Rhode Island Executive Office of Health and Human Services
Appeals Office, 57 Howard Ave., LP Building, 2nd Floor, Cranston, RI 02920
Phone: 401-462-6827 / Fax: 401-462-0458

Docket # 14-1991
Hearing Date: 02/16/15

Date: February17, 2015

ADMINISTRATIVE HEARING DECISION
The Administrative Hearing that you requested has been decided in against you. During the course of the proceeding, the following issue(s) were the matters before the hearing.

THE DHS POLICY MANUAL: Medical Assistance
SECTION: 0399.12.01 Criteria for Highest Need.

The facts of your case, the agency policy, and the complete administrative decision made in this matter follow. Your rights to Appeal of this decision are found on the last page of this decision.

Present at the hearing were you, your spouse, representatives from the Nursing facility and Agency Representative: Laurie Johnson, RN.

Copies of this decision have been sent to the following: You, Laurie Johnson and The Policy Unit.

ISSUE: Does the appellant meet the Highest Level of Care criteria for the Long Term Care?

DHS POLICIES:
Please see the attached APPENDIX for pertinent excerpts from the Rhode Island Department of Human Services Policy and Provider Manuals.

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

DISCUSSION OF THE EVIDENCE:

DISCUSSION OF THE EVIDENCE:

The agency representatives testified that:

- The Agency received a request for Highest Level of Care on July 9, 2014. In order to meet the level of care requirement for Nursing Facility an individual must meet the highest LOC (Level of Care) criteria.

- A recipient must have a need for extensive assistance or total dependence with at least one activity of daily living (ADL's) - such as, bathing, eating, dressing, toileting, or ambulation/transfers and require at least limited assistance with any other activities of daily living or lack of awareness of need or moderate impairment of decision making skills. The applicant must also have one of the following symptoms; wandering, verbal aggression, resisting care or at least one of the following conditions that require skilled nursing care on a daily basis; stage 3 or 4 pressure ulcer, ventilation, IV medication or one or more unstable medical, behavioral or psychiatric conditions.

- The records reviewed were one provider medical statements filled out by the primary care physician a diagnostic sheet, a medication sheet, continuity of care form, pre-admission ID screen dated 6/20/14, social worker evaluation of need for care in a Nursing Facility or Intermediate Care facility for .

- The appellant's diagnoses were Seizure non-compliance, constipation, diarrhea, cough, generalized pain, depressive disorder, vitamin D deficiency, Epilepsy, retention of urine, tobacco dependence and unspecified fever.

- He and his spouse are homeless.

- He was admitted into Orchard View Nursing Home with diagnosis of Ataxia vs functional disorder on June 23, 2014.

- The PM-1 dated July 7, 2014 accessed the appellant as independent in transfers, ambulation, bed mobility, eating, toileting and personal hygiene.

- He required limited assistance with dressing and bathing but was dependent for medication.

- The social worker evaluation indicated that he is independent with toileting, needs assistance with ambulation, some assistance with bathing and dressing.

- His cognitive status assessment on June 30, 2014 indicated that he was independent with bibs twelve over fifteen. Alert with no impairments.
- He was receiving PT and OT five times a week.
- After the review of objective medical evidence the Office of Medical Review determined that the appellant did not meet the Highest Level of Care.
- The appellant is not on Medicaid.

The appellant testified:

- He is homeless.
- He cannot stand for a long time.
- He does need help to take a shower and get dressed.
- He thinks he has applied for disability through the Medical Review Team in the past.
- The Agency said they did not receive it.
- He has been denied SSI and is Appealing.
- He has not been found disabled per the MART.
- He is on United Healthcare through Health Source RI.
- He has no income.
- His wife is homeless also.

The RN form the Nursing Home testified:

- She feels that he does not meet the criteria for Highest Level of Care.
- He does not need any critical nursing care at all.

FINDINGS OF FACT:

- The appellant applied for services on July 9, 2014.
- The Agency found the appellant did not meet the Level of Care requirements for the Highest Need and sent a notice on July 9, 2014.
- The appellant filed for an appeal.
- Hearing was scheduled for December 22, 2014 but was rescheduled.
- Hearing was scheduled for January 27,2015and was rescheduled.
- The hearing was held February 16, 2015.

CONCLUSION:

The issue to be decided is whether the appellant is eligible for the Highest Level of Care.

A review of Agency Policy reveals that to achieve the goal of rebalancing the long-term care system, the Global Consumer Choice Compact Waiver allows beneficiaries to obtain the Medicaid services they need in the most appropriate least restrictive setting. The types of long-term care available to beneficiaries are categorized as institutional and home and community-based. To qualify for Medicaid-funded long-term care services under the Global Waiver, a person must meet the general and financial eligibility requirements as well as meet certain clinical eligibility criteria. Clinical eligibility is determined by an assessment of a beneficiary's level of care needs.
Highest Level of Care beneficiaries require extensive assistance or total dependence with at least one of the following Activities of Daily Living (ADL) - toilet use, bed mobility, eating, or transferring AND require at least limited assistance with any other ADL; or lack awareness of needs or have moderate impairment with decision-making skills AND have one of the following symptoms/conditions, which occurs frequently and is not easily altered: wandering, verbally aggressive behavior, resists care, physically aggressive behavior, or behavioral symptoms requiring extensive supervision; or have at least one of the following conditions or treatments that require skilled nursing assessment, monitoring, and care on a daily basis: Stage 3 or 4 skin ulcers, ventilator, respirator, IV medications, naso-gastric tube feeding, end stage disease, parenteral feedings, 2nd or 3rd degree burns, suctioning, or gait evaluation and training; or have one or more unstable medical, behavioral or psychiatric conditions or chronic or reoccurring conditions requiring skilled nursing assessment, monitoring and care on a daily basis related to, but not limited to, at least one of the following: dehydration, internal bleeding, aphasia, transfusions, vomiting, wound care, quadriplegia, aspirations, chemotherapy, oxygen, septicemia, pneumonia, cerebral palsy, dialysis, respiratory therapy, multiple sclerosis, open lesions, tracheotomy, radiation therapy, gastric tube feeding, behavioral or psychiatric conditions that prevent recovery.

The Agency testified that the appellant did not meet the criteria for the Highest Level of Care. His medical records indicated that he did not require services listed above that meet the Highest Level of Care criteria. In determining clinical eligibility, the OMR staff uses an assessment instrument based on the nationally recognized Minimum Data Set (MDS) 2.0 Tool for NF care. To make the final determination of care needs, the results of this assessment are mapped against the needs-based and institutional level of care criteria. The Agency testified to what health records they used and produced them as evidence.
The Registered Nurse from the nursing home testified that the appellant was not in need of daily clinical nursing skills.
The appellant testified that he cannot stand for a long time and frequently has pain, which prevents him from doing work. He testified that he takes his medication but needs help with dressing and bathing. The appellant also testified that he is a fall risk.
He stated that his wife is his caretaker but that they are homeless. He has applied for SSDI and has been denied. He is appealing the denial. He is on United Health Care at this time.

In summary there is no objective medical evidence that indicates the appellant meets the criteria for the Highest Level of Care.

After careful and considerate review of the Agency's policies as well as the evidence and testimony submitted, this Appeals Officer finds that appellant does not meet the criteria for the Highest Level of Care; therefore his request for relief is denied.

G. Stanford

Geralyn B Stanford
Appeals Officer

APPENDIX

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.

0399.02 Transition to the Global Waiver

REV:07/2009

The authority for the State of Rhode Island to provide home and community-based services transitions from the authority found in 1915(c) of the Social Security Act to that found in Section 1115 of the Act on July 1, 2009. The transition in authority allows the State to implement new needs-based levels of care, expand the number of individuals that can access long-term care services, and increase the availability of home and community- based services. On June 1, 2009 letters were sent to all Home and Community-based Waiver participants notifying them of the transition in authority. The agencies with authority to determine access for LTC prior to July 1, 2009, shall retain that authority subsequent to the transition date unless otherwise stated in this rule.

0399.03 ACCESS TO LONG-TERM CARE

REV:07/2009

For the purposes of this section, Medicaid funded long-term care is defined as institutional services or home and community-based services and supports. Long-term care services are designed to help people who have disabilities or chronic care needs to optimize their health and retain their independence. Services may be episodic or ongoing and may be provided in a person's home, in the community (for example, shared living or assisted living), or in institutional settings (for example, intermediate care facilities, hospitals, or nursing homes).

0399.04 TYPES OF LONG-TERM CARE

REV:07/2009

To achieve the goal of rebalancing the long-term care system, the Global Consumer Choice Compact Waiver allows beneficiaries to obtain the Medicaid services they need in the most appropriate least restrictive setting. The types of long-term care available to beneficiaries are categorized as institutional and home and community-based.

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.

0399.11 CLINICAL ELIGIBILITY ASSESSMENT TOOL

REV:07/2009

In determining clinical eligibility, the OMR staff uses an assessment instrument based on the nationally recognized Minimum Data Set (MDS) 2.0 Tool for NF care. To make the final determination of care needs, the results of this assessment are mapped against the needs-based and institutional level of care criteria. The DHS shall make available to the public the procedural guidelines for use of the assessment as well as the instrument itself.

0399.12 APPLICATION OF NF LEVEL OF CARE CRITERIA

REV:07/2009

Upon completing the assessment, the OMR staff determines whether a beneficiary's care needs qualify as highest, high or preventive based on a set of criteria that reflect both best practices across the states and the standards of prevailing care within the LTC community in Rhode Island. Clinical eligibility based on these criteria is set forth in the following Sections.

0399.12.01 Highest Need

REV:07/2009

Beneficiaries shall be deemed to have highest level of care need when

they:
a) Require extensive assistance or total dependence with at least one of the following Activities of Daily Living (ADL) -- toilet use, bed mobility, eating, or transferring AND require at least limited assistance with any other ADL; or
b) Lack awareness of needs or have moderate impairment with decision-making skills AND have one of the following symptoms /conditions, which occurs frequently and is not easily altered: wandering, verbally aggressive behavior, resists care, physically aggressive behavior, or behavioral symptoms requiring extensive supervision; or
c) Have at least one of the following conditions or treatments that require skilled nursing assessment, monitoring, and care on a daily basis: Stage 3 or 4 skin ulcers, ventilator, respirator, IV medications, naso-gastric tube feeding, end stage disease, parenteral feedings, 2nd or 3rd degree burns, suctioning, or gait evaluation and training; or
d) Have one or more unstable medical, behavioral or psychiatric conditions or chronic or reoccurring conditions requiring skilled nursing assessment, monitoring and care on a daily basis related to, but not limited to, at least one of the following: dehydration, internal bleeding, aphasia, transfusions, vomiting, wound care, quadriplegia, aspirations, chemotherapy, oxygen, septicemia, pneumonia, cerebral palsy, dialysis, respiratory therapy, multiple sclerosis, open lesions, tracheotomy, radiation therapy, gastric tube feeding, behavioral or psychiatric conditions that prevent recovery.

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

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.