

**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.** 2013-61774 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"), and ██████████ ██████████ Adult Services Supervisor, appeared as witnesses for the Department.

**ISSUE**

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

**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 15)
2. The Appellant has been diagnosed with diabetes, hypertension, hyperlipidemia, GERD, bilateral shoulder pain, lumbago, and coronary artery disease status post pci/balloon angioplasty. The Appellant has also reported diabetic neuropathy in legs. (Exhibit 1, page 6)
3. The Appellant has been authorized to receive a total of ██████ hours and ██████ minutes of HHS for assistance with bathing, housework, laundry, shopping, and meal preparation with a total monthly care cost of ██████████ (Exhibit 1, page 9)

4. On ██████████, the Appellant's doctor completed a DHS-54A Medical Needs form verifying that the Appellant has a medical need for assistance with several listed personal care activities. (Exhibit 1, page 10)
5. On ██████████ the Adult Services Worker ("ASW") completed a home visit for the annual re-determination of the Appellant's HHS case. It was reported that the Appellant sees a new doctor. (Exhibit 1, page 8)
6. On ██████████ the enrolled HHS provider agency for the Appellant contacted the ASW indicating a DHS-54A Medical Verification form would be mailed from the Appellant's doctor. (Exhibit 1, page 8)
7. On ██████████, the Appellant called the ASW noting the new medical verification form was mailed in and asking if his provider would be getting more hours. The ASW said no explaining that just because there is a new medical diagnosis does not mean more hours would be authorized. The ASW documented that the new medical verification form listed coronary artery disease and status post pci/balloon angioplasty on it. (Exhibit 1, page 8)
8. On ██████████ the ASW and a manger with the enrolled HHS provider agency went to the ASW's office requesting an increase in the HHS authorization. It was reported that the Appellant's daughter helps with dressing due to rotator cuff problems. It was also reported that the Appellant is getting shots due to hip problems. The ASW again explained that a ████████ diagnosis does not always mean a financial change. The ASW noted: the authorized HHS monthly total care cost; that the Appellant can walk with a cane; and that there was disagreement with her assessment, which was the same as the previous ASW. The ASW provided a hearing request form to the Appellant and manager with the enrolled HHS provider agency. (Exhibit 1, page 8)
9. The Department did not issue a written notification to the Appellant of the determination from the ██████████ annual redetermination or the determination to deny the ██████████ request for an increase in the HHS authorization.
10. On ██████████ the Appellant's request for hearing was received by the Michigan Administrative Hearing System. (Exhibit 1, page 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 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.

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### **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

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.

Adult Services Manual (ASM 150, 11-1-2011), pages 1-4 addresses notification of eligibility determinations:

## **INTRODUCTION**

Individuals who submit an application (DHS-390) for home help services or adult community placement must be given written notification of approval or denial for services. A written notice must be sent within the 45 day standard of promptness.

Clients with active service cases must be provided written notice of any change in their services (increase, reduction, suspension or termination).

### **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.

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### **Adequate Negative Action Notice (DHS-1212A)**

The DHS-1212A, Adequate Negative Action Notice, is used and generated on ASCAP when home help services and adult community placement services cases have been denied. Appropriate notations **must** be entered in the comment section explaining the reason for the denial.

Adequate Negative Action Notices **do not** require a 10 business day notice to the client.

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### Administrative Hearings

The client may appeal any negative action by requesting an administrative hearing. A DCH-0092, Request for Hearing form, is generated whenever a negative action notice is printed from ASCAP and must be mailed to the client with the negative action notice.

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

The ASW and Adult Services Supervisor did not dispute that Appellant's right to a hearing to contest the denial of the requested increase in the HHS authorization, only that the policy did not require a negative action notice to be issued in this circumstance because there was no change to the ongoing HHS authorization.

This ALJ acknowledges that the Adult Services Manual policy, as written, is not clear regarding issuing action notices when there has been a determination to continue an ongoing HHS authorization with no changes in HHS hours or total monthly care cost. However, the policy does specify that an Adequate Negative Action notice is to be issued when services have been denied, that a client may appeal any negative action by requesting a hearing, and that a request for hearing form is generated whenever a negative action notice is printed and must be mailed to the client with the negative action notice. In this case, the Appellant requested an increase in HHS services that the Department denied, but no Adequate Negative Action notice was issued. The ASW only provided a hearing request form. When no written action notice is issued, the Appellant is not provided written notice of the action, the reason for the action, the legal basis for the determination and the appeal rights.

Further, not issuing a written action notice can cause confusion when an Appeals Review Officer prepares a case for a hearing. In this case the Appeals Review Officer motioned for a dismissal of the Appellant's hearing because the Department's computer system did not show that any actions had been taken on the case since ██████████ and the timeframe for submitting a request for hearing is █ days from the date that the written case action notice is mailed. (Exhibit 1, pages 2 and 16) The Department's motion to dismiss this case was denied on the record because even though no written action notice was issued, there was a recent action taken by the Department, the determination to deny the Appellant's ██████████ and ██████████ requests for an increase his HHS services. It is also noted that 42 CFR § 431.220 requires an opportunity for a hearing to be granted when a claim for service is denied or is not acted on with reasonable promptness. Accordingly, a hearing can also proceed when there has been a request for services and the Department has failed to take an action with reasonable promptness.

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While it is accurate that a new diagnosis does not always justify an increase in the HHS authorization, a thorough comprehensive assessment is needed to determine whether or not any changes should be made to the HHS authorization. In this case, there was a medical verification form documenting a new diagnosis of coronary artery disease status post pci. Further, the doctor indicated there is now a medical need for assistance with an ADL, though it is not clear if the doctor intended to check transferring and/or mobility because the check mark is between these two activities. (Exhibit 1, page 10) The Appellant was requesting an increase in his HHS authorization, made efforts to ensure the Department received the new medical verification form, and reported treatment for a hip impairment. (Exhibit 1, page 8)

In this case, the Department's evidence was not sufficient to establish that a thorough comprehensive assessment was completed in response to the Appellant's requests for an increase in his HHS authorization. The ASW's testimony indicated she did not have any discussion with the Appellant regarding functional abilities and needs for assistance with transferring or mobility. Rather, because of her observation the Appellant has adaptive equipment, a cane, the ASW inferred that the adaptive equipment allows the Appellant to be independent and no help is needed from the provider with these activities. (ASW Testimony; Exhibit 1, page 7) Further, there is no evidence that the ASW sought medical verification of the newly reported hip impairment or let the Appellant know this condition was not listed on the medical verification form so he could provide medical verification of this impairment if needed.

The Appellant's testimony confirmed that the ASW did not talk with him about transferring and mobility. The Appellant stated he has shortness of breath and limited his mobility due to the heart condition and a pinched nerve in his right buttock/hip area. The Appellant is in a lot of pain. The Appellant's daughter, the caregiver though the enrolled HHS provider agency, helps with mobility, such as getting to the bathroom, and transferring, such as getting out of bed sometimes. (Appellant Testimony)

While the ASW's observations are part of the comprehensive assessment and should be considered in making her determination, the Appellant must also be provided the opportunity to report his functional abilities and needs for assistance with activities included in the HHS program. The doctor's medical verification form supported a new need for assistance with transferring and/or mobility, the Appellant was requesting an increase in his HHS authorization, and the Appellant reported an additional new impairment with his hip. (Exhibit 1, pages 8 and 10) Yet, the ASW did not discuss functional abilities and needs for assistance with mobility or transferring with the Appellant. (ASW Testimony) It cannot be assumed that a piece of adaptive equipment, such as a cane, renders and individual independent with these activities. Some individuals may still require some hands on assistance from a caregiver. The Appellant was not given the opportunity to let the ASW know if he needed any hands on assistance from his caregiver with mobility or transferring. Accordingly, the determination to deny the request for an increase in the Appellant's HHS authorization cannot be upheld.

**DECISION AND ORDER**

The Administrative Law Judge, based on the above findings of fact and conclusions of law, finds that the Department improperly denied the Appellant's request for an increase in his HHS authorization based on the available information.

**IT IS THEREFORE ORDERED THAT:**

The Department's decision is REVERSED. The Department shall initiate re-assessing the Appellant's HHS case.

/s/

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

Date Signed: 

Date Mailed: 

CL/db

cc: 

**\*\*\* 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.