

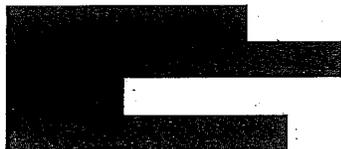


Rhode Island Executive Office of Health and Human Services
Appeals Office, 57 Howard Ave., LP Building, 2nd floor, Cranston, RI 02920
phone: 401.462.2132 fax: 401.462.0458

Docket#15-990

Hearing Date: June 10, 2015

June 19, 2015



ADMINISTRATIVE HEARING DECISION

The Administrative Hearing that you requested has been decided against you. During the course of the proceeding, the following issue(s), rules(s), and regulation(s) were the matters before the hearing:

**EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES (EOHHS)
R.I. MEDICAID CODE OF ADMINISTRATIVE RULES (MCAR)
SECTION 0399: THE GLOBAL CONSUMER CHOICE WAIVER
SECTION 0399.12.02: High Need**

The facts of your case, the pertinent Agency rules and regulations, and the complete administrative decision made in this matter follow. Your rights to judicial review of this decision are found on the last page of this decision.

Copies of this decision have been sent to the following: You (the appellant), and Agency representatives Mary Calner, RN, David Hankins, Theodore Dobek, Deborah Castellano, and Thomas Conlon.

Present at the hearing were: You, your son, and Agency representative Mary Calner.

ISSUE: Does the appellant meet the High Need Level of Care.

EOHHS Rules and Regulations:

Please see the attached APPENDIX for pertinent excerpts from the Rhode Island Executive Office of Health and Human Services Medicaid Code of Administrative Rules (MCAR).

APPEAL RIGHTS:

Please see attached NOTICE OF APPELLATE RIGHTS at the end of this decision.

DISCUSSION OF THE EVIDENCE:

The Agency representative testified:

- The appellant applied for the Personal Choice Waiver which is under the High Need Waiver.
- Policy section 0399.12.02 identifies what deems an individual to have a High Need Level of Care.
- Per the policy, to be eligible for services under the High Need waiver an individual must require at least limited assistance on a daily basis with at least two ADLs which include bathing/personal hygiene, dressing, eating, toilet use, walking or transferring. Or they must require skilled teaching or rehabilitation on a daily basis to regain functional ability, such as physical or occupational therapy. Or they must have impaired decision-making skills requiring constant or frequent direction. Or they must exhibit a need for a structured therapeutic environment to maintain health and safety.
- The OMR (Office of Medical Review) reviewed all the information submitted and determined that the appellant did not qualify for the High Level of Care.
- The information received and reviewed included a Provider Medical Statement called a PM-1, a consumer-directed assessment completed by a mobility specialist, and a comprehensive assessment tool called a UCAT, which is like a social worker's assessment.
- The appellant's diagnoses listed on the PM-1 are: chronic pain related to osteoarthritis in the hips and lumbar spine, depression, anxiety, PTSD, history of a knee infection in 2013, and a mini-stroke in 1987.
- The appellant is prescribed medication for pain and anxiety.
- The PM-1 was completed by a nurse practitioner and she listed the appellant as needing limited assistance with her ADLs which are activities of daily living and more assistance with her IADLs which are her instrumental activities of daily living, such as cooking, cleaning, laundry and shopping, but no supportive objective medical evidence was submitted to support any of the limitations.
- The mobility assessment listed the appellant as being very independent with most of her ADLs. The client reported she has some balance problems and limited

range of motion, that she uses a cane, and reported she needed help in and out of the shower.

- The UCAT also listed the appellant as independent and needing only minimal help with her ADLs and more assistance with her IADLs.
- Appellant lives in a condo with her adult son.
- Based upon review of all the information provided, community supports management, and discrepancies in the information received the Agency concluded that the appellant met the Preventative Level of Care but not the High Level of Care.
- The Preventative Level of Care would allow the appellant to receive some services, up to six hours a week, through a DHS waiver but she would have to receive those services from a home care agency, not her son.

The appellant's son, with the assistance of the appellant, testified:

- He has been out of work for a year on worker's compensation and has been taking care of his mother, the appellant, during that time. He told his mother's nurse that he had to go back to work and needed to make arrangements for someone to take care of his mother to make sure she is eating, taking her meds correctly, and make sure she does not fall.
- The nurse practitioner told him he could continue to take care of his mother and get paid for doing it through the Personal Choice Program. The nurse said she would qualify and that she would try to get them the 40 hours a week so that he could continue taking care of her.
- The nurse practitioner was the appellant's primary care provider at that time of application and completed the PM-1.
- Dr. Matthew Malek is now her primary care doctor and she has seen him three or four times.
- He misunderstood Dr. Malek's letter and thought it says she can do things that she cannot, like eating independently, so they thought that was why she was denied.
- She can feed herself but he does all the shopping and prepares all her meals.

- He needed to take care of her because she was falling and then her knee was getting bruised and swollen. She also was not taking her medication correctly and she was losing weight because she was not eating correctly.
- Also, since February she has gotten worse and needs more help because she was a passenger in a car accident, hit her head on the window, and got a concussion.
- She went to see a neurologist, Dr. Marano on May 12, 2015 as recommended by the attorney for the car accident. She has another appointment with Dr Marano on July 7 2015.
- Because she still suffers from the concussion, she gets headaches and nausea. She then doesn't eat and gets too physically weak to do anything. She has also lost 8 pounds.
- The symptoms of the concussion happen at random times and if he is not there she will fall because she gets weak. Sometimes she gets so weak that she just lies on the couch for hours and then he has to help her from the couch and actually put her into bed.
- She has been using a cane since she had her knee surgery because her knee still gives out on her sometimes and she falls. She now needs the cane more because she gets dizzy and loses her balance because of the concussion.
- Her fingers are also going numb and she is losing strength in her hands and they do not know if that is due to the concussion.
- She had been going to physical therapy/massage therapy but stopped because it was not helping. When she told Dr. Marano that she stopped going to therapy, he told her not to go anymore because he wanted to see if the headaches/concussion continued and he did not want her to be massaged in the shoulders due to the neck injury.
- Basically he does almost everything for his mother except bathing and toileting. He takes her wherever she needs to go, does the shopping, cooking, laundry, cleans the apartment, and is there to make sure she does not fall and hurt herself. While she is able to dress herself, if her hands are weak or numb he has to help her clasp her bra. He also helps her into bed when the concussion symptoms occur.

FINDINGS OF FACT:

- The appellant submitted an application for the Medicaid Personal Choice Program.
- The Personal Choice Program requires an applicant to have a High or Highest Need Level of Care.
- The Agency sent the appellant a notice dated April 3, 2015 informing her that her request for prior authorization for a High Need Waiver had been denied because she did not meet the High Level of Care.
- The appellant filed a timely request for hearing, received by the Agency on April 20, 2015.
- An Administrative Hearing was convened on June 10, 2015.
- The appellant has diagnoses of osteoarthritis of the hip and lumbar spine, depression, anxiety, and PTSD (post-traumatic stress disorder).
- The appellant had a mini-stroke in 1987 and a knee infection after left knee surgery in 2013.
- The appellant incurred a concussion in February 2015.
- The appellant needs extensive assistance with managing her medications, housekeeping, laundry, meal preparations, shopping, and transportation.
- On occasion, the appellant needs minimal assistance with dressing, but not on a daily basis.
- On occasion, the appellant needs assistance with walking and/or transferring to bed, but not on a daily basis.

CONCLUSION:

The issue to be decided is whether the appellant meets the High Need Level of Care.

The record establishes that the appellant applied for the Personal Choice Program. The Personal Choice Program provides consumer-directed home and community based services to Medicaid Long Term Care eligible beneficiaries who meet either a High or Highest Level of Care.

The Agency testifies that based upon the information provided, specifically a Provider Medical Statement (PM-1) form completed by a nurse practitioner, as well as assessments completed by a mobility specialist and a social worker, the Agency determined that the appellant does not meet the minimum High LOC needed for the Personal Care Program.

The appellant and her son testify that Dr. Malek is now her primary care doctor as opposed to the nurse practitioner who completed the PM-1. They report that the appellant is now also being seen by a Neurologist, Dr. Marano. The appellant submits at hearing an examination report from Dr. Albert J. Marano dated May 12, 2015 and a letter from Dr. Matthew Malek dated June 4, 2015. The appellant's son testifies that he resides with the appellant and has been taking care of her for the past year while he has been out of work. The appellant was advised to apply for the Personal Choice Program so that her son could continue taking care of her and receive payment as opposed to returning to other employment. The appellant's son testifies that he does all the shopping, cooking, laundry, and housekeeping, takes the appellant wherever she needs to go, makes sure the appellant eats and takes her medications properly, and makes sure she is safe. He testifies that she uses a cane to ambulate because her knee gives out at times due to a prior knee surgery and infection. The appellant's son further testifies that the appellant's need for assistance has increased since she was in a motor vehicle accident in February 2015, at which time she incurred a concussion. He testifies that because of the concussion, she gets dizzy and loses her balance. He further testifies that due to the concussion she gets headaches and nausea, causing her to be too weak to do anything and be at risk for falls. At these times he must help her into or actually put her into bed. While he does not provide any assistance with bathing or toileting, he testifies that since the concussion the appellant is experiencing some numbness and weakness in her hands and he at time has to provide some assistance with fastening her bra.

Per the Medicaid Code of Administrative Rules (MCAR), the Level of Care reflects the scope and intensity of an applicant's needs and is based on a comprehensive assessment and evaluation of the individual's medical, social, physical, and behavioral health needs. The MCAR specifically states that to qualify for a High Need Level of Care, an individual must:

- Require at least limited assistance on a daily basis with at least two of the following ADL's: bathing/personal hygiene, dressing, eating, toilet use, walking or transferring; or
- Require skilled teaching or rehabilitation on a daily basis to regain functional ability in at least one of the following: gait training, speech, range of motion, bowel or bladder control; or

- Have impaired decision-making skills requiring constant or frequent direction to perform at least one of the following: bathing, dressing, eating, toilet use, transferring or personal hygiene; or
- Exhibit a need for a structured therapeutic environment, supportive interventions and/or medical management to maintain health and safety.

A full review of the record finds that the Agency's Level of Care decision was based on assessments of the appellant's needs completed prior to her being in a motor vehicle accident and incurring a concussion, and prior to her being evaluated by either Dr. Malek or Dr. Marano. Any functional limitations and/or need for assistance reported at the time of application by the appellant's nurse practitioner thereby had to be related to the medical conditions that existed at that time, which included chronic pain due to osteoarthritis of the hip and lumbar spine, depression, anxiety and PTSD (post-traumatic stress disorder), a history of a mini-stroke in 1987, and a history of a left knee surgery in 2013 and post-surgical infection. The appellant's pain was described by the nurse practitioner as constant, moderate to severe, interfering with activity and movement, not relieved with medication/treatment, and worse at night. The nurse practitioner further reported that the appellant required supervision with eating and personal hygiene, limited assistance with dressing, bathing, toileting and transfers, and extensive assistance with medication management, ambulation and bed mobility, explaining that the appellant uses a cane, is at risk for falls, and has fallen out of bed on several occasions due to left leg weakness, and that she cannot go out unattended. The nurse practitioner indicated that anxiety caused the appellant to have some difficulty in new situations but that the appellant was not otherwise cognitively impaired relative to her ability to make daily decisions. According to the functional mobility assessment, the appellant reported needing assistance with some ADLs, specifically minimum assistance with dressing and showering and moderate assistance with mobility and transfers due to balance problems, pain, limited range of motion, and/or decreased endurance. She required no assistance with toileting, grooming, or skin care though required total assistance with shopping, meal preparation, and housekeeping. According to the UCAT assessment, the appellant is independent with hygiene and toileting though needs minimal assistance with eating, dressing, and bathing; moderate assistance with mobility and transferring; and total assistance with meal preparation, shopping, and housekeeping.

A full review of the record finds inconsistencies between the level of need reported on the assessments and the level of need and/or assistance currently being provided by the appellant's son as testified to at hearing by the appellant and/or her son. Despite testimony that the appellant has needed to use a cane since her knee surgery, neither the appellant or her son make any claim at hearing that she needs and/or had been receiving assistance with showering and further testify that only minimal and intermittent assistance with dressing is needed, and only since the appellant incurred a concussion.

While the appellant's son testifies that the appellant at times needs assistance with transferring to bed, he testifies that such need is due to the concussion which did not occur until after the assessments were completed. Additionally, while the appellant and her son testified that the appellant had received physical therapy but stopped because it was not working and/or because of the concussion, the nurse practitioner reports that there was a referral for physical therapy but that the appellant did not go.

A review of Dr. Marano's report dated May 12, 2015 finds that the appellant presented complaining of persistent headaches, neck pain, and paresthesias in both hands subsequent to a motor vehicle accident that occurred approximately three months prior on February 6, 2015. Per Dr. Marano, a CT scan of the brain and cervical spine on the day of the accident were normal though the appellant reported to him that the hospital had diagnosed her with a concussion. Dr. Marano concluded that the appellant had sustained a concussion and had features consistent with postconcussive syndrome though her prognosis for complete recovery was reasonable. While he opined that the parasthesias in her hands could be related to her reported neck pain, further testing was necessary. The appellant denied to Dr. Marano any weight loss, fatigue, weakness, or dizziness as alleged at hearing. Dr. Marano's objective examination of the appellant was normal except for an unsteady station and gait, though there was no mention of the use of a cane.

A review of Dr. Malek's letter finds that he assessed the appellant's functional capacity on June 1, 2015 and any ongoing effects of a concussion would thereby have been included in that evaluation. As to Activities of Daily Living (ADLs), Dr. Malek concluded that the appellant was independent in feeding, toileting, selecting attire, grooming, maintaining continence, bathing, walking and transferring, though needed assistance with putting on her clothes. As to Independent Activities of Daily Living (IADLs) Dr. Malek concluded that the appellant was independent with telephone usage, needed assistance with finances, preparing meals, managing medications, and housework/home maintenance, and was totally dependent for transportation and shopping. Dr. Malek concluded his letter by noting that the appellant's need for assistance was primarily with her IADLs.

In summary, while Dr. Marano has provided evidence that the appellant sustained a concussion on February 6, 2015, his report indicated that there were clear inconsistencies in the concussion-related symptoms reported to him and those reported at hearing. Additionally, Dr. Marano provided no objective evidence of functional loss other than with gait and station and was unclear as to the severity of that loss and/or the effects of the use of an assistive device. The information provided on the PM-1 by a nurse practitioner, the mobility assessment, and the UCAT, is inconsistent with that provided by the appellant's primary care physician, Dr. Malek, subsequent to more recent evaluation. Not only does Dr. Malek's opinion warrant more consideration because he is a physician, his assessment is also more current and occurred after the appellant sustained a concussion. It should also be noted, the testimony offered by the appellant's

son at hearing as to what assistance he actually provides to the appellant is more consistent with Dr. Malek's opinion. In essence, while the appellant needs significant assistance with IADLs such as shopping, meal preparation, housekeeping, laundry, and transportation, she does not need daily assistance with any ADLs.

In conclusion, the record fails to establish that the appellant meets any of the four criteria of the High Need LOC. Specifically, the record fails to establish that the appellant requires daily assistance with at least two ADLs or that she receives or requires daily rehabilitation. The record also fails to establish that she has impaired decision-making skills and thereby requires constant or frequent direction to perform ADLs. While the appellant's son testifies as to his concern for the appellant's safety due to her falling, the record is unclear and inconsistent as to the frequency of falls and/or the cause of the falls and thereby fails to establish that the appellant requires a structured therapeutic environment, supportive interventions, and/or medical management to maintain her safety.

After a careful review of the Agency's rules and regulations, as well as the evidence and testimony given, this Appeals Officer finds that the appellant does not meet a High Need Level of Care. The appellant's request for relief is thereby denied.



Debra L. DeStefano
Appeals Officer

APPENDIX

MEDICAID CODE OF ADMINISTRATIVE RULES (MCAR)

(Pertinent excerpts)

0399 THE GLOBAL CONSUMER CHOICE WAIVER

0399.01 OVERVIEW

REV:07/2009

One of the most important goals of the Global Consumer Choice Compact Waiver (Global Waiver) is to ensure that every beneficiary receives the appropriate services, at the appropriate time, and in the appropriate and least restrictive setting. To achieve this goal for long-term care (LTC) services, the waiver provides the state with the authority to collapse its existing section 1915 (c) home and community based service waivers (HCBS), which have different eligibility criteria and services, into its newly approved section 1115 (a) Global Waiver. Under the Global Waiver, the scope of services available to a beneficiary is not based solely on a need for institutional care, but is based on a comprehensive assessment that includes, but is not limited to, an evaluation of the medical, social, physical and behavioral health needs of each applicant.

0399.05.01.02 *Needs-based LTC Determinations*

REV:07/2009

The processes for determining clinical eligibility are based on a comprehensive assessment that includes an evaluation of the medical, social, physical and behavioral health needs of each beneficiary. The assessment shall be tailored to the needs of the beneficiaries services and, as such, may vary from one process to the next. Based on this assessment, the needs of the beneficiary are classified as "highest" or "high" to reflect the scope and intensity of care required and the range of services available. Beneficiaries already eligible for community MA who do not meet the highest or high level of care but are at risk for institutionalization may access certain short-term preventive services. There are two general types of services available to beneficiaries - core and preventive (see description in section 0399.10.20). An individual care plan is then developed that identifies the LTC core and preventive services and settings appropriate to meet the beneficiary's needs within the specified service classification.

The scope of services accessible to a beneficiary varies in accordance with individual needs, preferences, availability, and the parameters established in the Global Waiver and/or federal and state regulations, rules or laws. For example, a beneficiary with the highest need may be able to obtain the full range of services he or she needs at home or in a shared living arrangement, but may choose, instead, to access those services in a skilled nursing facility. Community-based care includes PACE and accessing services through a self-directed model. A beneficiary determined to meet the high need may have access to care in the home and community based setting - including PACE -- and self-directed care, but does not have the option of nursing facility care.

0399.10 OVERVIEW: DETERMINATIONS OF NF LEVEL OF CARE

REV:07/2009

The Global Waiver allows long-term care services to be provided in an institutional or home and community-based setting depending on the determination of the beneficiary's needs, individual plan of care, and the budget neutrality parameters established under the Global Waiver. Beneficiaries with care needs in the NF category also have an option for self-direction.

The service classifications designed to reflect the scope and intensity of the beneficiary's needs in this category are as follows:

- a) Highest need. Beneficiaries with needs in this classification have access to all core services defined in Section 0399.04.02.01 as well as the choice of receiving services in an institutional/nursing facility, home, or community-based setting.
- b) High need. Beneficiaries with needs in this classification have been determined to have needs that can safely and effectively be met at home or in the community with significant core services. Accordingly, these beneficiaries have access to an array of community-based core services required to meet their needs specified in the individual plan of care.
- c) Preventive need. Beneficiaries who do not yet need LTC but are at risk for the NF level of care have access to services targeted at preventing admission, re-admissions or reducing lengths of stay in a skilled nursing facility. Core home and community-based services are not available to beneficiaries with this level of need. Medicaid beneficiaries, eligible under Section 0399.12.03, who meet the preventive need criteria, are not subject to the LTC financial eligibility criteria established in Sections 0380.40-0380.40.35 and 0392.15.20-0392.15.30.

0399.12.02 High Need

REV:07/2009

Beneficiaries shall be deemed to have the high level of care need when they:

- a) Require at least limited assistance on a daily basis with at least two of the following ADL's: bathing/personal hygiene, dressing, eating, toilet use, walking or transferring;
or

- b) Require skilled teaching or rehabilitation on a daily basis to regain functional ability in at least one of the following: gait training, speech, range of motion, bowel or bladder control; or
- c) Have impaired decision-making skills requiring constant or frequent direction to perform at least one of the following: bathing, dressing, eating, toilet use, transferring or personal hygiene; or
- d) Exhibit a need for a structured therapeutic environment, supportive interventions and/or medical management to maintain health and safety.

PERSONAL CHOICE PROGRAM (Pertinent excerpts)

August 1, 2012

SECTION ONE GENERAL PROVISIONS

I. Overview

The Personal Choice Program (PCP) provides consumer-directed home and community-based services to Medicaid Long Term Care (LTC) eligible beneficiaries. Personal Choice is a Long Term Care service for individuals with disabilities who are over the age of eighteen (18) or elders aged sixty-five (65) or over who meet either a high or highest level of care. Services are geared toward reducing unnecessary institutionalization by providing specialized home and community-based services to qualified Medical Assistance beneficiaries at an aggregate cost which is less than or equal to the cost of institutional or nursing facility care.

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NOTICE OF APPELLATE RIGHTS

This Final Order constitutes a final order of the Department of Human Services pursuant to RI General Laws §42-35-12. Pursuant to RI General Laws §42-35-15, a final order may be appealed to the Superior Court sitting in and for the County of Providence within thirty (30) days of the mailing date of this decision. Such appeal, if taken, must be completed by filing a petition for review in Superior Court. The filing of the complaint does not itself stay enforcement of this order. The agency may grant, or the reviewing court may order, a stay upon the appropriate terms.