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. 15-007401 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 [redacted]. Appellant appeared and testified on his own behalf. [redacted], Appellant's provider, appeared as a witness for Appellant. [redacted], Appeals Review Officer, represented the Department of Health and Human Services (Department). [redacted], Adult Services Worker (ASW), Darlene Murphy, Registered Nurse (RN), Reviewer of HHS Cases; and [redacted], Independent Living Specialist appeared and testified as witnesses for the Department.

Respondent's Exhibit A pages 1-55 were admitted as evidence without objection. The record was left open until [redacted]. Appellant was ordered to provide the Department with an itemized list of times and tasks that are provided by his mother by [redacted]. The Department was required to complete the [redacted] six month assessment and to provide the updated in home assessment determination the RN, [redacted] by [redacted], so that she can conduct a complete Expanded Home Health Services assessment of Appellant's needs for HHS by [redacted]. That information should be forwarded to the Administrative Law Judge so that a complete record can be made.

State's Exhibit A pages 1-55 were admitted as evidence. The Hearing Decision and Order from Docket # 14-017802 is herein incorporated in its entirety.

ISSUE

Did the Department properly deny Appellant's request for additional Home Help Services (HHS)?

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 Medicaid beneficiary who has been diagnosed with quadriplegia, chronic Stage IV sacral sores, muscle spasm, chronic in-dwell catheter and decubitus on the buttocks. (States Exhibit A, p 5).

2. Appellant is totally paralyzed from the chest down and he is totally dependent on the care of others for everything. He has limited range of motion with his arms, but has no fine motor skills. He is bed bound. He requires complex care services for bowel program, catheters or leg bags, range of motion and bed sore care. (Exhibit A, p 8; Testimony).

3. Appellant's mother is providing Appellant with expanded HHS. There are two other people living in Appellant's home.

4. Before [redacted], Appellant was approved for 162:19 hours or $[redacted].

5. After the November 2014 in home visit, Appellant was approved for 139:44 hours or $[redacted].

6. In [redacted], the Adult Services Worker conducted an assessment and determined that Appellant had less of a need for range of motion for his personal care needs. The time previously allotted was reduced from 60 minutes to 15 minutes per day.

7. On [redacted], the Adult Services Worker sent Appellant an Advanced Negative Action notice informing him that HHS services would be reduced effective [redacted]. (Exhibit A, p 16).

8. On [redacted], the Michigan Administrative Hearing System (MAHS) received Appellant's Request for Hearing. In that request, Appellant stated that he wanted a hearing because range of motion was incorrectly allotted. He needs 15 minutes per limb for range of motion. He needs more time for dressing changes.

9. On [redacted], Administrative Law Judge Landis Y. Lain determined that Appellant had established that he continues to require range of motion for all of his limbs, which did not appear to be accounted for in the assessment. State's Exhibit A page 9. (Docket # 14-017802)

10. On [redacted], Administrative Law Judge Landis Y. Lain Ordered the Department to submit a written request for approval to the Department

of Community Health (Department of Health and Human Services) in accordance with Department policy and provide to Appellant written documentation (DCH-1785) of approval, and if Appellant is otherwise eligible pay to Appellant's provider the amounts to which she is entitled. State's Exhibit A page 9. (Docket # 14-017802)

11. On [redacted], a new assessment was completed by RN Murphy.

12. In the [redacted] assessment, the transferring was reduced from 25 minutes/12:32 to 10 minutes with the statement that a sliding board was used, stand and pivot-has trapeze, and special lotion to legs to prevent skin from breaking out. Range of Motion was increased from 15 minutes to 30 minutes. There were no other changes made to the assessment.

13. On [redacted], the Adult Services Worker sent Appellant a Services and Payment Approval Notice.

14. On [redacted], Appellant filed a hearings request stating that his **range of motion** needs to be reinstated to the original 1 hour time period (15 minutes per limb). **Skin care** time needs to be increased because he has incurred new skin care issues on top of the pre-existing skin issues which require medicated skin treatment twice per day. **Bowel Program** changed from once every other day to once per day, due to stomach issues. His **medication** has increased.

15. On [redacted], a face to face annual redetermination was held with Appellant and his provider in his home.

16. On [redacted], the Hearing was held.

17. At the hearing, the parties waived the time limits so that additional information could be provided: Appellant was ordered to provide the Department with an itemized list of times and tasks that are provided by his mother by [redacted] as well as any updated medical information from [redacted]. The department was required complete the [redacted] six month assessment and to provide the updated in home assessment determination the RN, [redacted] by [redacted], so that she can conduct a complete Complex Home Health Services assessment of Appellant's needs for HHS by [redacted].

18. On [redacted], Appellant's provider provided a completed list of all tasks that she performs for Appellant. (Administrative Law Judge Exhibit 1)

19. On [redacted], the Department provided the updated HHS assessment for Appellant.

20. On [redacted], the record closed.

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 Manuals 120 (12-1-2013) (hereinafter "ASM 120") address the issues of what services are included in Home Help Services and how such services are assessed. Pertinent department policy states:

> **Home Help Payment Services**
>
> 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.
>
> Home help services are defined as those tasks which the department is paying for through Title XIX (Medicaid) funds. These services are furnished to individuals who are **not** currently residing in a hospital, nursing facility, licensed foster care home/home for the aged, intermediate care facility (ICF) for persons with developmental disabilities or institution for mental illness.
>
> These activities **must** be certified by a Medicaid enrolled medical professional and may be provided by individuals or by private or public agencies. **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) 120

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 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.. This form is primarily used for APS cases.
- Follow rules of confidentiality when home help cases have companion adult protective services cases; see SRM 131, Confidentiality. ASm 120, pages 1-2

The **Bridges Eligibility** module in **ASCAP** contains information pertaining to the client's type of assistance (TOA) eligibility, scope of coverage and level of care.

The **Medical** module in **ASCAP** contains information regarding the physician(s), diagnosis, other health issues, adaptive equipment, medical treatments and medications. The medical needs certification date is entered on the diagnosis tab, at initial certification and annually thereafter, if applicable; see ASM 115, Adult Services Requirements.

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 level 3 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 if assessed at a level 3 or greater.

Example: Ms. Smith is assessed at a level 4 for bathing. However, she refuses to receive assistance or her daughter agrees to assist her at no charge. Ms. Smith would be eligible to receive assistance with IADL's if the assessment determines a need at a level 3 or greater.

> **Note:** If an individual uses adaptive equipment to assist with an ADL, and without the use of this equipment the person would require hands-on care, the individual must be ranked a level 3 or greater on the functional assessment. This individual would be eligible to receive home help services.

Example: Mr. Jones utilizes a transfer bench to get in and out of the bathtub, which allows him to bathe himself without the hands-on assistance of another. The adult services specialist must rank Mr. Jones a 3 or greater under the functional assessment. Mr. Jones would be eligible to receive home help services.

Assistive technology includes such items as walkers, wheelchairs, canes, reachers, lift chairs, bath benches, grab bars and hand held showers.

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.

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.

The specialist will allocate time for each task assessed a rank of 3 or greater, 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, a rationale **must** be provided.

An assessment of need, at a ranking of 3 or greater, 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 (IADL) 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.

Responsible Relatives

A responsible relative is defined as an individual's spouse or a parent of an unmarried child under age 18.

Activities of daily living (ADL) may be approved when the responsible relative is **unavailable** or **unable** to provide these services.

> **Note: Unavailable** means absence from the home for an extended period due to employment, school or other legitimate reasons. The responsible relative must provide a work or school schedule to verify they are unavailable to provide care. **Unable** means the responsible person has disabilities of their own which prevent them from providing care. These disabilities must be documented and verified by

a medical professional on the DHS-54A, Medical Needs form.

Do **not** approve shopping, laundry, or light housecleaning, when a responsible relative of the client resides in the home, **unless** they are unavailable or unable to provide these services. Document findings in the general narrative in ASCAP.

Example: Mrs. Smith is in need of home help services. Her spouse is employed and is out of the home Monday thru Friday from 7a.m. to 7p.m. The specialist would not approve hours for shopping, laundry or house cleaning as Mr. Smith is responsible for these tasks.

Example: Mrs. Jones is in need of home help services. Her spouse's employment takes him out of town Monday thru Saturday. The specialist may approve hours for shopping, laundry or house cleaning.

Expanded home help services (EHHS) exists if all basic home help services eligibility criteria are met and the assessment indicates the client's needs are so extensive that the cost of care cannot be met within the monthly maximum payment level of $549.99.

When the client's cost of care exceeds $1299.99 for **any** reason, the adult services specialist must submit a written request for approval to the Michigan Department of Community Health (MDCH).

Follow the **Procedures for Submitting Expanded Home Help Requests** found on the Adult Services Home Page. Submit the request with all required documentation to:

Michigan Department of Community Health
Long Term Care Services Policy Section
Capital Commons Building, 6th Floor
P.O. Box 30479
Lansing, MI 48909

MDCH will provide written documentation (DCH-1785) of approval. A new request **must** be submitted to the Michigan Department of Community Health whenever there is an increase in the cost of care amount. A new request is **not** require if the cost of care decreases below the approved amount set by MDCH.

Note: If an expanded home help case closes and reopens within 90 days and the care cost remains the same, a new MDCH approval is **not** required. ASM, 120.

In the instant case the Appellant qualifies for Expanded Home Help Services (EHHS). According to ASM 120, page 5 eligibility for EHHS services exist if all Basic Home Help Services eligibility criteria are met and the assessment indicates the client's needs are so extensive that the cost of care cannot be met within the monthly maximum payment level of $[redacted]. If the cost of care exceeds $[redacted] per month, the ASW must request approval from the Michigan Department of Community Health (MDCH).

In a Home visit-Redetermination note dated [redacted], the ASW classifies Appellant as a paraplegic who is able to move his arms and lift himself up with a lift bar and on [redacted] gave Appellant 52 minutes per day for range of motion. Respondent's Exhibit A pages 12 and 15. On [redacted], total care approval was $[redacted].

A six month review was conducted with Appellant and his provider on [redacted]. The review notes indicate that the home appeared very clean and well kept. There was no safety issues observed. Appellant denied any new health issues. Medications were observed and noted. Appellant denied any recent hospital stays. He has doctor visits at the home once per month, and a nurse comes two times per year. Client and provider reported that it takes about 15 minutes per day for range of motion. ADLs and IADLs were reviewed. State's Exhibit A, page 12.

On [redacted], the ASW determined that Appellant was approved for total care costs of $[redacted] which included the 15 minute range of motion reduction allotment. State's Exhibit A page 17.

The minimum wage increased as as of [redacted], Appellant was certified as eligible to receive services in the amount of $[redacted]. The amount included the one hour range of motion allowance. This proposed Time and Task assignment requires the Adult Services Specialist to submit a written request for approval to the Department, which the ASW has agreed to submit. The Department agreed to provide written documentation of approval for any services that Appellant feels that his provider has not been given sufficient time to perform. Exhibit A page 16. (Docket #14-017802).

Respondent has established through medical diagnosis and credible testimony that he is a quadriplegic rather than a paraplegic and that he continues to require range of motion for all of his limbs, which does not appear to be accounted for in the ASW's latest assessment. The ASW did not give a sufficient reason or provide documentation for the reduction in time for range of motion.

As discussed above, Appellant been originally approved for one hour per day range of motion. After the November assessment, the worker reduced Appellant's range of motion to 15 minutes with no justification for the actions. Appellant testified that his range of motion takes 15 minutes for each limb which results in the one hour that he was given in the past. Appellant testified credibly at the [redacted] hearing that his condition had not changed. He does have some movement in his hands, but needs range of motion for his hands so they do not close due to his paralysis. The ASW notes

indicate that Appellant has had no change in condition. Thus, the original reduction makes little sense to this Administrative Law Judge and is not justified anywhere in the ASW's assessment.

The Complex Care Assessment, (a paper assessment only), which was conducted by the RN on [redacted], resulted in an increase in range of motion to 30 minutes, which Appellant feels is still not sufficient for his needs, as it is still less than the original one hour. Appellant was due for his six month review assessment as of [redacted]. The new in home visit was conducted by a new caseworker in [redacted], but the assessment was not completed pending this hearing, which is in violation of Department policy, if there was no new Services and Payment Approval Notice, notifying the Appellant of the approved level of HHS benefits. The new caseworker simply extended the prior provider payment authorization for six months, but did not make an updated assessment of Appellant's current needs. The new caseworker stated that she did not have the experience or expertise to make the appropriate assessment in this case. Assessments must be conducted every six months in accordance with Department policy. Appellant stated that not only have his needs not been properly assessed, his needs have increased and those increases have not been taken into consideration.

A new assessment was conducted [redacted]. An updated Complex Care Assessment was conducted by RN Murphy, dated [redacted]. On the assessment she determined that Appellant's medications should be given eight minutes per day or 4:01 hours per month; transferring was given 25 minutes per day or 12:32 hours per month and wound care was given 25 minutes per day or 12:32 hours per month. The bowel program was increased to seven days instead of four, at 50 minutes per day or 14:20 hours per month. Range of motion was given one hour per day of 30:06 hours per month. Appellant was given a total of 170:33 hours per month in total care hours.

Based on the evidence presented, Appellant has established, by a preponderance of the evidence, that he required more HHS than he was approved for. The Department properly conducted the new Complex Care Assessment on [redacted] and increased Appellant's level of care hours for HHS.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, finds that the Department did appropriately conduct a Complex Care Assessment and determine that Appellant is entitled to receive 170:33 monthly hours of total care hours and appropriately approved Appellant's request for additional HHS service hours to begin in accordance with Departmental policy.

IT IS THEREFORE ORDERED THAT:

The Department's decision is **AFFIRMED**.

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

Date Signed: [redacted]

Date Mailed: [redacted]

LYL/[redacted]

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 March 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.