STATE OF MICHIGAN
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
FOR THE DEPARTMENT OF HEALTH AND HUMAN SERVICES
P.O. Box 30763, Lansing, MI 48909
(877) 833-0870; Fax: (517) 373-4147

IN THE MATTER OF:

[redacted],

Docket No. 15-005166-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 hearing was held on May 27, 2015. Appellant appeared at the hearing. Allison Pool, Appeals Review Officer; Princess Nunley, Adult Services Supervisor; and Eliza Ijames, Adult Services Worker, appeared and testified as witnesses for the Michigan Department of Health and Human Services (MDHHS or the Department or the Respondent).

State's Exhibit A pages 1-21 were admitted as evidence.

ISSUE

Did the Department properly fail to pay to the Appellant Provider Home Health Services (HHS) payments to which he is entitled?

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 HHS Provider.

2. Appellant provided services to [redacted], a Medicaid recipient in 2012

3. In January 2012, Appellant notified the department that [redacted] was having surgery.

4. After the surgery, the Department ASW came to [redacted] home and conducted a Home visit with Demetris Hudgins and Appellant.

5. In May 2012, the Department sent [redacted] a letter stating that this HHS benefit would increase because Appellant was performing toileting, grooming and wound care for [redacted].

6. Appellant's pay for services performed was incorrect.

7. Appellant was continuously in contact with the Department because of the discrepancy in his HHS payments.

8. Appellant was not paid the increased amount.

9. On April 10, 2015, the Department received a request for a hearing contesting the lack of resolution on this issue and to request supplemental payment for services provided.

10. At the hearing, the ASW conceded on the record that Appellant had not been paid for services provided.

11. At the hearing the ASW conceded that Appellant is entitled to payments from January 24, 2012 through December 2013, for wound care which the worker had forgotten to add.

CONCLUSIONS OF LAW

The regulations governing the hearing and appeal process for applicants and recipients of public assistance in Michigan are found in the Michigan Administrative Code, MAC R 400.901-400.951. An opportunity for a hearing shall be granted to an applicant who requests a hearing because his or her claim for assistance has been denied. MAC R 400.903(1). Clients have the right to contest a department decision affecting eligibility or benefit levels whenever it is believed that the decision is incorrect. The department will provide an administrative hearing to review the decision and determine the appropriateness of that decision. BAM 600.

MAHS may grant a hearing about any of the following:

- Denial of an application and/or supplemental payments.
- Reduction in the amount of program benefits or service.
- Suspension or termination of program benefits or service.
- Restrictions under which benefits or services are provided.
- Delay of any action beyond standards of promptness.
- For **FAP only**, the current level of benefits or denial of expedited service.

MA Only

MAHS may grant a hearing about any of the following:

- Community spouse income allowance.
- Community spouse's income considered in determining the income allowance.
- Initial asset assessment (but only if an application for MA has actually been filed for the client).
- Determination of the couple's countable assets or protected spousal amount.
- Community spouse resource allowance. BAM 600, pages 4-5

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, 5-01-2013, 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, 12-01-2013, 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,
4-01-2015, Pages 1-3 of 3

Adult Services Manual (ASM 120, 12-01-2013), 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, 12-01-2013,
Pages 1-5 of 5

In the instant case, the Department representative agreed that the Appellant (provider) did provide enhanced services to a qualified Medicaid recipient for which he was not paid. The ASW testified that a prior caseworker had worked on the case and there was an attempt to put the payment on the system. The ASW stated that January 17, 2012, she determined that the client needed wound care after a medical procedure. At that time she did not have the logs that represented wound care. Appellant provided all documentation for the care that he was providing in a timely manner. Appellant should be entitled to payments which include wound care from January 24, 2012 through

December 2013 for which he has not been paid. The payments were not placed on the system and Appellant was not paid for wound care.

The Department is responsible for correctly determining accurate service for payment. Adult Services Manual (ASM) 165, page 1. ASM 165 states that a computer or mechanical process may fail to generate the correct payment amount to the client and/or provider resulting in overpayment. The specialist must initiate recoupment of the overpayment from the provider or client, depending on who was overpaid. Though the policy is silent as to the appropriate procedure for underpayments, it logically follows that the specialist should re-process the case and make a correct determination of appropriate level of benefit eligibility and then issue a supplemental payment for any HHS for which Appellant has not been paid. The testimonial record and the evidence contained in the written record establish that there has been an underpayment of HHS payments made to Appellant and that the error is administrative in nature. Appropriate action must be taken when administrative errors occur. In this case the service provider is responsible for correct billing procedures. ASM 165, page 3. Appellant has correctly billed for services which have been authorized and that he has already delivered to the client. It is now the Department's responsibility to ensure that all correct payments have been paid to the provider.

Based on the evidence presented, Appellant has established, by a preponderance of the evidence that [redacted] required and was approved for more HHS than Appellant (provider) was paid for. The Department ASW has agreed to submit a written request for MDHHS approval in accordance with Department policy.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, finds that the Department did not properly compensate Appellant for his provision of HHS under the circumstances.

IT IS THEREFORE ORDERED THAT:

> The Department's decision is REVERSED. The Department is ORDERED to re-assess Appellant's HHS payments from January 24, 2012 through December 2013. Once the redetermination has been conducted, the Department shall notify Appellant in writing as to the amount Appellant's HHS benefit should be increased and pay to Appellant any supplemental HHS benefits to which he is entitled.

Landis Y. Lain
Administrative Law Judge
for Nick Lyon, Director
Michigan Department of Community Health

LYL/sb

[redacted]
Docket No. 15-005166 HHS
Decision and Order

cc: [redacted]

Date Signed: 6/5/2015

Date Mailed: 6/5/2015

***** 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.