

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. 2013-59539 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 telephone hearing was held on ██████████. The telephone hearing proceedings were adjourned for several hours due to a fire alarm, but were completed later that same date. ██████████ provider, represented the Appellant. ██████████ the Appellant, appeared and testified. ██████████ Appeals Review Officer, represented the Department. ██████████ Adult Services Worker ("ASW"), and ██████████ Adult Services Supervisor, appeared as witnesses for the Department.

ISSUES

- 1) Did the Department properly increase the Appellant's Home Help Services ("HHS") authorization?
- 2) Did the Department properly suspend the Appellant's HHS 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 receiving HHS since at least ██████████ (Exhibit 1, page 23)
2. The Department has received medical certification that the Appellant has been diagnosed with right side paralysis, cerebrovascular accident, hypertension, diabetes and hyperlipidemia. (Exhibit 1, page 14)
3. The Appellant lives with her HHS provider. (Exhibit 1, page 17)

4. On ██████████ the ASW went to the Appellant's home and completed an assessment for a redetermination of the Appellant's HHS case pursuant to a reinstatement. The Appellant and her provider requested an increase in the HHS authorization. The ASW went over the complex care activity of Range of Motion exercises ("ROM"), the Activities of Daily Living ("ADL"s) and the Instrumental Activities of Daily Living ("IADLs") included in the HHS program. (Exhibit 1, pages 17-18; ASW Testimony)
5. The ASW authorized HHS for the Appellant with a monthly care cost of approximately ██████████. (ASW Testimony)
6. On ██████████ the ASW received a fax from the Appellant's doctor's office, but there was no information regarding the need for ROM. The ASW determined ROM should remain eliminated from the Appellant's HHS authorization. (Exhibit 1, page 20)
7. On ██████████ the ASW received a call from the provider disagreeing with the results of the redetermination. (Exhibit 1, page 20)
8. On ██████████ the ASW called the Appellant's doctor's office and spoke with a nurse. The nurse verified the ROM instruction from the doctor was massage technique to the right arm for ██████████ minutes once per day, ██████████ days per week. (Exhibit 1, page 19)
9. The ASW added ROM to the Appellant's HHS authorization, which then totaled ██████████ hours and ██████████ minutes per month with a monthly care cost of ██████████ (Exhibit 1, page 21)
10. On ██████████ the Department issued a Services and Payment Approval Notice to the Appellant stating effective ██████████ the HHS authorization would be increased to ██████████. The notice indicated ROM had been added based on the information from the nurse at the Appellant's doctor's office. (Exhibit 1, pages 6-7)
11. On ██████████ the Department issued an Advance Action Notice to the Appellant, which informed her that effective ██████████ the HHS case would be suspended because provider information is necessary for the case file. Specifically, a clear and readable copy of a current ██████████ for the provider, with the current address, was requested. (Exhibit 1, pages 8-10)
12. On ██████████, the Department received copies of a social security card and a driver's license for the provider. (Exhibit 1, page 5)
13. On ██████████, the Appellant's request for hearing was received by the Michigan Administrative Hearing System. (Exhibit 1, pages 3-4)

14. On ██████████ the Department issued an Advance Action Notice to the Appellant, which informed her that effective ██████████ the HHS case would be suspended because the copy of the provider's ID and social security card the Department received ██████████ were not clear and readable, nor did the current address show on the ID. A second request was made for these items. (Exhibit 1, pages 11-13)

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) 101 addresses HHS payments:

Payment Services 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.

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

Adult Services Manual (ASM) 105 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) 120 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.

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

Certain services are not covered by HHS. Adult Services Manual (ASM) 101 provides a listing of the 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.*

Adult Services Manual (ASM) 150 addresses notification of eligibility determinations:

Written Notification of Disposition

All notifications are documented under ASCAP contacts when they are generated. This documentation acts as the file copy for the case record. For this purpose, the form letters used are:

- DHS-1210, Services Approval Notice.
- DHS-1212A, Adequate Negative Action Notice.
- DHS-1212, Advance Negative Action Notice.

Each notification letter includes an explanation of the procedures for requesting an administrative hearing.

The adult services specialist **must sign** the bottom of the second page of all notices (DHS-1210, DHS-1212A, DHS-1212) before they are mailed to the client.

Services Approval Notice (DHS-1210)

Notification Services Have Been Approved

If independent living services (non-payment services) or adult community placement services are approved, the DHS-1210, Services Approval Notice, is sent indicating what services have been authorized.

If home help services will be authorized, note the amount and the payment effective date. Print and attach a copy of the Time and Task worksheet. The DHS-1210 is completed and generated through the Adult Service Comprehensive Assessment Program (ASCAP).

Notification Services Have Been Increased

The DHS-1210 must also be used when there is an increase in the amount of home help services on an open case. Appropriate notations must be entered in the comment section. A copy of the Time and Task worksheet must be printed and sent with the notice.

Advance Negative Action Notice (DHS-1212)

The DHS-1212, Advance Negative Action Notice, is used and generated on ASCAP when there is a reduction, suspension or termination of services. Appropriate notations must be entered in the comment section to explain the reason for the negative action.

- Reduced - decrease in payment.
- Suspended - payments stopped but case remains open.
- Terminated - case closure.

Negative Actions Requiring Ten Day Notice

The effective date of the negative action is ten business days **after** the date the notice is mailed to the client. The effective date must be entered on the negative action notice.

*Adult Services Manual (ASM) 150, 11-1-2011,
Pages 1- 2 of 4.*

Adult Services Manual (ASM) 135 addresses HHS provider requirements, which include:

PROVIDER INTERVIEW

An initial face-to-face interview must be completed with the home help provider. A face-to-face or phone contact must be made with the provider at the six month review or redetermination to verify services are being furnished.

Explain the following points to the client and the provider during the initial interview:

- Provider must display a valid picture identification card and social security card.

HOME HELP STATEMENT OF EMPLOYMENT (MSA-4676)

The purpose of the MSA-4676, Home Help Services Statement of Employment, is to serve as an agreement between the client and provider which summarizes the general requirements of employment. The form is completed by the adult services specialist as part of the provider enrollment process.

An employment statement must be signed by **each** provider who renders service to a client.

The statement of employment does the following:

- Requires positive identification of the provider by means of a picture ID and social security card.

*Adult Services Manual (ASM) 135, 11-1-2011,
Pages 3-5 of 7.*

Adult Services Manual (ASM) 170 addresses suspensions of HHS payments rather than case closure:

Suspension of Home Help Payments

The adult services specialist may choose to suspend payments, rather than terminate payments and initiate closing procedures, in the following circumstances:

- Client's Medicaid has ended and it appears to be temporary.
- Client's provider fails to meet qualification criteria. This allows the client time to locate a new provider.
- Provider logs were not submitted timely but it is believed the client and provider will return completed forms within a specified time period noted on a negative action notice.

Note: Any suspended payment action must be temporary. The adult services specialist should allow no more than 90 days for the situation to be resolved. (The DHS-390, Adult Services Application and the DHS-54A, Medical Needs form, are valid for 90 days after case closure). Case closure procedures should be initiated once it has been determined the situation that resulted in the suspension will not be resolved.

Adult Services Manual (ASM) 170, 11-1-2011,
Page 1 of 2.

The Appellant's HHS provider raised many issues with how the Appellant's HHS case has been handled by the local Department of Human Services ("DHS") office. As explained during the hearing proceedings, this ALJ has no authority to review issues regarding the professionalism of DHS staff. Concerns about the conduct of an ASW or other DHS staff should be raised with the supervisors at the local DHS office. This ALJ can only review actions the Department has taken on the Appellant's HHS case. The Appellant's HHS provider asserted that the Department is constantly messing with the checks, i.e. starting/stopping payments as well as raising/lowering amounts. (Exhibit 1, page 4; Provider Testimony) The scope of this hearing is limited to reviewing actions taken on the Appellant's HHS case within █ days of when the Request for Hearing was filed on the Appellant's behalf, which includes increasing the HHS authorization and the suspension of the HHS payments.

Increase to the HHS Authorization

On █, the ASW went to the Appellant's home and completed an assessment for a redetermination of the Appellant's HHS case pursuant to a reinstatement of her HHS case. The Appellant and her provider requested an increase in the HHS authorization. The ASW credibly testified she thoroughly went over the complex care activity of ROM, the ADLs and the IADLs included in the HHS program. The ASW even added HHS hours for mobility to the Appellant's time and task authorization based on the information reported during the home visit. (Exhibit 1, pages 15-18 and 21; ASW Testimony) On █ the ASW received a fax from the Appellant's doctor's office, but there was no information regarding the need for ROM. The ASW determined ROM should remain eliminated from the Appellant's HHS authorization at that time. (Exhibit 1, page 20)

The ASW had authorized HHS with a total monthly care cost of approximately █ (ASW Testimony) The Appellant and her provider asserted the HHS hours authorized were not sufficient. (Appellant and Provider Testimony) The ASW's testimony confirmed that she agreed the HHS hours for housework and shopping should have been approved at half the monthly maximums allowed under the above cited policy and that the HHS hours for laundry should have been approved at the monthly maximum allowed by policy. (ASW Testimony)

It appears that because the Appellant's HHS case was reinstated with a new referral date, not all of the action notices are documented in the materials that were submitted for this hearing. For example, the ASW credibly testified she issued a written notice to the Appellant of an HHS authorization for approximately ██████ per month after the ██████ home visit and assessment were completed, but there is no documentary evidence of this notice. (ASW Testimony) However, the date of the providers call contesting this determination, ██████ indicates that the notice was sent to the Appellant more than ██████ days before the ██████ hearing request was filed on the Appellant's behalf. (Exhibit 1, page 20) Accordingly, this ALJ does not have jurisdiction to review the ██████ assessment and resulting HHS authorization of approximately ██████. Only the more recent authorization, the ██████ Payment Approval Notice stating effective ██████ the Appellant's HHS authorization would be increased to ██████ can be reviewed in this hearing proceeding based on the date the request for hearing was filed. (Exhibit 1, pages 4-7)

The increase in the Appellant's HHS authorization was based on the ASW's call to the Appellant's doctor's office. The ASW spoke with a nurse, who verified the ROM instruction from the doctor was massage technique to the right arm for ██████ minutes once per day, ██████ days per week. (Exhibit 1, pages 6-7 and 19; ASW Testimony) The ASW increased the Appellant's HHS authorization to a total of ██████ hours and ██████ minutes of HHS per month with a total monthly care cost of ██████. This included ROM at ██████ minutes, ██████ days per week (██████ hour and ██████ minutes per month). (Exhibit 1, page 21) The ASW properly added ROM to the Appellant's HHS authorization based on the average of the time range provided from the Appellant's doctor's office for this activity.

Suspension

On ██████ the Department issued an Advance Action Notice to the Appellant, which informed her that effective ██████ the HHS case would be suspended because provider information is necessary for the case file. Specifically, a clear and readable copy of a current ██████ for the provider, with the current address, was requested. (Exhibit 1, pages 8-10)

On ██████, the Department issued an Advance Action Notice to the Appellant, which informed her that effective ██████ the HHS case would be suspended because the copy of the provider's ID and social security card the Department received ██████, were not clear and readable, nor did the current address show on the ID. A second request was made for these items. (Exhibit 1, pages 11-13)

The above cited policy regarding the provider interview and the Home Help Services Statement of Employment require a valid ID and social security card for the provider. The copies submitted on ██████ are not very clear and readable. In part, the top of social security card is cut off, the year of the expiration date for driver's license is not legible, and the driver's license does not have the current address on the front or a change of address sticker on the back. (Exhibit 1, page 5)

The provider lost his ID when he was robbed. The provider further explained that it will be a lengthy process to get a new ID due to both financial and logistical issues, such as obtaining a copy of his birth certificate from [REDACTED]. (HHS Provider Testimony)

The ASW's testimony indicates her understanding of the provider's circumstances and that she has allowed additional time for the provider to work out the logistics to getting a new ID. The ASW's testimony further indicated that once this issue is resolved, the HHS payments will be authorized retroactively to the effective date of the suspension. (ASW Testimony)

The ASW's determination to suspend the Appellant's HHS payments until the provider has a current, valid ID is consistent with the above cited Department policy and 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 increased and subsequently suspended the Appellant's HHS case based on the available information.

IT IS THEREFORE ORDERED THAT:

The Department's determinations are AFFIRMED.

/s/

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

Date Signed: [REDACTED]
Date Mailed: [REDACTED]

CL/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.