STATE OF MICHIGAN
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
FOR THE DEPARTMENT OF COMMUNITY HEALTH
P.O. Box 30763, Lansing, MI 48909
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IN THE MATTER OF:

Docket No. 14-015226 HHS

[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 hearing was held on [redacted] Appellant personally appeared and testified. [redacted], Appellant's Supports Coordinator for [redacted] County Treatment Services since [redacted] appeared on behalf of Appellant as a witness.

[redacted], Appeals Review Officer (ARO), represented the Department. The Adult Services Worker (ASW) who has personal knowledge of this case did not appear at the administrative hearing. At the time and place of the scheduled hearing, the Department requested an adjournment on the grounds that the ASW was on previously approved administrative leave. The undersigned Administrative Law Judge (ALJ) denied the request on the grounds that the request for adjournment was not made prior to the onset of the administrative hearing despite the Department's knowledge that the ASW was on previously approved leave, and, that the request did not comply with the adjournment instructions on the Notice of Hearing. [redacted] [redacted] Adult Services Supervisor (ASS) appeared on behalf of the Department.

ISSUE

Did the Department properly reduce Appellant's HHS at redetermination?

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 [redacted] year old DAC, who is a beneficiary of Medicaid programs. Appellant's diagnoses include Post-TBI and PST-brain tumor resection. (Exhibit a.10). Appellant has been a recipient of HHS since

approximately [redacted] but the Department could not confirm as the Department failed to bring Appellant's file to the administrative hearing. (Testimony).

2. On [redacted] the Department issued an Advance Negative Action Notice reducing Appellant's grant from [redacted] to [redacted] (Exhibit A.5-7). The Department had no knowledge or information as to whether the action took place. (Testimony).

3. On [redacted] the ASW conducted an in-home redetermination assessment of Appellant's HHS case with Appellant and her aide. ASW notes found the printout submitted by the Department marked as Exhibit A.8 state in part: "…Time and task reviewed and she stated that [redacted] does her own bathing and toileting… [redacted] was advised that bathing and toileting will be left on her time and task but will be removed as chore that agency is provided…" (Exhibit A.8). The Department could not clarify the meaning of the ASW's statement that bathing and toileting will be 'removed but left on.' (Testimony).

4. The ASW removed medication as a time and task without indicating in the narrative of the home assessment on Exhibit A.8 that medication was discussed, or, the reason for the removal. (Exhibit A.8) Appellant needs assistance with putting drops in her eyes twice per day. (Testimony)

5. Appellant needs assistance with bathing and grooming. Appellant is unstable and needs to use both of her hands holding her walker at all times. Appellant previously fell while bathing requiring staples to her scalp. (Testimony).

6. On [redacted] Appellant filed a request for an administrative hearing. (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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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.
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 preparationProration 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.

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.

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 form must be completed by the medical professional and not the the client. 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.

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

Do **not** authorize home help services prior to the date of the medical professional signature on the DHS-54A.

The medical needs form does not serve as the application for services. If the signature date on the DHS-54 is **before** the date on the DHS-390, payment for home help services must begin on the date of the application.

The local office adult services unit receives a DHS-54A signed on 1/18/2011 but a referral for home help was never made. The adult services staff enters a referral on ASCAP and mails an application to the client. The application is returned to the office with a signature date of 2/16/2011. Payment cannot begin until 2/16/2011, or later, if the provider was not working during this time

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

Here, the Department notes printed from the ASCAP entered by the absent ASW indicate that the ASW decided that Appellant is no longer eligible for bathing and toileting. In addition, the negative action notice and the time and task chart removed medication; however, the ASW notes do not discuss medication. In addition, there were questions that the Department was unable to answer as it did not have Appellant's file at the administrative hearing.

Appellant argues that she needs assistance with bathing, toileting, and medication, at the levels previously approved, and, presumably, at the levels previously approved since approximately [redacted].

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 must base the hearing decision on the preponderance of the evidence offered at the hearing or otherwise included in the record.

While an Appellant does have the burden of proof at an administrative hearing, the Department has the burden of going forward in such a manner as to adequately explain the action, and, cite the authority relied upon in taking the action. The Department could do so in this case. As noted above, the ASW was absent; the ASW was not present for testimony and/or cross-examination. In addition, the statement by the ASW notes in the notes for the home assessment were ambiguous and the Department was not able to clarify the meaning (that bathing and grooming would be left on and at the same time removed).

Appellant credibly testified that she needs assistance with bathing and grooming. Appellant is unstable, has weak ankles, must always use both hands in ambulating in her walker, had previously fallen in the shower and required staples in her scalp.

Appellant also credibly testified that she always has and continued to need assistance with eye drops twice per day. As noted, the ASW made no notes regarding the removal of medication, and, was not present at the administrative hearing for testimony and/or cross-examination.

Appellant presented credible and substantial evidence to support her case; the burden of proof shifted to the Department. The Department did not rebut the shift of the burden of proof, and thus, the evidence does not support the action, and must be reversed.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the Department failed to present credible and substantial evidence to support the reduction of Appellant's HHS grant.

[redacted]
Docket No. 14-015226 HHS
Decision and Order

IT IS THEREFORE ORDERED that:

The Department's actions are REVERSED.

The Department is ordered to re-instate Appellant's case as the prior grant, if it had previously reduced the grant, and, initiate a new assessment in accordance with policy and procedure, and issue any supplemental benefits to Appellant that she is entitled to, if eligibility otherwise exists.

It is so Ordered.

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

Date Signed: [redacted]

Date Mailed: [redacted]

JSdb

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.