RICK SNYDER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
Christopher Seppanen
Executive Director

SHELLY EDGERTON
DIRECTOR

[redacted]

Date Mailed: March 29, 2017
MAHS Docket No.: 16-016193
Agency No.: [redacted]
Petitioner: [redacted]

ADMINISTRATIVE LAW JUDGE: Steven Kibit

DECISION AND ORDER

This matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9 and 42 CFR 431.200 *et seq.*, and upon the Petitioner's request for a hearing.

After due notice, an in-person hearing was begun on January 4, 2017. However, the hearing was not completed that day because Petitioner had to leave for a doctor's appointment and the undersigned Administrative Law Judge granted her request that the hearing be continued. After due notice, the hearing was completed on February 21, 2017.

On both hearing days, Petitioner appeared and testified on her own behalf. [redacted] Appeals Review Officer, appeared and testified on behalf of the Respondent Department of Health and Human Services. [redacted] Adult Services Worker (ASW), and [redacted] Adult Services Supervisor, also testified as witnesses for the Department.

During the hearing, the Department offered two exhibits that were admitted into the record:

Exhibit A: Hearing Summary and Packet, pages 1-48
Exhibit B: Hearing Summary Addendum, pages 1-2, 4-30

ISSUE

Did the Department properly deny Petitioner's request for retroactive payments for Home Help Services (HHS)?[1]

[1] Petitioner also initially raised the issue of payments after November 1, 2016, but the Department confirmed on the record during the second day of hearing that such payments had been reauthorized in February of 2017 and that Petitioner should be receiving them soon. Petitioner's second issue is therefore resolved and legally moot.

FINDINGS OF FACT

The Administrative Law Judge, based upon the competent, material and substantial evidence on the whole record, finds as material fact:

1. Petitioner is a fifty-four-year-old Medicaid beneficiary who has been diagnosed with breast cancer, neuropathic pain syndrome, sciatica, and bipolar disorder. (Exhibit A, pages 7, 9).

2. She also reports having hip pain, neck pain, knee pain, and headaches. (Exhibit A, page 9).

3. On April 22, 2010, Petitioner was approved for HHS through the Department, with an effective start date of February 3, 2010. (Exhibit A, page 8).

4. Specifically, Petitioner was approved for assistance with the tasks of bathing, housework, laundry, shopping, and meal preparation. (Exhibit A, pages 26-27).

5. For the time period of August 31, 2015 through October 31, 2015, Petitioner was approved for [redacted] per month in HHS. (Exhibit 8, pages 21-22).

6. Petitioner also received payments for services provided during that time period, and she and provider both signed warrants dated July 9, 2015; August 6, 2015; and October 8, 2015. (Exhibit A, page 22; Exhibit B, pages 20-25).

7. On October 1, 2015, ASW R. Davis, the worker assigned to Petitioner's case at the time, completed a home visit and reassessment with Petitioner and Petitioner's home help provider, a [redacted], in Petitioner's home. (Exhibit A, pages 29-30).

8. During that meeting, ASW [redacted] and Petitioner discussed an invalid Medical Needs Form that had recently been completed and sent in by Petitioner, and the fact that Petitioner would need to have a new one completed by a medical professional. (Exhibit A, page 30).

9. ASW [redacted] wrote in her notes that a new Medical Needs Form would be sent out next week and that payments would be approved for two months until a new form was received. (Exhibit A, page 30).

10. On October 31, 2015, the payment authorization of HHS for Petitioner expired. (Exhibit 8, page 21).

11. No new authorization was entered at that time and, between November 1, 2015 and April 25, 2016, no HHS payments were authorized for or made to Petitioner. (Exhibit 8, pages 21-22).

12. At some point in 2015, ASW [redacted] retired. (Testimony of Adult Services Supervisor).

13. After ASW [redacted] retirement, Petitioner's case was not being actively monitored, as there had been no case closure, but any contacts or information regarding the case would have been directed to the Adult Services Supervisor. (Testimony of Adult Services Supervisor).

14. No contact, further information, or updated Medical Needs Form was received from Petitioner during that time period. (Testimony of Adult Services Supervisor).

15. In March of 2016, ASW [redacted] was assigned Petitioner's case. (Testimony of Adult Services Supervisor).

16. On April 19, 2016, ASW [redacted] attempted to complete a home visit and reassessment with Petitioner, but Petitioner was not at home. (Exhibit A, page 29).

17. Petitioner subsequently spoke with both ASW [redacted] and the Adult Services Supervisor. (Exhibit A, pages 28-29).

18. On April 26, 2016, ASW [redacted] completed a home visit and reassessment with Petitioner and Petitioner's provider. (Exhibit A, pages 26-27).

19. Following that visit, ASW [redacted] determined that payments would resume upon receipt of an updated Medicaid Needs Form. (Exhibit A, page 28).

20. On May 10, 2016, the Department received a Medical Needs Form signed by the Medicaid enrolled provider on that day. (Exhibit A, page 24).

21. Subsequently, Petitioner was approved for [redacted] per month in HHS for the time period of April 26, 2016 to October 31, 2016. (Exhibit 8, pages 21-22).

22. On October 25, 2016, ASW [redacted] attempted a home visit and reassessment with Petitioner, but Petitioner was not at home and only requested the Adult Services Supervisor's telephone number. (Exhibit A, page 27).

23. On October 26, 2016, Petitioner contacted [redacted] by telephone and requested back pay for her provider. (Exhibit A, pages 13-14).

24. [redacted] then advised Petitioner that she must be available for her home visit and that no payments would be sent out until the review is completed. (Exhibit A, pages 13-14).

25. [redacted] also wrote in her notes that she would review the case to determine what back pay Petitioner was referring to. (Exhibit A, page 14).

26. On October 26, 2016, the Department also sent Petitioner written notice that her HHS would be suspended as of November 10, 2016 because she missed a scheduled appointment. (Exhibit A, page 6).

27. On November 9, 2016, the Michigan Administrative Hearing System (MAHS) received the request for hearing filed in this matter regarding that suspension and the denial of back payments. (Exhibit A, page 5).

28. On November 10, 2016, the Department sent Petitioner written notice that her HHS would be terminated on November 29, 2016 because she has failed to make herself available for a scheduled home visit or contact her ASW to reschedule the appointment. (Exhibit A, pages 15-16).

29. On November 14, 2016, Petitioner telephoned ASW [redacted] regarding the home visit and any retroactive payments. (Exhibit A, page 13).

30. On November 16, 2016, Petitioner came into the Department's office and provided a copy of a Medical Needs Form signed by the Medicaid enrolled profession in October of 2015. (Exhibit A, pages 12-13, 23).

31. On December 6, 2016, a home visit and reassessment was completed with Petitioner in her home. (Exhibit A, pages 11-12).

32. On December 21, 2016, Petitioner's home help provider met with ASW [redacted] in the Department's office. (Exhibit B, page 3).

33. Petitioner's HHS were subsequently reauthorized, with an effective start date of November 1, 2016. (Testimony of Adult Services Supervisor).

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 statutes, 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.

In order to be approved for HHS, a client must provide a Medical Needs Form completed by a medical professional and, with the respect to such forms, Adult Services Manual (ASM) 115 (8-1-2016) (hereinafter "ASM 101"), provides:

> **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.).
> - Physician assistant.
> - Nurse practitioner.
> - Occupational therapist.
> - Physical therapist.
>
> The medical needs form is only required for home help recipients at the initial opening of a case, unless one of the following exists:
>
> - The specialist assesses a decline in the client's health which significantly increases their need for services.
> - The specialist assesses an improvement in the client's ability for self-care, resulting in a decrease or elimination of services and the client states their care needs have not changed.
> - The current medical needs form has a specified time frame for needed services and that time frame has elapsed.
>
> At each case review, [sic] the specialist must document in the general narrative if a medical needs form is or is not needed.
>
> 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.
>
> Home help services cannot be authorized prior to the date of the medical professional's 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.
>
> **Example:** The local office adult services unit receives a DHS-54A signed on 1/18/2016 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 2/16/2016. Payment cannot begin until 2/16/2016, or later, if the provider was not working during this time period or not enrolled. Refer to ASM 135 for information regarding provider enrollment.
>
> If the case is closed and reopened within 90 days with no changes in the client's condition, a new DHS-54A is not necessary . . .
>
> *ASM 115, pages 1-2*
> *(Underline added for emphasis)*

Moreover, ASM 101 and ASM 120 address the issues of what services are included in HHS and how such services are assessed. For example, ASM 101 provides in part:

> 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.

Personal care services which are eligible for Title XIX funding are limited to:

Activities of Daily Living (ADL)

- Eating.
- Toileting.
- Bathing.
- Grooming.
- Dressing.
- Transferring.
- Mobility.

Instrumental Activities of Daily Living (IADL)

- Taking medication.
- Meal preparation/cleanup.
- Shopping for food and other necessities of daily living.
- Laundry.
- Light housecleaning.

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 [sic] 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 would include such items as walkers, wheelchairs, canes, reachers, lift chairs, bath benches, grab bars and handheld showers.

* * *

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

ASM 101, pages 1-3, 5

Similarly, ASM 120 states in part:

Functional Assessment

The **Functional Assessment** module of the **ASCAP** comprehensive assessment is the basis for service planning and for the HHS 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 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. Ms. Smith would

be eligible to receive assistance with IADL's [sic] 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 per-formed 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.

Time and Task

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.

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 suggested 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.

ASM 120, pages 2-7

Here, as discussed above, the Department has denied Petitioner's request for retroactive payments for HHS.

In appealing that decision, Petitioner testified, after initially misidentifying some dates, that she is specifically seeking retroactive payments for July of 2015 through April of 2016. She also testified that she was receiving services in June of 2015, with ASW [redacted] as her worker, but that ASW [redacted] retired that month and payments stopped in July of 2015. Petitioner further testified that she did not hear from anyone at the Department from June of 2015 to April of 2016 and that her complaints about missing payments were never addressed during that time period, despite repeatedly calling in regarding the missing payments; coming to the office multiple times, including an office visit with the Adult Services Supervisor in November of 2015; and providing an updated Medical Needs Form in October of 2015. According to Petitioner, she also filed three hearing requests regarding missing checks; in October of 2015, November of 2015 and August of 2016, but never received a hearing date or any response from the Michigan Administrative Hearing System when she called it. Moreover, while ASW [redacted] restarted payments when she took over the case in April of 2016, the ASW improperly failed to approve retroactive payments for the time Petitioner and her provider were not receiving any payments.

In response, the Adult Services Supervisor testified that, after ASW [redacted] completed a home visit in October of 2015, she mailed out a new Medical Needs Form and decided not to approve payments, even for the two month period referenced in the cases notes, until an updated form was received. However, as no updated form was received prior to ASW [redacted] retirement, she did not authorize payments later either. The Adult Services

Supervisor further testified that, while Petitioner's case was still open, it was not being actively monitored and the Adult Services Supervisor, who still in charge of the case, did not take any action, positive or negative, with respect to the case prior to reassigning it to ASW [redacted] in March of 2016 because there was no issues with it that she was aware of. She also testified that Petitioner never contacted the Department during that time period and that, if Petitioner had done so, Petitioner would have been forwarded to the Adult Services Supervisor. The Adult Services Supervisor did agree that the Department received a Medical Needs Form purportedly signed by a medical professional in October of 2015, but also noted that it was not received until November of 2016.

Petitioner bears the burden of proving by a preponderance of the evidence that the Department erred in denying her request for retroactive HHS payments.

As an initial matter, the undersigned Administrative Law Judge would note that Petitioner's testimony incorrectly identified the time period when payments were not authorized. While, after initially stating that payments stopped in April of 2015, Petitioner expressly testified that she is seeking retroactive payments for June of 2015 to April of 2016, the record clearly reflects that payments were made for services provided in June, July, August, September, and October of 2015. Not only does the payment history in the Department's system reflect that warrants were issued and paid for those months (Exhibit A, page 22), but the Department also provided three warrants signed by Petitioner for months that she claimed payments were not made (Exhibit B, pages 20-25).

Moreover, with respect to the actual time period for which payments were not made, *i.e.* November 1, 2015 through April 25, 2016, Petitioner has failed to meet her burden of the proof and the Department's decision must therefore be affirmed. The Department credibly established both that payments stopped because Petitioner failed to provide an updated Medicaid Needs Form as required by the above policy and that payments resumed once such a form was provided. Petitioner's testimony in turn was inconsistent and lacks credibility regarding what occurred. For example, while Petitioner claims that she provided an updated Medical Needs Form in October of 2015, that testimony is unsupported and conflicts with her claims regarding when payments stopped and what contact she had with the Department between June of 2015 and April of 2016. Similarly, while Petitioner claims that she previously requested three hearings regarding missing payments, her testimony must be rejected as two of the dates she claims she requested a hearing on would have been before payments even stopped and she could not produce copies of her requests for hearing on either hearing date in this case. Overall, Petitioner's timeline of events was unsupported and contradicted by the remainder of the record, and the undersigned Administrative Law Judge does not find her credible.

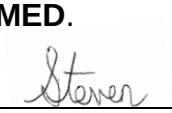
Accordingly, given the record and applicable policies in this case, Petitioner has failed to meet her burden of proof and the Department's decision must be affirmed.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the Department properly denied Petitioner's request for retroactive payments.

IT IS, THEREFORE, ORDERED that:

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



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Steven Kibit
Administrative Law Judge
for Nick Lyon, Director
Department of Health and Human Services

NOTICE OF APPEAL: A party may appeal this Order in circuit court within 30 days of the receipt date. A copy of the circuit court appeal must be filed with the Michigan Administrative Hearing System (MAHS).

A party may request a rehearing or reconsideration of this Order if the request is received by MAHS within 30 days of the date the Order was issued. The party requesting a rehearing or reconsideration must provide the specific reasons for the request. MAHS will not review any response to a request for rehearing/reconsideration.

A written request may be mailed or faxed to MAHS. If submitted by fax, the written request must be faxed to (517) 335-6088; Attention: MAHS Rehearing/Reconsideration Request.

If submitted by mail, the written request must be addressed as follows:

Michigan Administrative Hearings
Reconsideration/Rehearing Request
P.O. Box 30763
Lansing, Michigan 48909-8139

DHHS Department Rep.

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]