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:

Docket No. 2014-22385 HHS
Case No.

Appellant
______________________/

DECISION AND ORDER

This matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9 and 42 CFR 431.200 *et seq.*, upon Appellant's request for a hearing.

After due notice, a hearing was held on . Appellant personally appeared and testified. Appellant's witnesses included: , Processing Agent with , and, , caregiver.

, 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 close (on), and properly deny (on) Appellant's Home Help Services ("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. Appellant is a year old male Medicaid beneficiary, born .

2. Appellant is paraplegic. (Exhibit A.13)

3. On the ASW conducted an in home visit with Appellant. Appellant lives with his mother. Under the ASW assessment notes the worker stated: "…an updated medical form was mailed to his physician on due to their [sic] being two different signatures on the form."…"he will be eligible for services once the updated medical needs form is received." (Exhibit A.19)

4. The Department ranked Appellant at a 3 for the following ADLs: Bathing, grooming, dressing, toileting, transferring. (Exhibit A.15)

5. The Department opened Appellant's HHS case.

6. The Department testified at hearing that it sent a medical needs form to Appellant's doctor on [redacted] and again on [redacted]. (Exhibit A.6)

7. On [redacted] the Department issued an "Adequate Action Notice" (Exhibit A.6) and "closed" Appellant's case" (Exhibit A and Testimony). On [redacted] the Department issued an Adequate Negative Action Notice denying Appellant's case.

8. An [redacted] entry by the worker states that the Department received a phone call from Appellant's physician's office stating that they never received the form; the Department stated that another was mailed that day. On [redacted] the ASW notes state: "Call from Doctor's office assistance stating that the doctor has added the diagnosis to the form and fax it back." (Exhibit A.20) On [redacted] the ASW notes state that the Department informed the client that the same medical needs form was returned and his case was being terminated. (Exhibit A.21)

9. The Department failed to submit any evidence or copies of the purported DHS-54A's, complete or incomplete. The Department testified that as of the day of the hearing, it had in its possession what it considered to be a complete DHS-54A.

10. Department testimony was in part that the DHS-54As' submitted were not acceptable as they contained more than one signature and that was an indication that the document may have been tampered with or there was fraud. One of the signatures is clearly identified as an "MD". There was no issue that the physician was not a Medicaid provider. The Department testified that another DHS-54A did not contain the diagnosis in section F even though section C clearly states "paraplegia." (Exhibit B)

11. Appellant submitted evidence of confirmed faxes of a DHS-54A on the following dates: [redacted]; [redacted]; [redacted]; and [redacted]. (Exhibit B) Appellant submitted evidence of documentary and testimonial evidence of communications with the Department regarding attachments and clarifications regarding the DHS-54A on [redacted] and [redacted]. (Exhibit B)

12. On [redacted], the Michigan Administrative Hearing System (MAHS) received Appellant's hearing request.

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, 11-1-11, 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, 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 120, 5-1-2012), pages 1-4 of 5 addresses the adult services 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 will 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 IADLs 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 adjoined 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. 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.

The Adult Services Requirements policy is found at ASM 115. This item addresses "Contacts" between the client and the ASW:

> The specialist must, at a minimum, have a face-to-face interview with the client, prior to case opening, then every six months in the client's home, at review and redetermination.
>
> …A face-to-face or phone contact must be made with the provider at the next review or redetermination to verify services are being furnished.
>
> Adult Services Manual (ASM) 115, 5-1-2013, Page 3 of 3.

In this case, the DHS testified that it opened Appellant's case in the first instance, without the DHS-54A as required by policy, as workers have the discretion to do so. However, the Department further argues that it did not receive an acceptable DHS-54A, and thus, closed Appellant's case. Following this, the Department argues that Appellant had a new referral, and that the DHS-54A was again not received and the case was denied.

The Department's case herein is that it did in fact receive a number of DHS-54As, but that they were not completed correctly. None of the DHS-54As' were submitted as evidence.

First, The Department contends that one of the DHS-54A's was incomplete as this form cannot have two signatures. Without pointing to policy as support, the Department argued that two signatures are not acceptable as it raised an issue that the form may have been tampered with. This Administrative Law Judge (ALJ) is confused as to why two signatures, one clearly signed as an "MD," will not suffice. Policy requires that the physician be a Medicaid provider. There is no question herein that the physician is not a Medicaid provider. The Department offered no policy or law that will allow it to prevail on this argument.

Second, the evidence as to the insufficiency of the form was that the diagnosis was not contained twice-in Section C and F. This form evidently clearly contained the diagnosis in Section C. The necessity that it be written again in Section F was presented without authority; no policy or law was offered on the grounds to support this requirement.

More important, Appellant submitted documentary evidence of having submitted DHS-54As on a number of occasions, including verified faxes. Appellant's witness at hearing corroborated a series of communications and repeated faxes responding to the Department's requests. Moreover, the physician's office indicated that the purported DHS-54A was never received by that office. (Exhibit A.21)

The DHS contention that it never received the DHS-54A was credibly rebutted by the documentary evidence submitted by Appellant. Thus, the Department's actions are reversed.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, finds that the Department's closure of Appellant's HHS case was not correct.

IT IS THEREFORE ORDERED THAT:

> The Department's decision is hereby REVERSED.
>
> The Department is order to immediately reinstate Appellant's HHS case, from the date of closure, and issue supplemental benefits to Appellant to which he may be entitled, as permitted under policy and procedure.

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Janice Spodarek
Administrative Law Judge
for James K. Haveman, Director
Michigan Department of Community Health

Date Signed: April 7, 2014

Date Mailed: April 14, 2014

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.