[redacted]
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Date Mailed: December 17, 2020
MOAHR Docket No.: 19-005102
Agency No.: [redacted]
Petitioner: [redacted]

ADMINISTRATIVE LAW JUDGE: Robert J. Meade

DECISION AND ORDER

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

APPEARANCES

Attorneys Kyle Williams, Simon Zagata, and John Schwend appeared on behalf of Petitioner, [redacted].

Assistant Attorney Generals H. Daniel Beaton and Shelly McCormick appeared on behalf of Respondent, Michigan Department of Health and Human Services.

PROCEDURAL SUMMARY

On May 28, 2019, Petitioner's Request for Hearing was received by the Michigan Office of Administrative Hearings and Rules (MOAHR). On June 7, 2019, a Notice of Hearing was issued, scheduling a hearing for June 25, 2020. The June 25, 2020 hearing was adjourned per Petitioner's request and a Prehearing Conference was scheduled for July 16, 2019. On July 11, 2019, Petitioner's first counsel withdrew, and the July 16, 2019 Prehearing Conference was adjourned. On July 31, 2019, Petitioner's current counsel filed an Appearance, and a Prehearing Conference was scheduled for September 24, 2019. At the September 24, 2019 Prehearing Conference, Petitioner's counsel indicated an intent to file a Motion for Summary Disposition. Petitioner's Motion was received on October 18, 2019, Respondent's Response was received on December 9, 2019, after an extension was granted, and Oral Arguments were held on December 17, 2019. On December 30, 2019, an Order Denying Petitioner's Motion for Summary Disposition was issued.

On January 23, 2020, a Notice was issued, scheduling a Telephone Prehearing Conference for February 20, 2020. At the prehearing conference, the parties agreed that this matter would commence with a joint hearing including other similarly situated Petitioners to cover general testimony and evidence and an in-person hearing was

scheduled for April 14, 2020. The April 14, 2020 in-person hearing, as well as subsequently scheduled in-person hearings in May 2020 and June 2020 were adjourned due to the COVID-19 pandemic. With in-person hearings still suspended at MOAHR, the parties agreed to proceed with a telephone hearing. The joint hearing commenced on September 15, 2020 and was continued on September 17, 2020. Petitioner's hearing was held on December 9, 2020.

EXHIBITS AND WITNESSES

Petitioner's Exhibits:

Exhibit 4.2: NOT ADMITTED

Exhibit 26: HHA Comparison Spreadsheet

Exhibit 27: MSA 18-12 Bulletin

Exhibit 28: MDHHS Medicaid Provider Manual

Exhibit 29: NOT ADMITTED

Exhibit 30: MSJ JRG Transcript, dated December 17, 2019

Exhibit 31.1: CFR 431.205

Exhibit 31.2: CFR 431.206

Exhibit 31.3: CFR 431.210

Exhibit 31.4: CFR 431.211

Exhibit 31.5: CFR 431.213

Exhibit 31.6: CFR 431.214

Exhibit 31.7: CFR 431.230

Exhibit 31.8: CFR 431.240

Exhibit 31.9: CFR 431.242

Exhibit 33: OIG Memo

Petitioner's Witnesses:

Natalya Luko, RN, M&Y Care (at joint hearing)

Respondent's Exhibits:

Joint Exhibit A: Medical Services Administration Bulletin MSA 18-12

Joint Exhibit B: Adult Services Manual (ASM) 121

Joint Exhibit C: Medicaid Provider Manual, Home Health Chapter

Joint Exhibit D: ASM 101

Berezkin Exhibit A: Hearing Summary: 101 pages

Respondent's Witnesses:

Lori Hinkle, State Administrative Manager

ISSUE

Did the Department properly deny Petitioner's prior authorization (PA) request for Home Health services?

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 [redacted]year-old Medicaid beneficiary, born [redacted] 1942. ([redacted] Exhibit A, p 3; Testimony)

2. On February 7, 2019, the Department's Program Review Division, received a prior authorization request from Petitioner's provider, M&Y Care, LLC for Petitioner to receive Home Health aide services. ([redacted] Exhibit A, pp 3-58; Testimony)

3. In his prior authorization request, Petitioner requested Home Health aide services to assist with showering, shampooing, shaving, oral care, assistance with mobility and exercise, assistance with dressing, skin care, nail care (hands and feet), and encouraging the intake of fluids. The diagnoses listed on Petitioner's prior authorization request included hypertension, benign neoplasm of prostate, generalized osteoarthritis, and peripheral vascular disease. ([redacted] Exhibit A, pp 3, 10, 13; Testimony)

4. The Assessment Summary provided with Petitioner's PA requests indicates that Petitioner has not had any hospitalizations, emergency room visits, medication changes, or other changes in his conditions within the past 60 days of the certification. ([redacted] Exhibit A, pp 14-15; Testimony)

5. At the time the PA request was made, Petitioner was also receiving Home Help Services (HHS) through the Department. Specifically, Petitioner was receiving

HHS to assist with:

- bathing (using tub or shower, managing faucets, shampooing, bathing-sponge bath, giving sponge bath, getting in/out of shower, cleaning body, drying, preparing water/supplies, and cleaning up after),
- dressing (putting on and taking off clothes, fastening/unfastening garments),
- grooming (hair combing and brushing, shaving, toenail care, oral hygiene, fingernail care),
- housework (sweeping, washing floors, cleaning bathroom, taking garbage out, picking up, cleaning/defrosting refrigerator, vacuuming, washing kitchen counters/sink, changing bed linens, and dusting),
- laundry (gaining access to machines, manipulating soap containers, handling wet laundry, hanging laundry to dry, folding, sorting, reaching into machines, operating machine controls, putting clothes in dryer, and storing),
- medication (setting up medication, assistance with taking medication),
- meal preparation (menu planning, opening packages, cans and/or bags, lifting pots and pans, cooking, setting table, washing/drying dishes or loading dishwasher, washing, peeling, slicing, mixing ingredients, rehearing food, operating oven/stove/microwave, serving meal, putting dishes away), and
- shopping for food (compiling list, bending, reaching, lifting, transferring items to home, phoning in/picking up prescriptions, managing cart/basket, and putting items away). ([redacted] Exhibit A, pp 59-63; Testimony)

6. On February 28, 2019, after reviewing the PA request, the Department determined that Petitioner was not eligible for Home Health aide services because the services were not medically necessary, and the services were duplicative of the HHS Petitioner was receiving. ([redacted] Exhibit A, pp 68-101; Testimony)

7. On March 1, 2019, the Department sent Petitioner a Notification of Denial, including Petitioner's appeal rights. ([redacted] Exhibit A, pp 66-67; Testimony)

8. On May 28, 2019, MOAHR received Petitioner's Request for Hearing.

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.

On May 25, 2018, the Department's Medical Services Administration issued Bulletin Number 18-12, to be effective July 1, 2018. Bulletin 18-12 informed providers of Home Health services that prior authorization would be required for continuation of Home Health services after the initial 90 days of services:

> The purpose of this bulletin is to notify Medicaid Home Health Agencies (HHAs) of changes to Medicaid Home Health policy. Effective July 1, 2018 services provided by a home health aide will require prior authorization (PA) for all Medicaid beneficiaries after the initial 90 days of services, and every 90 days thereafter for continuation of services. The Program Review Division will require submission of PA requests for services provided on or after August 1, 2018. The PA and documentation requirements listed in this bulletin apply to all affected Medicaid beneficiaries.
>
> ### I. General Information
>
> Home health is a covered Medicaid benefit for beneficiaries who require services on an intermittent basis for treatment of an injury, illness, or disability. An HHA is an organization that provides home health services, such as skilled nursing, physical therapy (PT), occupational therapy (OT), speech therapy (ST), and care by home health aides. Home health services must be medically necessary, ordered by a physician, and provided in any setting in which normal activities take place and does not include services in a hospital, nursing facility, or intermediate care facility for individuals with intellectual disabilities (ICF/IID). It is the responsibility of the HHA to comply with Medicare Conditions of Participation (42 CFR §484).
>
> At times, the request to begin services will be submitted by the certifying physician; however, a person other than the certifying physician (e.g., physicians who attend to the beneficiary in the acute and post-acute setting) may certify the medical need for home health aide services. The physician attending to the needs of the beneficiary in the acute and post-acute setting certifying medical need for home health aide services must complete the face-to-face encounter and initiate the Plan of Care (POC) for home health services. In the event that the physician in the acute or post-acute setting is certifying the need for home health aide services, the

beneficiary's care must "handed off" to the community based physician to review and sign off on the POC.

II. Definition of Home Health Aide

The home health aide is a covered benefit for health services on an intermittent basis that must be medically necessary and ordered by the attending physician. Consistent with 42 CFR §440, home health aide services are not contingent on the receipt of skilled nursing or therapy services. Also, the qualifications and training provided by the home health aide must comply with regulations outlined in 42 CFR §484.80.

Care provided by the home health aide must be for a specific beneficiary and supervised by a Registered Nurse (RN) or other appropriate skilled professional (e.g., PT, OT, ST) with written care instructions for the beneficiary's care. It is the responsibility of the supervising RN or another appropriate skilled professional to co-sign all documentation completed by the home health aide. The home health aide services and written instructions must be consistent with the home health aide competencies and consistent with the medical needs of the beneficiary. Services provided by the home health aide are not solely to prevent an illness, injury, disability, or based on convenience.

III. Home Health Aide Prior Authorization

Home health aide services for Medicaid beneficiaries must be authorized by the Michigan Department of Health and Human Services (MDHHS) Program Review Division after the initial 90 days, and every 90 days thereafter if continued services are deemed medically necessary.

Effective July 1, 2018, the Program Review Division will require the servicing HHA to submit the MSA-181 form for all services provided on or after August 1, 2018 each time services are requested for:

- continuation of services beyond the initial 90 days;
- continuation of services beyond the end date of the current authorization period (renewal);
- an increase in services; or
- a decrease in services.

After the initial 90 days, home health aide services may be provided up to a maximum of 36 visits within 90 consecutive calendar days. If the beneficiary's attending physician orders home health aide services, the

HHA must assess the availability of the family or another entity (e.g., Home Help Program or MI Choice Waiver) to perform the services. Physicians ordering home health aide services must determine that medical services are medically necessary and appropriate for continuation of services beyond the initial 90 days, and for each PA request thereafter.

In some cases, the beneficiary's attending physician may order home health aide services that extend beyond the maximum of 36 visits within 90 consecutive calendar days. For requests that extend beyond 36 or more visits within 90 consecutive calendar days, the PA request will be reviewed for medical appropriateness, the availability of the family or another entity (e.g., Home Help Program or MI Choice Waiver), and the cost effectiveness of other programs available for the beneficiary.

Following receipt and review of the Home Health Aide Prior Approval Request/ Authorization form (MSA-181) and the required documentation by the Program Review Division, a determination notification is sent to the HHA and beneficiary or primary caregiver indicating the outcome of the review (a copy of the MSA-181 is attached). If approved, the notification letter will contain the PA number and approved authorization dates. It is important to include this PA number on every claim and in all other communications to the MDHHS Program Review Division.

If a beneficiary receiving home health aide services continues to require the services after the initial authorization period, a new MSA-181 must be submitted by the HHA along with the required documentation to support medical necessity for continuation of services beyond the approved authorization dates. This request must be received by the Program Review Division no less than 15 business days before the end of the current authorization period. Failure to do so may result in a delay of authorization for continued services which, in turn, may result in delayed services or no payment for services rendered without authorization. The length of each subsequent authorization period will be determined upon review by the Program Review Division and will be specific to each beneficiary based on several factors, including the beneficiary's medical and functional needs, personal care services through another entity (e.g., Home Help Program, waiver services, or other community services), and family or caregiver support.

IV. Documentation Requirements

The following documentation is required for all initial PA requests for Home Health aide services and must accompany the MSA-181:

- documentation of the Face-to-Face encounter;

- all components of the POC as identified in 42 CFR §484 and MDHHS policy;
- OASIS; and
- other documentation as requested by MDHHS.

The documentation listed above is also required at subsequent 12-month intervals. The anniversary date is the date 12 months from the date services were first provided.

- For services beyond the initial authorized 90 days and for subsequent requests, the MSA-181, an updated POC complete with all components, and other documentation as requested by MDHHS must be submitted to the Program Review Division for review.
- If a beneficiary's condition changes during an authorization period, warranting an increase or decrease in the number of approved hours or discontinuation of services, the HHA must report the change to the Program Review Division. It is important that the HHA report all changes as soon as they occur, as well as properly update the POC and written instructions for the home health aide.
- To request an increase in hours, the following are required:
    - an updated MSA-181 indicating the increase in hours;
    - an updated and signed POC; and
    - documentation from the attending physician.
- To request a decrease in hours, the following are required:
    - an updated MSA-181 indicating the decrease in hours; and
    - an updated and signed POC.

PA and documentation requirements listed in this bulletin apply to all Medicaid beneficiaries.

V. Definition of Medical Necessity

Home health aide services must be reasonable to support the beneficiary's medical and functional needs based on the beneficiary's medical condition and associated symptoms. Documentation to support medical necessity must include the beneficiary's progress or lack of progress, medical condition, functional losses, and treatment goals (e.g.,

the POC). MDHHS identifies criteria for medical necessity as one or more of the following that directly impact the beneficiary's medical and functional needs:

- New onset or acute exacerbation of diagnosis (supportive documentation must include the date of the new onset or acute exacerbation)

- New or changed prescription medications (e.g., newly prescribed medications within the last thirty days or changed dosage, frequency, or route of administration within the last 60 days; including but not limited to diagnosis such as diabetes or hypertension);

- Recent hospitalizations (must include the date and reason for the hospitalization);

- Recent discharge from an acute or post-acute setting (e.g., skilled nursing facility);

- Change in caregiver status, absence of a caregiver, or unstable caregiving situation; or

- Complicating factors (e.g., presence of Stage III or IV decubiti).

The beneficiary's medical necessity must be clearly identified by the physician and documented in the POC. All PA requests will be considered on an individualized basis to determine medical necessity, reasonableness for home health aide services, and consistency with MDHHS policy.

VI. Personal Care Services

In some cases, the beneficiary may receive home health aide services and personal care services through another entity (e.g., Home Help, MI Choice Waiver). Home health aide services may not be duplicative in nature with other personal care services (e.g., Home Help, MI Choice Waiver) and cannot occur simultaneously with other personal care services on any given day.

It is the responsibility of the HHA to identify other services the beneficiary may be receiving to ensure the services of the home health aide and personal care services through another entity (e.g., Home Help, MI Choice Waiver) are not duplicative in nature, nor occur simultaneously. There must be coordination between the two providers and documentation in the POC to verify there is no duplication, or simultaneous receipt of personal care services.

VII. Reminders Regarding Prior Authorization

A. Retroactive Prior Authorization

Services provided before PA is approved will not be covered unless the beneficiary was not Medicaid eligible on the date of service but became eligible retroactively. If MDHHS eligibility information does not demonstrate retroactive eligibility, then the request for retroactive PA will be denied.

B. Beneficiary Eligibility

Approval of the MSA-181 confirms that the service is authorized for the beneficiary. The approval does not guarantee that the beneficiary is eligible for Medicaid. If the beneficiary is not eligible on the date of service, MDHHS will not reimburse the provider for services provided and billed. To assure payment, the HHA must verify beneficiary eligibility monthly at a minimum.

(Berezkin Exhibit A, pp 68-77; Testimony)
Emphasis added

Language from MSA Bulletin 18-12 was later incorporated into the Medicaid Provider Manual, which contains Medicaid policy in Michigan. (Berezkin Exhibit A, pp 78-89; Testimony)[1]

With regard to prior authorizations, the MPM states, in pertinent part:

1.9 PRIOR AUTHORIZATION

Medicaid requires prior authorization (PA) to cover certain services before those services are rendered to the beneficiary. The purpose of PA is to review the medical need for certain services. . . .

Medicaid Provider Manual
Practitioner Chapter
January 1, 2019, p 4

With regard to Home Health services, the MPM provides, in pertinent part:

SECTION 1 – GENERAL INFORMATION

This chapter applies to Home Health providers.

[1] Respondent's Exhibit includes the Home Health Chapter from the October 1, 2020 MPM. Because Petitioner's services were denied on March 1, 2019, the January 1, 2019 MPM is applicable. The policy is the same, but the section numbers changed April 1, 2019.

Home health is a covered Medicaid benefit for beneficiaries whose conditions do not require continuous medical/nursing and related care but do require health services on an intermittent basis for the treatment of an injury, illness, or disability. Medicaid covered services may be provided in any setting in which normal life activities take place. 'Normal life activities' refers to activities that could occur in or out of an individual's home. Except as detailed in this chapter, the beneficiary's primary need must be for nursing care, physical therapy and/or home health aide services rather than personal care or physician's care.

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6.1.L. TEACHING AND TRAINING ACTIVITIES

HHA services are not covered if the beneficiary has a willing, available, and competent designated caregiver (e.g., family member, friend, neighbor, Home Help provider) that can demonstrate the ability for the beneficiary and/or designated caregiver to provide appropriate care. Medicaid does cover HHA teaching and training activities to enable the beneficiary to become independent of skilled care. The teaching of a procedure or service is covered if it is reasonable and necessary for the treatment of a specific illness, injury or disability.

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SECTION 8 – HOME HEALTH AIDES

Home health aide services may be rendered independently, and not contingent upon the need of skilled nursing or therapy services. Home health aide services are covered only when ordered by the attending physician and authorized according to Medicaid policy. The services provided by the home health aide must be medically necessary. Medicaid would not cover home health aide services solely for personal care needs, or for the convenience of the beneficiary. The POC must clearly outline the duties to be performed by the home health aide.

The HHA must identify the availability of other caregiver(s) (e.g., family member or another caregiver). The availability of the caregiver(s) must be identified in the POC. When a caregiver is providing services that adequately meet the member's needs, it is not medically necessary for the HHA to provide services. If the family or other entity is unable to perform the service, the reason must be fully documented in the POC. (Refer to the Personal Care Section in this chapter for additional information.)

8.1 HOME HEALTH AIDE PRIOR AUTHORIZATION

Home health aide services for Medicaid beneficiaries must be authorized by the MDHHS Program Review Division after the initial 90 days, and every 90 days thereafter if continued services are deemed medically necessary.

Prior authorization is required each time services are requested for:

- continuation of services beyond the initial 90 days;
- continuation of services beyond the end date of the current authorization period (renewal);
- an increase in services; or
- a decrease in services.

After the initial 90 days, home health aide services may be provided up to a maximum of 36 visits within 90 consecutive calendar days. If the beneficiary's attending physician orders home health aide services, the HHA must assess the availability of the family or another entity (e.g., Home Help Program or MI Choice Waiver) to perform the services. Physicians ordering home health aide services must determine that medical services are medically necessary and appropriate for continuation of services beyond the initial 90 days, and for each PA request thereafter.

In some cases, the beneficiary's attending physician may order home health aide services that extend beyond the maximum of 36 visits within 90 consecutive calendar days. For requests that extend beyond 36 or more visits within 90 consecutive calendar days, the PA request will be reviewed for medical appropriateness, the availability of the family or another entity (e.g., Home Help Program or MI Choice Waiver), and the cost effectiveness of other programs available for the beneficiary.

Following receipt and review of the Home Health Aide Prior Approval Request/ Authorization form (MSA-181) and the required documentation by the Program Review Division, a determination notification is sent to the HHA and beneficiary or primary caregiver indicating the outcome of the review. (Refer to the Forms Appendix for a copy of MSA-181.) If approved, the notification letter will contain the PA number and approved authorization dates.

It is important to include this PA number on every claim and in all other communications to the MDHHS Program Review Division.

If a beneficiary receiving home health aide services continues to require the services after the initial authorization period, a new MSA-181 must be

submitted by the HHA along with the required documentation to support medical necessity for continuation of services beyond the approved authorization dates. This request must be received by the Program Review Division no less than 15 business days before the end of the current authorization period. Failure to do so may result in a delay of authorization for continued services which, in turn, may result in delayed services or no payment for services rendered without authorization. The length of each subsequent authorization period will be determined upon review by the Program Review Division and will be specific to each beneficiary based on several factors, including the beneficiary's medical and functional needs, personal care services through another entity (e.g., Home Help Program, waiver services, or other community services), and family or caregiver support.

8.1.A. DOCUMENTATION REQUIREMENTS

The following documentation is required for all initial PA requests for home health aide services and must accompany the MSA-181:

- documentation of the face-to-face encounter;
- all components of the POC as identified in 42 CFR §484 and MDHHS policy;
- OASIS; and
- other documentation as requested by MDHHS.

The documentation listed above is also required at subsequent 12-month intervals. The anniversary date is the date 12 months from the date services were first provided.

- For services beyond the initial authorized 90 days and for subsequent requests, the MSA-181, an updated POC complete with all components, and other documentation as requested by MDHHS must be submitted to the Program Review Division for review.
- If a beneficiary's condition changes during an authorization period warranting an increase or decrease in the number of approved hours or discontinuation of services, the HHA must report the change to the Program Review Division. It is important that the HHA report all changes as soon as they occur, as well as properly update the POC and written instructions for the home health aide.
- To request an increase in hours, the following are required:

- an updated MSA-181 indicating the increase in hours;
- an updated and signed POC; and
- documentation from the attending physician.

- To request a decrease in hours, the following are required:
  - an updated MSA-181 indicating the decrease in hours; and
  - an updated and signed POC.

PA and documentation requirements apply to all Medicaid beneficiaries.

8.1.B. MEDICAL NECESSITY

Home health aide services must be reasonable to support the beneficiary's medical and functional needs based on the beneficiary's medical condition and associated symptoms. Documentation to support medical necessity must include the beneficiary's progress or lack of progress, medical condition, functional losses, and treatment goals (e.g., the POC). MDHHS identifies criteria for medical necessity as one or more of the following that directly impact the beneficiary's medical and functional needs:

- New onset or acute exacerbation of diagnosis (supportive documentation must include the date of the new onset or acute exacerbation);
- New or changed prescription medications (e.g., newly prescribed medications within the last 30 days or changed dosage, frequency, or route of administration within the last 60 days, including but not limited to diagnosis such as diabetes or hypertension);
- Recent hospitalizations (must include the date and reason for the hospitalization);
- Recent discharge from an acute or post-acute setting (e.g., skilled nursing facility);
- Change in caregiver status, absence of a caregiver, or unstable caregiving situation; or
- Complicating factors (e.g., presence of Stage III or IV decubiti).

The beneficiary's medical necessity must be clearly identified by the physician and documented in the POC. All PA requests will be considered

on an individualized basis to determine medical necessity, reasonableness for home health aide services, and consistency with MDHHS policy.

8.1.C. BENEFICIARY ELIGIBILITY

Approval of the MSA-181 confirms that the service is authorized for the beneficiary. The approval does not guarantee that the beneficiary is eligible for Medicaid. If the beneficiary is not eligible on the date of service, MDHHS will not reimburse the provider for services provided and billed. To ensure payment, the HHA must verify beneficiary eligibility monthly at a minimum.

8.1.D. RETROACTIVE PRIOR AUTHORIZATION

Services provided before PA is approved will not be covered unless the beneficiary was not Medicaid eligible on the date of service but became eligible retroactively. If MDHHS eligibility information does not demonstrate retroactive eligibility, then the request for retroactive PA will be denied.

8.2 SUPERVISORY VISIT

HHA registered nurses (RNs) must assign a Home Health aide to a particular beneficiary, prepare written instructions for the beneficiary's care, and supervise home health aide visits. It is the responsibility of the supervising RN to co-sign all documentation completed by the Home Health aide. Also, RNs must make a

supervisory visit to the beneficiary's home at least once every two weeks and document the supervisory visit in the beneficiary's medical record.

Medicaid Provider Manual
Home Health Chapter
January 1, 2019, pp 1, 12, 16-19
Emphasis added

Policy for the Home Help Services program is found in the Adult Services Manual. The ASM provides, in pertinent part:

ASM 101 Available Services

PROGRAM DESCRIPTION

Home help services offer a range of payment and nonpayment related services to individuals who require advice or assistance to support effective functioning within their home or the household of another.

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Home help 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.

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Expanded Home Help Services (EHHS)

Expanded home help services can be authorized for individuals who have severe functional limitations which require such extensive care that the service cost must be approved by the adult services supervisor/local office designee and/or the MDHHS Home Help Policy Section. See ASM 120 (Adult Services Comprehensive Assessment).

Complex Care

Complex care refers to conditions requiring intervention with special techniques and/or knowledge. These complex care tasks are performed on clients 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 or feeding assistance.
- Catheters or leg bags.
- Colostomy care.
- Bowel program.
- Suctioning.
- Specialized skin care.
- Range of motion exercises.
- Dialysis (In-home).
- Wound care.
- Respiratory treatment.
- Ventilators.
- Injections.

****

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
August 1, 2018, pp 1-5

ASM 125 COORDINATION WITH OTHER SERVICES

PARTNERSHIPS

The adult services worker (ASW) has a critical role in developing and maintaining partnerships with community resources. To facilitate these partnerships the adult services worker will:

- Advocate for programs to address the needs of clients.

- Emphasize client choice and quality outcomes.

- Encourage access and availability of supportive services.

- Work cooperatively with other agencies to ensure effective coordination of services.

- Coordinate available resources with Home Help services in developing a plan of care that addresses the full range of client needs.

The Medicaid State Plan program for personal care services is Home Help. Medicaid (MA) also includes several other programs, listed below, with personal care services. ASWs should be familiar with each of the programs to help clients understand what resources are available to them.

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HOME HEALTH CARE

Home Health services must be ordered by a physician and provided by a Medicare certified Home Health agency. Home Health is intended for individuals requiring services on an intermittent basis. . . .

****

Home Help personal care services may be authorized in addition to Home Health care as long as they do not duplicate services provided by the Home Health agency. Example: Mr. Brown receives assistance with bathing from the Home Health aide on Monday, Wednesday and Friday. The adult services worker may approve assistance for bathing for the remaining days, if needed.

ASM 125
January 1, 2017, p 1, 4
Emphasis added

At the joint hearing, the Department's State Administrative Manager (SAM) testified that she oversees a group of analysts who review PA requests and performs some reviews herself. The Department's SAM testified that she has a Bachelor of Arts degree in nursing and has experience working in both acute care and home care settings. The Department's SAM indicated that she was solely responsible for the review of all the Home Health PA's involved in these matters.

The Department's SAM testified that there was a change in the policy for Home Health requirements in May 2018 and the changes were effective July 1, 2018. The Department's SAM noted that the policy indicates that a PA is needed for Home Health after the first 36 visits and Home Health must be medically necessary, according to policy, and not duplicative of other services a beneficiary is receiving. The Department's SAM reviewed the new policy, found in MSA Policy Bulletin 18-12 (Exhibit A) and noted that the policy was later incorporated into the Medicaid Provider Manual (Exhibit C). The Department's SAM reviewed the policy for Home Health Aides, medical necessity, and documentation requirements under the new policy. The Department's SAM reviewed the Plan of Care requirements in policy and noted that it is required that the provider note in the Plan of Care whether benefits have been coordinated with Home Help Services (HHS) as well as whether the family or informal supports are able to provide the services. (Exhibit C, p 40.) The Department's SAM also reviewed the Other Services section of policy, which again indicates that Home Health must be coordinated with other benefits and there must be no duplication of services. (Exhibit C, p 48.) The Department's SAM reviewed ASM 101, which outlines what HHS covers, including its coverage of Complex Care needs. (Exhibit D, pp 51-52.) The Department's SAM noted that when a PA comes in for Home Health, she looks to see what each service is providing and looks for any overlap in services.

The Department's SAM testified that she has received specific training on the MPM. The Department's SAM testified that there was no PA requirement for Home Health before the policy change, so she was not involved with Home Health prior to that time. The Department's SAM noted that each beneficiary here was receiving Home Health prior to the policy change and there was no authorization or reauthorization process; hence, providers were paid for whatever they submitted. In looking at Petitioner's Exhibit 26, The Department's SAM noted that she did not review specific times for each task the beneficiary was receiving through HHS and Home Health but reviewed the services. The Department's SAM noted that duplication of services was only one of the reasons that Home Health was denied to the beneficiaries in these matters and that it does not matter how long it took the provider to perform the services, it mattered only what the services were.

The Department's SAM testified that all the beneficiaries here were also receiving HHS and she determined that HHS was meeting their needs. The Department's SAM noted that Home Health services are determined per visit, per week, whether the visit is 15 minutes or two hours, unlike HHS where services are paid to the minute. The Department's SAM testified, for example, that if the beneficiary were receiving bathing services through Home Health and HHS, that would be duplicative. The Department's SAM noted that she would not need to know how long the service took to make that determination and that if a beneficiary was not receiving sufficient time for bathing through HHS, the beneficiary would go to HHS and ask for more time for bathing, not request Home Health services. The Department's SAM noted that she was not that familiar with the difference between Enhanced HHS and Complex Care under HHS other than reviewing the policy found in ASM 101. The Department's SAM testified that she was not aware what definition, if any, existed in policy for medical necessity for Home Health prior to the 2018 changes.

The Department's SAM testified that an individual could receive HHS and Home Health at the same time, however they cannot be for the same service and workers cannot be in the home at the same time, per policy. The Department's SAM reviewed the policy found in ASM 125 regarding Coordination of Services and noted that she is not involved in the development of any policy. The Department's SAM testified that Home Health aides have slightly higher qualifications than HHS workers and that teaching and supervision is available through HHA. The Department's SAM noted that exercise was covered under HHS in the Complex Care area and that HHS covers specialized skin care. The Department's SAM agreed that while Home Health aides are supervised by a nurse, HHS workers are not. The Department's SAM testified that the PA form used is the same for each participant and that PA form would indicate if any of the beneficiaries were receiving skilled nursing care.

The Department's SAM testified that much of the language in the denial notices is standard and refers to policy and that she authored the denial notices. The Department's SAM testified that while the denial notice indicates a quantity of "1", if an individual was approved for Home Health, they would receive a notice outlining the

number of approved visits. The Department's SAM noted that Michigan Medicaid does not determine the Description for the Procedure Code; that is done at the federal level. The Department's SAM testified that she is unsure as to what affect moving to a PA requirement in Home Health had on the program. The Department's SAM testified that she does not recall if any additional information was requested from any of the beneficiaries in these matters. The Department's SAM noted that if additional information is requested, it is treated as a new PA and does not affect timeliness.

M&Y Care's RN testified that she has an associate degree in nursing and provides Home Health care to beneficiaries. M&Y Care's RN testified that she performed the Home Health assessments in these matters, which begin with a referral from a physician. M&Y Care's RN testified that she then meets the patient and completes the Plan of Care. M&Y Care's RN indicated that she goes through the individual's body system and does consider what other services they are receiving. M&Y Care's RN indicated that she might consider whether the individual needs a social worker, a physician, transportation. M&Y Care's RN testified that she looks to see how many hours of HHS an individual is receiving and then determines how many additional hours the individual would need through Home Health. M&Y Care's RN testified that the need of the patient depends on the patient's condition and diagnosis. M&Y Care's RN indicated that it is an individual assessment and some individuals need more care and some need less.

M&Y Care's RN testified that Home Health is supplemental to HHS and fills in gaps in care where needed. M&Y Care's RN noted that an individual might be wheelchair bound and incontinent so might need to be changed more than twice a day, so she would order Home Health to come in a third time per day. M&Y Care's RN testified that Home Health aides are supervised by her. M&Y Care's RN testified that she meets with the aide and the patient every two weeks to see if there are any changes in care needs and to ensure that the aide is performing all necessary duties. M&Y Care's RN noted that she is also available to the aides 24/7 for questions. M&Y Care's RN testified that she can also provide training if necessary.

M&Y Care's RN testified that she was not familiar with MSA Bulletin 18-12 but was aware the Department changed its policy. M&Y Care's RN testified that the way she conducts assessments did not change, however, with the policy change. M&Y Care's RN testified that she was not familiar with the Department's policies or whether someone who needs more help should go to HHS instead of receiving Home Health.

At Petitioner's individual hearing, the Department's SAM testified that she prepared the Hearing Summary and Hearing Packet that were accepted into the record as Berezkin Exhibit A. The Department's SAM testified that she received a Prior Authorization for Home Health for Petitioner in this matter. The Department's SAM reviewed the PA form in detail and noted each box that she reviews for information, such as box 2 for the provider name to ensure the provider is enrolled to provide Home Health services, box 11 to verify the beneficiary's name and to ensure that all information provided with the PA applies to the same beneficiary, box 23 to see if a primary caregiver is indicated,

box 20 for the diagnoses codes, box 31 for the current medications, boxes 27 and 28 for the start and end date of the PA request, box 34 for the table of services and the beneficiary's ability to perform those functions, and box 35 for how frequently services are performed. The Department's SAM indicated that instead of looking at box 33 for exercise, she looked instead at the physical therapy evaluation included with the PA request. The Department's SAM noted that box 34 also indicates what other services are being provided and that in Petitioner's case skilled nursing, HHS, and physical therapy were all checked. The Department's SAM also indicated that box 25 indicated that Petitioner's services were all listed as needed seven days per week.

The Department's SAM reviewed a memo included in the hearing packet beginning on page 3. The Department's SAM explained that she included the memo in the packet because the provider submitted the memo in response to her inquiry to them about the Petitioner receiving both HHS and Home Health for the same functions. The Department's SAM noted that the provider verbally referred to a federal pilot program in support of its actions but that the memo mentioned no such program and, while the memo referred to a finding that 11 states had restricted access to Home Health, Michigan was not one of them. The Department's SAM then reviewed in detail all of the information submitted with the PA and indicated that she conducted the same review upon receipt of the PA and used that information to determine that the PA would be denied.

The Department's SAM reviewed Section 8.1.L from the October 1, 2020 MPM Home Health Chapter[2], which indicates that Home Health is not covered if the beneficiary has someone else who can provide the services, including a family member or a Home Help provider. The Department's SAM also reviewed Section 10 from the October 1, 2020 MPM Home Health Chapter[3], which indicates that Medicaid would not cover home health aide services solely for personal care needs or for the convenience of the beneficiary. The Department's SAM pointed out that the policy also indicates that the POC must clearly outline the duties performed by the home health aide.

Petitioner did not testify at his hearing.

Here, Petitioner argues that there was not an individual assessment done by the Department. Rather, Petitioner argues, the Department determined that the Home Health services were duplicative of HHS on their face and did not consider the amount or scope of HHS when making that determination. Petitioner argues that the Department cannot determine that services are duplicative without knowing exactly what those services are, how often they are performed, and for how long the services are performed. Petitioner argues that Petitioner was simply adding two programs together to ensure that his total medical need was met, which is allowed by policy.

[2] This section is 6.1.L in the applicable January 1, 2019 MPM.
[3] This is section 8 in the applicable January 1, 2019 MPM.

Petitioner further argues that the Department is ignoring relevant policy and only relying on policy that supports its position. Petitioner argues that while the Department argues that Home Health cannot supplement HHS, policy in Section 5 of the Home Health Chapter of the MPM and policy found in ASM 125 support Petitioner's argument that Home Health can supplement HHS. Petitioner points out that this language allowing supplementation is also found under Part 6 of MSA Bulletin 18.12. Petitioner argues that the Department cannot pick and choose which policy to follow and that the process the Department followed was so flawed, the outcome cannot be correct.

Petitioner also argues that there is no exhaustion requirement found in policy that requires a beneficiary to exhaust HHS before turning to Home Health. Petitioner notes that the Department's witness could not point to any policy supporting an exhaustion requirement. Petitioner also argues that if the Department meant for there to be an exhaustion requirement for HHS before turning to Home Health, it would have been in policy, as it is under the Community Living Supports section of ASM 125. Petitioner argues that there is no support for the Department's assertion of an exhaustion requirement besides its witness' testimony, but that testimony is not supported by policy.

Petitioner also argues that under the medical necessity requirement for Home Health, there must be more complicating factors then just bed sores, which the policy uses only as an example.

The Department argues that Petitioner seems to have a fundamental misunderstanding of the Home Health program. The Department points out that the program changed with the introduction of MSA Bulletin 18-12, which was later incorporated into the MPM. The Department argues that policy now requires a prior authorization before Home Health can be authorized and, to get a PA approved, a beneficiary must show that Home Health is medically necessary and not duplicative of other services.

Here, the Department argues that the services being requested are duplicative because those services are available through HHS. The Department argues that it does not matter how many hours of HHS a beneficiary is receiving for a particular service; if that service is available through HHS, a beneficiary cannot receive the same service through Home Health. In other words, the Department argues that you cannot get a more skilled worker through Home Health to do the work that a less skilled worker under HHS is already doing.

The Department further argues that in addition to being duplicative, Petitioner has failed to demonstrate that the requested services are medically necessary. The Department argues that Petitioner has presented no evidence to demonstrate that the services requested through Home Health meet the medical necessity requirements found in the new policy.

The Department argues that while ASM 125 does allow HHS to supplement Home Health, the reverse is not true. The Department argues that in the example given in

ASM 125, the beneficiary is already receiving Home Health and policy indicates that HHS could be used to supplement that Home Health. Here, the Department argues, Petitioner has not been approved for Home Health, he has submitted a prior authorization for Home Health. The Department also argues that in cases such as Petitioner's, where he is already receiving HHS, the proper recourse is to ask for more HHS if what is approved is not meeting his needs, as the Department's witness indicated. The Department points out that the testimony of its witness is unrefuted.

Having considered the parties arguments in full, and based on the evidence presented, Petitioner has failed to prove, by a preponderance of the evidence, that the Department erred in denying his prior authorization request for Home Health services.

As indicated above, following MSA Bulletin 18-12, effective July 1, 2018, Home health aide services for Medicaid beneficiaries must be authorized by the MDHHS Program Review Division after the initial 90 days. Policy further states that services provided by the home health aide must be medically necessary and Medicaid will not cover home health aide services solely for personal care needs, or for the convenience of the beneficiary. To be medically necessary, Home Health services must meet one or more of the criteria listed in policy. Finally, Home health aide services may not be duplicative in nature with other personal care services (e.g., Home Help, MI Choice Waiver) and cannot occur simultaneously with other personal care services on any given day.

Here, a thorough review of the evidence presented leads to a very clear conclusion that the Home Health services requested here are not medically necessary and are duplicative of the Home Help services Petitioner is currently receiving.

In his prior authorization request, Petitioner requested Home Health aide services to assist with showering, shampooing, shaving, oral care, assistance with mobility and exercise, assistance with dressing, skin care, nail care (hands and feet), and encouraging the intake of fluids. The diagnoses listed on Petitioner's prior authorization request included hypertension, benign neoplasm of prostate, generalized osteoarthritis, and peripheral vascular disease. Clearly, none of Petitioner's medical conditions meet the medical necessity criteria for Home Health as none of these conditions reflect a new onset or acute exacerbation of a diagnosis. Petitioner's conditions are chronic and ongoing. In addition, nothing in Petitioner's PA request points to new or changed prescription medications, recent hospitalizations, recent discharge from an acute or post-acute setting, a change in caregiver status, absence of a caregiver, or unstable caregiver situation, or a complicating factor. As such, Petitioner's PA request fails to meet any of the medical necessity criteria in policy. Petitioner's conditions are long term and chronic and the services he is requesting are all personal care services. Again, Medicaid will not cover Home Health services solely for personal care needs.

In addition, the services requested by Petitioner are duplicative of the services Petitioner is already receiving through HHS. As indicated above, Petitioner is receiving HHS for bathing, dressing, grooming, mobility, transferring, housework, laundry, medication, meal preparation, and shopping. Clearly this is duplicative of Petitioner's

request for Home Health for showering, shampooing, shaving, oral care, assistance with mobility and exercise, assistance with dressing, skin care, nail care (hands and feet), and encouraging the intake of fluids. And while Petitioner is not currently receiving HHS for exercise, the HHS program does allow for range of motion exercises under the policy for complex care needs.

Petitioner's arguments to the contrary are without merit. First, Petitioner's argument that the Department did not perform an individual assessment is simply incorrect, as evidenced by the detailed testimony provided by the Department's SAM about each individual document she reviewed in the lengthy record before coming to her conclusion. It was clear from the testimony and evidence presented that the Department completed a very thorough individual assessment of Petitioner's prior authorization request. Furthermore, as discussed more thoroughly below, it was not necessary for the Department to know exactly how much HHS Petitioner was receiving in order to determine that the services were duplicative of Home Health because Petitioner simply cannot receive Home Health services solely for personal care needs.

Second, while Petitioner focuses most of his argument on the duplication aspect of the Department's denial, which will be discussed below, Petitioner did not argue that Petitioner's PA request met the new medical necessity criteria in policy. Again, as indicated above, Petitioner's conditions are chronic and long-term. There is no evidence in the record that Petitioner has any new conditions, that his current conditions have become exacerbated, that his prescriptions have changed, that he has been hospitalized or released from an acute care setting, that he has an unstable caregiver situations (he has a regular HHS caregiver), or that he has a complicating factor. As such, the requested Home Health services are not medically necessary for Petitioner, regardless of whether those services are also duplicative of the HHS Petitioner receives.

Regarding the duplication of services, Petitioner's arguments also lack merit. Petitioner argues that policy found in ASM 125 and Section 5 of the Home Health Chapter of the MPM, added April 1, 2019, supports the assertion that Home Health can supplement HHS. As a general proposition, that is true – Home Health can supplement HHS, provided the Home Health is medically necessary and not duplicative of HHS. However, the example found in ASM 125 does not support Petitioner's argument that Home Health can be used to supplement HHS in Petitioner's case. Again, as outlined above, the portion of policy Petitioner relies upon states:

> Home Help personal care services may be authorized in addition to Home Health care as long as they do not duplicate services provided by the Home Health agency. Example: Mr. Brown receives assistance with bathing from the Home Health aide on Monday, Wednesday and Friday. The adult services worker may approve assistance for bathing for the remaining days, if needed. (ASM 125)

The example found in ASM 125 contemplates a beneficiary who is already approved for Home Health and is seeking HHS to supplement those services. That is not the case here. Here, Petitioner is approved for HHS and has submitted a prior authorization request seeking Home Health. The example given in ASM 125 is not applicable to such a situation. In addition, it must be pointed out that for Home Help to supplement Home Health, a beneficiary must be receiving Home Health for something *other than personal care services*. This is so because policy clearly indicates that Home Health cannot be used solely for personal care services. Here, Petitioner is only seeking Home Health for personal care services, which is not allowed in policy. And, while Section 5 of the Home Health Chapter in the MPM does talk about Coordination of Services, that section also clearly states that Home Health must avoid duplication of services with Home Help.

Petitioner's argument that there is no requirement for a beneficiary to exhaust HHS before seeking Home Health is also without merit. First, as stated above, Petitioner cannot receive Home Health solely for personal care services. If Petitioner cannot receive Home Health solely for personal care services, he certainly cannot use Home Health to supplement the personal care services he is already receiving through Home Help. And, while there is no specific exhaustion requirement written into ASM 125, such a requirement is not necessary given the above. Home Health cannot be used solely for personal care services. Home Health cannot be duplicative of HHS. A beneficiary may not seek Home Health to supplement personal care services under Home Help. Logically then, if Petitioner needs more help with personal care services, he would need to request more personal care services through HHS.

Given the above, and based on the evidence presented, the Department's decision was proper and must be upheld. Petitioner's prior authorization request does not meet the medical necessity requirements found in policy. Petitioner's prior authorization request is for services that are duplicative of the services he is already receiving through Home Help.

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 prior authorization for Home Health services.

IT IS THEREFORE ORDERED that:

The Department's decision is AFFIRMED.

RM/sb

Robert J. Meade
Administrative Law Judge
for Robert Gordon, 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 Office of Administrative Hearings and Rules (MOAHR).

A party may request a rehearing or reconsideration of this Order if the request is received by MOAHR 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. MOAHR will not review any response to a request for rehearing/reconsideration.

A written request may be mailed or faxed to MOAHR. If submitted by fax, the written request must be faxed to (517) 763-0155; Attention: MOAHR Rehearing/Reconsideration Request.

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

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

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