

**STATE OF MICHIGAN  
MICHIGAN ADMINISTRATIVE HEARING SYSTEM  
FOR THE DEPARTMENT OF COMMUNITY HEALTH**

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**IN THE MATTER OF:**

██████████

Appellant

**Docket No.** 2014-9645 HHS  
**Case No.** ██████████

**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 ██████████. Appellant representative, ██████████, personally appeared and testified. ██████████, Appeals Review Officer, represented the Department. Constance ██████████, Adult Services Worker ("ASW"), and ██████████, Adult Services Supervisor, appeared as witnesses for the Department.

**ISSUE**

Did the Department properly close and deny payment for Appellant's HHS case for a closed ended period time-from ██████████ through ██████████?

**FINDINGS OF FACT**

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

1. At all relevant times, Appellant has been and continues to be beneficiary of the Medicaid Program administered by the State of Michigan under the federal SSI program. Appellant is a ██████ year old female whose date of birth is ██████████.
2. Appellant was previously approved for HHSs. Appellant's case was open. The prior DHS 54-A that was presented in conjunction with Appellant's prior case opening certified Appellant in Section E: "for 4-6 months." (Exhibit A.18)
3. Appellant's case was open from ██████████ through ██████████. On ██████████, the DHS stopped HHS payments.
4. On March 27, 2013 Appellant's worker's notes submitted state: "due to oversight, I am mailing notice with logs & duplicate medical form 54a to you this date-my apologies. Pls send back completed logs by 4.8.2013. Pls

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- submit updated medical form 54A by ██████████ if you want your circumstances to be reviewed for continuing home help servs.” (Exhibit A.13)
5. On ██████████ Appellant faxed an updated DHS 54-A showing needs for ADLs. Unknown to Appellant at this time, Appellant’s worker left her employ with the State of Michigan. That worker and that worker’s supervisor were not at the administrative hearing, and not available for testimony and/or cross-examination.
  6. The Department did not follow up on the 54-A until ██████████. (Exhibit A.12)
  7. On ██████████ the Department made a home visit, noting in part: “...son ironically has waited several months before reporting that he did not have a check...” (Exhibit A.10)
  8. Appellant contacted the Department on the following dates inquiring as to the status of the case: ██████████ the Department’s notes/evidence states: “...has called several times daily for updates status.” (Exhibit A.12)
  9. The Department requested another DHS54A, which was subsequently submitted and dated ██████████. The Department re-opened Appellant’s case and began payments beginning ██████████. Appellant had an increase in hours.
  10. On ██████████ the Department issued a Services and Payment Approval Notice stating that approval was given for a monthly home help grant effective ██████████. (Exhibit A.2)
  11. On ██████████, Appellant filed a Hearing Request contesting non-payment for the closed ended period of time. (Exhibit A.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.\*\*
- **Medical Need Certification**

Medical needs are certified utilizing the DHS-54A, Medical Needs form and must be completed by a Medicaid enrolled medical professional. Completed DHS-54A or veterans administration medical forms are acceptable for individual treated by a VA physician; see ASM 115, Adult Services Requirements.

## **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 2-3 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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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.

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

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.*

#### MEDICAL NEEDS FORM (DHS-54A)

...If the medical needs form has not been returned, the adult services specialist should follow-up with the client and/or medical professional

#### Six Month Review Requirements

...Follow-up collateral contacts with significant others to assess their role in the case plan, if applicable.

*Adult Services Manual (ASM) 155, 5-1-2013  
Pages 1-2*

After a careful review of the substantial and credible evidence on the whole record, this ALJ reverses the Department's actions for the reasons set forth below.

As noted in the Findings of Fact, the original worker, and/or her supervisor were not available at the administrative hearing for testimony and/or cross-examination. Appellant contends that he faxed the 54-A on ██████████. The Department contends it did not receive it, and, that there were patent ambiguities in the document.

Unrefuted evidence on the record is that Appellant's worker left her employ with the state of Michigan at this time. There is no evidence that Appellant was informed of the new worker. Appellant did receive a communication from the previous worker who

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stated that she failed “due to oversight” to act timely on Appellant’s case. (Exhibit A.13) The worker’s own statement indicates that the worker’s actions were not in conformance with Department procedures.

The Department also contends the 54-A was “questionable” and looked as if perhaps Appellant changed or made some notes on the document. This ALJ finds that Appellant adequately rebutted the Department’s contentions as the doctor’s office indicated that the physician was on staff. Moreover, this ALJ does not find the writing on the document suspicious. The Department did not submit the original into evidence. On examination, this ALJ does not find the copy submitted as evidence questionable or patently ambiguous. (Exhibit A. 5)

The Department also contends in a ██████████ note pursuant to a home visit: “...son ironically has waited several months before reporting that he did not have a check...” (Exhibit A.10) However, evidence shows that Appellant had, as of the ██████████ entry contacted the Department numerous times—at least four: Appellant contacted the Department on the following dates inquiring as to the status of the case: ██████████ the Department’s notes/evidence also state: “...has called several times daily for updates status.” (Exhibit A.12)

Further, policy requires the Department to follow up on the status of the 54A (see ASM 115 cited above). No evidence was presented that would support the Department doing so herein.

Last, the Department argued that the delay in setting up a review or doing a home visit for about 6 months was due to the fact that the department was investigating the suspicious DHS54-A dated ██████████. However, the Department wants to argue at the same time that it did not receive the 54-A until ██████████. The Department’s testimony was not credible


For these reasons, and for the reasons stated, above, this ALJ finds that the Department did not act in accordance with its policy and procedure, and 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 improperly closed Appellant’s case on ██████████, and improperly failed to pay HHS payments from the date of closure until re-opened (on ██████████). The Department’s actions during this closed ended period of time are reversed.

**IT IS THEREFORE ORDERED THAT:**

The Department is ordered to initiate the procedure(s) for making supplemental payments to Appellant for the period from ██████████ through ██████████.

  
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The Department's action is REVERSED.

/s/

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

  
cc:



Date Signed: February 4, 2014

Date Mailed: February 7, 2014

**\*\*\* 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.