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:

[redacted],

Docket No. 14-014089 HHS
Case No. [redacted]

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 the Appellant's request for a hearing. After due notice, a telephone conference hearing was held on [redacted].

Appellant appeared and testified.

[redacted], Appeals Review Officer, represented the Department. The following individuals appeared as witnesses on behalf of the Department: [redacted], Adult Services Worker, and [redacted], Adult Services Supervisor, [redacted], Regulation Agent for the Office of Inspector General with the Michigan Department of Human Services.

ISSUE

Did the Department properly reduce Appellant's Home Help Services ("HHS") hours?

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 a Medicaid beneficiary of the Social Security program under the MA-AD-Care category, and a beneficiary of the HHS program. Appellant is a [redacted] year old female.

2. Appellant has been diagnosed with diabetes mellitus, HTN, asthma, and bipolar. (Exhibit A.11).

3. On [redacted] Appellant's case was scheduled by the Department for a yearly review. The ASW notes state in part: 'On [redacted] Appellant and her provider came into the local office to meet with the worker to complete the review. On [redacted] Appellant called the Department to inform of change in address. On [redacted] Appellant called stating that she only received one

check in [redacted]. Appellant had been sent 2 rewritten checks for different months during the last month. The Department set up an appointment with Appellant and her provider to examine the signatures. Provider then informed the department that she no longer works for Appellant since the "whole check problem happened" and that she was in jail from [redacted] to [redacted] or [redacted] and Appellant signed her name and cashed the checks.' (Exhibit A.19-21).

4. On [redacted] the ASW completed a Medicaid Services Fraud Intake Form. The ASW indicated possible fraud for warrants and for not needing the amount of assistance she claims to need. (Exhibit A.21-22).

5. On [redacted] the OIG conducted an assessment with Appellant in her home. The OIG agent concluded that Appellant's needs for the HHS grant total $[redacted], a reduction from her previous grant. (Exhibit A).

6. On [redacted] the Department issued an Advanced Negative Action Notice informing Appellant that her HHS will be reduced to $[redacted] due to a reduction after an OIG FEE investigation findings. (Exhibit A.6).

7. On [redacted], Appellant filed a Request for Hearing contesting the reduction. (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.**

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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 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)

Note: The above list is not all inclusive.

Adult Services Manual (ASM) 101, 11-1-2011,
Pages 3-4 of 4.

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.

Adult Services Manual (ASM) 120, 12-1-2013
Page4 of 7.

ASM 160 is the Department's policy and procedure regarding Warrants. The Department offered this policy into evidence to support the initial referral regarding the

reported warrant(s) problem, although, no specific action was reviewed herein regarding any action the OIG took or may possibly take as to warrant fraud issues.

As to the issue regarding the reduction in services, the purview of an administrative law judge (ALJ) is to review the Department's action and to make a determination if those actions are in compliance with Department policy, and not contrary to law. The ALJ at an administrative hearing must base a decision upon the evidence of record that was available to the Department at the time of the assessment. The Department cannot be held accountable for evidence it was unaware of at the time of its determination.

In this case, the action taken is essentially one that resulted from an assessment. This assessment was a full functional/physical assessment of Appellant's limitations and rankings under the HHS policy for HHS service hours. As a result of the assessment, the Department deterred that Appellant was eligible for $[redacted]. (See Exhibit A).

Appellant's hearing request contests the reduction. However, at the administrative hearing, Appellant was no more specific. At hearing Appellant stated that she did not understand anything, and did not know what paperwork was necessary. Appellant did not dispute any of the evidence or findings of the Department in its evidentiary packet and/or testimony of record.

The purview of an Administrative Law Judge is to make a determination if the Department acted correctly under its policy and procedure, and to ensure that the determination is not contrary to law.

After a careful review of the credible and substantial evidence on the whole record, the undersigned ALJ finds that the action is supported by credible and substantial evidence of record. Thus, the Department is upheld.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, finds that the Department correctly reduced Appellant's HHS hours pursuant to the OIG FEE assessment of [redacted].

IT IS THEREFORE ORDERED THAT:

The Department's reduction of Appellant's HHS is hereby AFFIRMED.

/s/ Spodarek
Janice Spodarek
Administrative Law Judge
for Nick Lyon, Director
Michigan Department of Community Health

JS/[redacted]

cc: [redacted]

Date Signed: [redacted]

Date Mailed: [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.