

**STATE OF MICHIGAN
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
FOR THE DEPARTMENT OF HEALTH AND HUMAN SERVICES**

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IN THE MATTER OF:

██████████,

Appellant

Docket No. 15-020151 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 personally appeared and testified.

██████████, Appeals Review Officer, represented the Department. ██████████, Adult Services Worker, (ASW), and ██████████, Adult Services Supervisor, (ASS), appeared as witnesses for the Department.

ISSUE

Did the Department properly deny Appellant's Home Help Services ("HHS") application?

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 ██████ year old female beneficiary of the Medicaid welfare program. Appellant resides with her ██████ children, ages ██████████ (Exhibit A.10).
2. On ██████████ the Department completed an initial assessment at Appellant's residence pursuant to a referral for the HHS program. The ASW did not assess that Appellant had any needs with any of her ADLs. The ASW did assess that Appellant had needs with IADLs, including housework, laundry, and meal preparation. The ASW indicated that Appellant sometimes have someone help with Appellant's hair for non-medical reasons. (Exhibits A.10; Testimony).

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3. On ██████████ the Department received a DHS-54A from Appellant's physician that does not indicate that Appellant has any needs with any ADLs. (Exhibit B.1).
4. On ██████████ the Department issued a notice of denial informing Appellant that she was not eligible for HHS's as policy requires at least one activity of daily living (ADL) at a rank of 3 or higher, and that medical documentations did not identify any ADL's ranking at a 3 or higher. (Exhibit A.8-10).
5. On ██████████, Appellant filed a Hearing Request at the local office in the Oakman District. The County failed to forward the request to MAHS until ██████████. (Exhibit A).

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.

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.

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 adjoining 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.*

At hearing herein, Appellant's DHS-54A-the Medical Needs Form was not reviewed in depth. However, ASM policy and procedure is quite specific as to what is required and what the contents of a DHS-54A must entail. This policy states in part:

**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 form must be completed by the medical professional and not 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. ASM 115, page 1 of 3. 5-1-2013 Effective Date.

Here, Appellant first requested a review of Appellant's claim that the Department failed to timely forward her hearing request to MAHS. Evidence of record shows that Appellant's hearing request is date stamped by the DHS Oakman District ██████████. The MAHS date stamp is indicated on the document as ██████████. MAHS did not receive Appellant's hearing request for almost 60 days. Appellant is correct-the county failed to timely forward the Request for a Hearing as required by policy and procedure.

Having determined that the Department failed to timely forward Appellant's hearing request, the next question is the remedy. While Appellant is correct as to the untimely forwarding of the Request for Hearing, Appellant offered no law or policy that would entitle her to prevail absent evidence to show that she is otherwise eligible. In other words, the delay by the Department will not, in and of itself, entitle Appellant to benefits unless she can show medical eligibility for the HHS program, discussed below.

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Here, the Department presented evidence that Appellant does not have any ADL needs, and as such, no eligibility under law and policy for the HHS program. In support of its position, the Department offered the evidence and testimony of the ASW who conducted the assessment. In addition, the Department offered into the record evidence of DHS-54A completed by Appellant's physician. That Form indicates that Appellant has needs with IADLs, but does not have any needs with ADLs. (Exhibit B.1).

Appellant argues that she needs assistance with her hair, and other "personal care like grooming due to my medical problems..." (Exhibit A.5).

Pursuant to ASM 105 cited above, federal and state law prohibits the Department from opening an HHS where the applicant's physician did not certify eligibility. Here, there is no certification on the DHS-54A as required by federal and state law. Appellant acknowledged that the physician who completed the form is in fact her doctor, and, that she chose this doctor to complete her assessment of her medical needs.

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. The ALJ at an administrative hearing must base a decision upon the evidence of record focusing at the time of the assessment. The Department cannot be held accountable for evidence it was unaware of at the time of its determination.

Here, there is no dispute regarding any request or need for IADLs. However, as noted in the above cited policy, Appellant does not meet the eligibility criteria with regard to the assessment showing ADL needs, as well as medical certification from her physician with regards to ADLS. As noted above, policy requires the Department to have verification from a recipient's physician certifying the need for assistance. The Department cannot open an HHS case unless there is medical certification verifying the need for assistance with at least one ADL at a rank of 3 or greater.

As Appellant's physician did not certify that Appellant has an ADL needs, and, as the assessment did not show a need for an ADL, there can be no eligibility. As the Department denial is consistent with policy and procedure, the ALJ must uphold the denial.

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DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, finds that the Department properly denied Appellant's HHS application.

IT IS THEREFORE ORDERED THAT:

The Department's decision is AFFIRMED.



Janice Spodarek
Administrative Law Judge
for Nick Lyon, Director
Michigan Department of
Health and Human Services

Date Mailed: [REDACTED]

JS/cg

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.