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.: 17-000045
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 held on February 21, 2017. [redacted] from the [redacted] appeared and testified on Petitioner's behalf. Petitioner also testified on his own behalf. [redacted] from the [redacted] was also present during the hearing. [redacted], represented the Respondent Department of Health and Human Services. [redacted], [redacted], testified as a witness for the Department. [redacted], [redacted]; was also present during the hearing for Respondent.

ISSUE

Did the Department properly terminate Petitioner's 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. Petitioner is a sixty-year-old Medicaid beneficiary who was approved for HHS beginning September 9, 2010 due to a need for services arising from his prostate cancer and multiple myeloma. (Exhibit A, pages 2, 6).

2. At the time of the decision at issue in this case, Petitioner was approved for 44 hours and 18 minutes per month of HHS, with a total monthly care cost of $[redacted]. (Exhibit A, page 23).

3. Specifically, Petitioner was authorized for assistance with the Activity of Daily Living (ADL) of bathing and the Instrumental Activities of Daily Living (IADLs) of laundry, shopping, and meal preparation. (Exhibit A, page 23).

4. On September 22, 2016, the Adult Services Specialist completed an Annual Review with Petitioner and his provider in Petitioner's home. (Exhibit A, pages 21-22).

5. During that review, the provider failed to directly answer specific questions about the approved tasks, including the ADL of bathing, and, instead, just generally stated that he did what needed to be done. (Exhibit A, pages 22-23; Testimony of Petitioner; Testimony of Department's witness).

6. Based on those answers and her concerns regarding whether Petitioner continued to qualify for HHS, the Adult Services Specialist provided Petitioner with a new Medical Needs Form for his doctor to complete and certify a need for services. (Exhibit A, page 21; Testimony of Department's witness).

7. On October 10, 2016, the Department received a Medical Needs Form signed by Petitioner's doctor on October 5, 2016. (Exhibit A, page 10).

8. However, the form failed to identify Petitioner's diagnoses and the doctor did not certify that Petitioner had a medical need for assistance with any of the listed personal care activities. (Exhibit A, page 10).

9. On November 4, 2016, the Department received another Medical Needs Form and, while treatment was identified and a medical need for assistance certified, there was no specific diagnosis identified; the new form just had additional information written on top of the previously-received form; there was no indication who had provided that information; and there was no new signature from the doctor. (Exhibit A, page 10).

10. On November 7, 2016, the Adult Services Specialist faxed a copy of the original Medical Need Form that the Department had received and asked the doctor to update it. (Exhibit A, page 12).

11. On December 1, 2016, the Department received a third Medical Needs Form, but the section for identifying diagnoses was missing and, while a medical need for assistance was certified, that certification had just been made on top of the original form and there was no indication who had provided that certification or new signature from the doctor. (Exhibit A, page 13).

12. On December 9, 2016, the Department sent Petitioner written notice that his HHS would be terminated on December 27, 2016. (Exhibit A, pages 16-20).

13. The reason given in the notice for the termination was that no need for HHS was found during the last review; a new medical needs form was then requested, but not received; and there was no need for hands-on service based on the previous medical needs diagnosis. (Exhibit A, pages 16-20).

14. On January 5, 2017, the Michigan Administrative Hearing System received the request for hearing filed by Petitioner in this matter regarding the decision to terminate his services. (Exhibit A, pages 4-5).

15. On January 17, 2017, the Department received another Medical Needs Form via a fax from Petitioner's doctor's office. (Exhibit A, pages 14-15).

16. That form identified a diagnosis of multiple myeloma and certified a need for medical assistance, but it also just added additional information to the original form; there was no indication who had provided that information; and there was no new signature from the doctor. (Exhibit A, page 15).

17. On February 7, 2017, the Department received a new Medical Needs Form signed and completed by Petitioner's doctor that day. (Exhibit 1, page 1).

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.

Veteran's Administration (VA)

A DHS-54A completed by a Veteran's Administration physician or the VA medical form in lieu of the medical needs form is acceptable.

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

As described in the above policy, an individual is only eligible to receive HHS in general, or with any IADLs in particular, if he or she has a need for assistance with at least one ADL at a level 3 or greater on the functional scale.

In this case, the Department decided to terminate Petitioner's HHS on the basis that Petitioner did not have a need for assistance with any ADLs at a level 3 or greater on the functional scale. Specifically, the ASW testified and wrote in her notes that, while Petitioner was previously authorized to receive assistance with the ADL of bathing, the provider's reports during the home visit suggested that no such care was needed or being provided and, despite multiple attempts and contacts with Petitioner and his doctor, no complete and valid updated Medical Needs Form certifying a current need for any assistance was ever provided as requested.

In response, Petitioner testified he has had multiple myeloma and spinal problems for over seven years and that, during that time, he has never had issues with his HHS or providing any necessary forms until recently. He also testified that he is very familiar with the forms and that his doctor filled out every one that was submitted. Petitioner further testified that his provider assists him with housework, shopping, bathing and personal care, but that his provider did not answer "yes" or "no" to the worker's direct questions about specific tasks during the assessment and instead just said he does what he is supposed to be doing.

Petitioner's representative testified that Petitioner has health difficulties, but that he has still gone the extra mile in providing the form requested by the Department. She also testified that she herself has had difficulties in trying to contact Petitioner's doctor.

Petitioner bears the burden of proving by a preponderance of the evidence that the Department erred in terminating his HHS.

Given the evidence and applicable policies in this case, Petitioner has failed to meet his burden of proof and the Department's decision must therefore be affirmed. The only assistance with an ADL that Petitioner was previously approved for was bathing and it is undisputed that, at best, Petitioner's provider declined to specifically confirm that Petitioner needs assistance with bathing, or any other ADL, and instead only offered a general statement that he does what is needed, which is insufficient to show that Petitioner meets the above criteria. Moreover, while the information provided during the reassessment failed to show that Petitioner continued to meet the criteria for HHS, the Department did not immediately terminate Petitioner's services and instead gave him an opportunity to provide a new Medical Needs Form certifying his current need for services. An updated Medical Needs Form is only required in certain circumstances, but one such circumstance is when 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 that their care needs have not changed, and that is what occurred here. However, despite multiple attempts and contacts by the Adult Services Specialist, no complete and valid Medical Needs Form was received prior to the decision at issue in this case as the submitted forms were incomplete; contained information added on to an earlier form, without any indication of who had added the information or a new signature from Petitioner's doctor; or both.

The failure to provide a complete and valid Medical Needs Form may be the fault of Petitioner's doctor, but it is Petitioner's responsibility under the applicable policy to obtain the medical certification of need under the applicable policy. He failed to do so in this case prior to the decision to terminate his services and, given that failure to provide an updated Medical Needs Form and the insufficient information provided regarding Petitioner's care during the home visit, the undersigned Administrative Law Judge finds that Petitioner has failed to meet his burden of proof and that the Department's decision must therefore 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 terminated Petitioner's HHS.

IT IS, THEREFORE, ORDERED that:

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

SK/tm

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] **Hearing Rep.**

[redacted]

[redacted]

DHHS-Location Contact

[redacted]