

**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.** 2014-34650 EDW

██████████

██████████

██████████

Appellant

\_\_\_\_\_ /

**DECISION AND ORDER**

This matter is before the undersigned Administrative Law Judge (ALJ) pursuant to MCL 400.9 and 42 CFR 431.200 *et seq.*, and upon a Request for Hearing filed by Appellant.

After due notice, a hearing was held on ██████████, Appellant's daughter, appeared and testified Appellant's behalf. ██████████ Community Services Director, appeared and testified on behalf of the Department of Community Health's Waiver Agency, the ██████████ ("Waiver Agency" or "██████").

**ISSUE**

Did the Waiver Agency properly deny Appellant's request for services through the MI Choice Waiver Program?

**FINDINGS OF FACT**

The Administrative Law Judge, based upon the competent, material and substantial evidence on the whole record, finds as material fact:

1. ████████ is a contract agent of the Department and the agency responsible for the provision of Appellant's MI Choice services.
2. On ██████████, Appellant's daughter applied for waiver services on Appellant's behalf and a telephone intake was completed. (Respondent's Exhibit A, pages 1-6).
3. Based on the answers given during that intake, the Waiver Agency found that Appellant was probably ineligible for the waiver program. (Respondent's Exhibit A, page 6).
4. That same day, the Waiver Agency sent Appellant written notice stating that, following a review of her long term care needs, it has been presumed that she would not qualify for the waiver program. (Respondent's Exhibit C, page 1).

5. The notice also stated that Appellant had a right to request one or both of the following: an in person determination or a Medicaid Fair Hearing. (Respondent's Exhibit C, page 1).
6. On ██████████, the Michigan Administrative Hearing System (MAHS) received the request for hearing filed in this matter. (Petitioner's Exhibit 1, page 1).
7. Following the receipt of the request for hearing, the Waiver Agency's representative contacted Appellant's representative about scheduling an in person assessment. (Testimony of Appellant's representative; Testimony of ██████████).
8. However, at that time, Appellant's representative stated that she was no longer interested in services or pursuing the hearing. (Testimony of Appellant's representative; Testimony of ██████████).
9. No written withdrawal of the request for hearing was ever received, so the hearing was initiated as scheduled on ██████████.
10. During that hearing, the representatives for the parties agreed to schedule an in person assessment at some later date. (Testimony of Appellant's representative; Testimony of ██████████).
11. Appellant's representative also stated that she wished to proceed with the hearing. (Testimony of Appellant's representative).

### **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.

Appellant is claiming services through the Department's Home and Community Based Services for Elderly and Disabled. The waiver is called MI Choice in Michigan. The program is funded through the federal Centers for Medicare and Medicaid Services to the Michigan Department of Community Health (Department). Regional agencies, in this case ██████████, function as the Department's administrative agency.

Waivers are intended to provide the flexibility needed to enable States to try new or different approaches to the efficient and cost-effective delivery of health care services, or to adapt their Programs to the special needs of particular areas or groups of recipients. Waivers allow exceptions to State plan requirements and permit a State to implement

innovative programs or activities on a time-limited basis, and subject to specific safeguards for the protection of recipients and the program. Detailed rules for waivers are set forth in subpart B of part 431, subpart A of part 440, and subpart G of part 441 of this chapter.

*42 CFR 430.25(b)*

A waiver under section 1915(c) of the Social Security Act allows a State to include as “medical assistance” under its plan, home and community based services furnished to recipients who would otherwise need inpatient care that is furnished in a hospital, SNF (Skilled Nursing Facility), ICF (Intermediate Care Facility), or ICF/MR (Intermediate Care Facility/Mentally Retarded), and is reimbursable under the State Plan. See 42 CFR 430.25(c)(2).

Types of services that may be offered include:

Home or community-based services may include the following services, as they are defined by the agency and approved by CMS:

- Case management services.
- Homemaker services.
- Home health aide services.
- Personal care services.
- Adult day health services
- Habilitation services.
- Respite care services.
- Day treatment or other partial hospitalization services, psychosocial rehabilitation services and clinic services (whether or not furnished in a facility) for individuals with chronic mental illness, subject to the conditions specified in paragraph (d) of this section.

Other services requested by the agency and approved by CMS as cost effective and necessary to avoid institutionalization.

*42 CFR 440.180(b)*

However, with respect to the waiver program, federal regulations require that Medicaid pay for services only for those beneficiaries who meet specified level of care criteria.

Here, ████████ decided to deny Appellant's request for services on the basis that she was not functionally eligible for the program.

With respect to functional eligibility for the waiver program, the Medicaid Provider Manual (MPM) provides:

## **2.2 FUNCTIONAL ELIGIBILITY**

The MI Choice waiver agency must verify applicant appropriateness for services by completing the online version of the Michigan Medicaid Nursing Facility Level of Care Determination (LOCD) within 14 calendar days after the date of the participant's enrollment. (Refer to the Directory Appendix for website information.) The LOCD is discussed in the Michigan Medicaid Nursing Facility Level of Care Determination subsection of this chapter. Additional information can be found in the Nursing Facility Coverages Chapter and is applicable to MI Choice applicants and participants.

The applicant must also demonstrate a continuing need for and use of at least one covered MI Choice service. This need is originally established through the Initial Assessment using the process outlined in the Need For MI Choice Services subsection of this chapter.

### **2.2.A. MICHIGAN MEDICAID NURSING FACILITY LEVEL OF CARE DETERMINATION**

MI Choice applicants are evaluated for functional eligibility via the Michigan Medicaid Nursing Facility Level of Care Determination. The LOCD is available online through Michigan's Single Sign-on System. (Refer to the Directory Appendix for website information.)

Applicants must qualify for functional eligibility through one of seven doors. These doors are:

- Door 1: Activities of Daily Living Dependency
- Door 2: Cognitive Performance

- Door 3: Physician Involvement
- Door 4: Treatments and Conditions
- Door 5: Skilled Rehabilitation Therapies
- Door 6: Behavioral Challenges
- Door 7: Service Dependency

The LOCD must be completed in person by a health care professional (physician, registered nurse (RN), licensed practical nurse (LPN), licensed social worker (BSW or MSW), or a physician assistant) or be completed by staff that have direct oversight by a health care professional.

The online version of the LOCD must be completed within 14 calendar days after the date of enrollment in MI Choice for the following:

- All new Medicaid-eligible enrollees
- Non-emergency transfers of Medicaid-eligible participants from their current MI Choice waiver agency to another MI Choice waiver agency
- Non-emergency transfers of Medicaid-eligible residents from a nursing facility that is undergoing a voluntary program closure and who are enrolling in MI Choice

Annual online LOCDs are not required, however, subsequent redeterminations, progress notes, or participant monitoring notes must demonstrate that the participant continues to meet the level of care criteria on a continuing basis. If waiver agency staff determines that the participant no longer meets the functional level of care criteria for participation (e.g., demonstrates a significant change in condition), another face-to-face online version of the LOCD must be conducted reflecting the change in functional status. This subsequent redetermination must be noted in the case record and signed by the individual conducting the determination.

Copies of the LOCD for participants must be retained by the waiver agency for a minimum period of six years. This information is also retained in the MDCH LOCD database for six years.

*MPM, April 1, 2014 version  
MI Choice Waiver Chapter, pages 1-2*

Pursuant to the above policy, the Waiver Agency determined that Appellant did not pass through any of the seven doors and was therefore ineligible for the program.

Appellant bears the burden of proving by a preponderance of the evidence that the Waiver Agency erred in denying services.

The ██████████ intake was the basis for the action at issue in this case. In order to be found eligible for Medicaid nursing facility coverage the Appellant must have met the requirements of at least one door:

**Door 1**  
**Activities of Daily Living (ADLs)**

**Scoring Door 1:** The applicant must score at least six points to qualify under Door 1.

**(A) Bed Mobility, (B) Transfers, and (C) Toilet Use:**

- Independent or Supervision = 1
- Limited Assistance = 3
- Extensive Assistance or Total Dependence = 4
- Activity Did Not Occur = 8

**(D) Eating:**

- Independent or Supervision = 1
- Limited Assistance = 2
- Extensive Assistance or Total Dependence = 3
- Activity Did Not Occur = 8

**Door 2**  
**Cognitive Performance**

**Scoring Door 2:** The applicant must score under one of the following three options to qualify under Door 2.

1. "Severely Impaired" in Decision Making.
2. "Yes" for Memory Problem, and Decision Making is "Moderately Impaired" or "Severely Impaired."

3. "Yes" for Memory Problem, and Making Self Understood is "Sometimes Understood" or "Rarely/Never Understood."

**Door 3**  
**Physician Involvement**

**Scoring Door 3:** The applicant must meet either of the following to qualify under Door 3

1. At least one Physician Visit exam AND at least four Physician Order changes in the last 14 days, OR
2. At least two Physician Visit exams AND at least two Physician Order changes in the last 14 days.

**Door 4**  
**Treatments and Conditions**

**Scoring Door 4:** The applicant must score "yes" in at least one of the nine categories above [Stage 3-4 pressure sores; Intravenous or parenteral feedings; Intravenous medications; End-stage care; Daily tracheostomy care, daily respiratory care, daily suctioning; Pneumonia within the last 14 days; Daily oxygen therapy; Daily insulin with two order changes in last 14 days; Peritoneal or hemodialysis] and have a continuing need to qualify under Door 4.

**Door 5**  
**Skilled Rehabilitation Therapies**

**Scoring Door 5:** The applicant must have required at least 45 minutes of active ST, OT or PT (scheduled or delivered) in the last 7 days and continues to require skilled rehabilitation therapies to qualify under Door 5.

**Door 6**  
**Behavior**

**Scoring Door 6:** The applicant must score under one of the following 2 options to qualify under Door 6.

1. A "Yes" for either delusions or hallucinations within the last 7 days.

2. The applicant must have exhibited any one of the following *behaviors* for at least 4 of the last 7 days (including daily): Wandering, Verbally Abusive, Physically Abusive, Socially Inappropriate/Disruptive, or Resisted Care.

**Door 7**  
**Service Dependency**

**Scoring Door 7:** The applicant must be a current participant [and has been a participant for at least one (1) year] and demonstrate service dependency under Door 7.

In this case, the Waiver Agency determined that Appellant did not pass through any of the 7 Doors and was therefore ineligible for the waiver program.

Given the evidence and testimony presented during the hearing, it is clear that the Waiver Agency's decision must be sustained. It is undisputed that Appellant's representative reported during the intake that Appellant is independent in all the tasks identified in Door 1; Appellant does not have memory problems or difficulty making decisions; Appellant had not recently been examined by any medical provider with the examination resulting in further visits or order changes; Appellant was not being treated for any of the medical conditions identified in Door 4; Appellant was not receiving and was not scheduled to receive speech, occupational or physical therapy; and Appellant has not exhibited any of the behaviors identified in Door 6 in the past 7 days. (Respondent's Exhibit A, pages 1-6; Testimony of Appellant's representative).

Appellant's representative did testify that Appellant's condition has worsened since the intake was performed in this case and that Appellant may qualify for the program now. However, this Administrative Law Judge's jurisdiction is limiting to reviewing the Waiver Agency's decision in light of the information available at the time of that decision. Here, given the information available at the time, Appellant clearly did not meet the criteria for the program.

To the extent Appellant's circumstances have changed or she has new or additional information to provide, Appellant is free to reapply for waiver services at any time and the representatives for the parties have already agreed to schedule an in home assessment. The decision to deny services at issue in this appeal, however, must be affirmed.

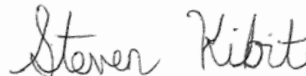
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**DECISION AND ORDER**

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the Waiver Agency properly denied Appellant's request for services based on the available information.

**IT IS THEREFORE ORDERED** that:

The Waiver Agency's decision is **AFFIRMED**.



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Steven J. Kibit  
Administrative Law Judge  
for James K. Haveman, Director  
Michigan Department of Community Health

Date Signed: [REDACTED]

Date Mailed: [REDACTED]

SK/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.