [REDACTED]. (Exhibit 2, page 2)
8. On [REDACTED], the MDCH RN had a phone conference with the Appellant, all three enrolled HHS providers, a nurse from an agency, the ASW, the ASW's supervisor, and two specialists from DCH. The Appellant's needs for assistance and what each provider does were discussed in detail. (Exhibit 2, pages 7-8; MDCH RN Testimony)
9. The MDCH RN determined that the Appellant should be ranked at functional level 4 for mobility and eating and functional level 5 for all remaining ADLs and IADLs. (Exhibit 2, page 9)
10. On [REDACTED] the Department sent the Appellant an Advance Negative Action Notice, which informed him that effective [REDACTED] the EHHS authorization would be reduced to [REDACTED] per month. (Exhibit 1, page 4)
11. On [REDACTED], the MDCH issued a Policy Decision indicating an EHHS approval for up to [REDACTED] hours and [REDACTED] per month starting [REDACTED]. (Exhibit 2, page 13)
12. On [REDACTED], the Request for Hearing filed on the Appellant's behalf was received by the Michigan Administrative Hearing System. (Exhibit 3, page 2)
13. On [REDACTED], the Michigan Administrative Hearing System sent the Appellant a letter indicating a hearing could not be scheduled because his signature (or mark) was not on the Request for Hearing form nor was there documentation of a legal guardian. The letter gave [REDACTED] days for the Appellant to sign and return the form or provide documentation of a legal guardian. (Exhibit 3, page 10)
14. On [REDACTED] and [REDACTED] the Appellant returned a copy of the Request for Hearing with his signature on it to the [REDACTED] County Department of Human Services office. (Exhibit 3, page 2)

15. On ██████████ the Appellant wrote a letter requesting his hearing, with attachments, including a copy of the original Request for Hearing form with the date stamps documenting the prior receipt by the ██████████ County Department of Human Services office and the Michigan Administrative Hearing System. (Exhibit 3)
16. On ██████████ the Appellant's EHHS case was closed because he began receiving services through the MI Choice Waiver program. (Exhibit 1, page 22)

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.

For unknown reasons, the copies of the Request for Hearing signed by the Appellant and submitted to the ██████████ County Department of Human Services office on ██████████ and ██████████ were not received by the Michigan Administrative Hearing System. It is also unknown why the Appellant's ██████████ request for hearing was not forwarded to the Michigan Administrative Hearing System until ██████████. However, based on the ██████████ date stamp from the ██████████ County Department of Human Services office, the Appellant did submit a copy of the request for hearing with his signature within ██████████ days of the ██████████ letter from the Michigan Administrative Hearing System indicating the Appellant's signature or documentation of a legal guardian were needed before a hearing could be scheduled. (Exhibit 3) Accordingly, this ALJ proceeded with the hearing regarding the ██████████ ██████████ Advance Action Notice of the reduction to the Appellant's EHHS case.

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.

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.

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.

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:

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- 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 had been authorized for EHHS with a total monthly care cost of ██████████ since 1 ██████████. (Exhibit 2, page 2)

On ██████████, the ASW wrote a request for an increase in the Appellant's EHHS authorization to MDCH noting that the Appellant had entered the hospital and would be needing more care when he returns home. The ASW requested an increase in the monthly EHHS authorization to ██████████. (Exhibit 2, page 2)

On ██████████, the MDCH RN had a phone conference with the Appellant, all three enrolled HHS providers, a nurse from an agency, the ASW, the ASW's supervisor, and two specialists from DCH. The Appellant's needs for assistance and what each provider does were discussed in detail. The MDCH RN asked for information on the average amount of time it takes to complete tasks. The MDCH RN provided testimony regarding the new authorizations for the various ADL, IADL and complex care activities included in the HHS program. While there was an overall reduction to the Appellant's monthly EHHS authorization, the new hours were a more accurate representation of the reported care provided by each of the three enrolled providers. For example, time for wound care was added to the EHHS authorization. (Exhibit 2, pages 7-8; MDCH RN Testimony)

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The MDCH RN determined that the Appellant should be ranked at functional level 4 for mobility and eating and functional level 5 for all remaining ADLs and IADLs. (Exhibit 2, page 9) On ██████████, the Department sent the Appellant an Advance Negative Action Notice, which informed him that effective ██████████ the EHHS authorization would be reduced to ██████████ per month. (Exhibit 1, page 4)

The Appellant disagrees with the reduction to his EHHS case. However, the Appellant's testimony indicated he had increased care needs based on subsequent changes in his condition. For example, following a spring surgery there was a period when the Appellant's mobility was down, he was dependent on caregivers for everything. As he recovered and spent some time up out of bed, but not all day in his wheelchair, there were also additional transfers. The Appellant did not report these changes to the Department as they occurred. Rather the Appellant was waiting for his hearing to discuss all issues related to his EHHS case. The Appellant also stated that when he began receiving services through the MI Choice Waiver program, they immediately authorized hours of services approximately equal to the EHHS authorization prior to the reduction. Lastly, the Appellant explained that his needs can vary from day to day, so authorizing a set time per day for each activity does not always work out. If there is a need for more time to be spent on one activity, this does not leave enough time to complete other activities. (Appellant Testimony)

While this ALJ understands that the Appellant was waiting for his hearing, the Department could not reconsider the ongoing EHHS authorization as changes in the Appellant's condition and needs occurred because these changes were not reported to the Department. The Department presented sufficient evidence that the reduction to the Appellant's EHHS authorization was based on the needs he and his caregivers reported to the MDCH RN during the conference call. (Exhibit 2, pages 7-8; MDCH RN Testimony) The Appellant's care needs may vary some from day to day, but it was appropriate for the Department to utilize the average times needed to complete activities based on the above cited policy outlining how EHHS hours are to be authorized. The Department's determination to reduce the Appellant's EHHS authorization was appropriate based on the information available to the Department at the time of the MDCH RN's review. Further, there is no evidence that the Appellant made any subsequent request to the Department to increase his EHHS authorization as his condition and needs changed while he was still receiving services through the HHS program. Accordingly, the Department's determination to reduce the Appellant's EHHS authorization must be upheld.

DECISION AND ORDER

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

