STATE OF RHODE ISLAND AND PROVIDENCE PLANTATIONS
DEPARTMENT OF HUMAN SERVICES
APPEALS OFFICE
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July 14, 2014

Docket # 14-451
Date of Hearing: May 28, 2014

ADMINISTRATIVE HEARING DECISION

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

THE DHS POLICY MANUAL: Medical Assistance
Section: 0399.05 Eligibility Requirements, 0399. 10 Overview Level of Care, **0399.12.02 Criteria for High Need**

The facts in your case, the Agency policy, and the complete administrative decision 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 Holly Peabody, Robert Palin, Jacqueline Lemoine, RN, and the Policy Unit.

Present at the hearing were: You, your daughter and agency representative Jacqueline Lemoine, RN.

ISSUE: Does the appellant meet the High Level of Care criteria for the Core Waiver?

DHS POLICIES: Please see the attached **Appendix** for pertinent excerpts from the Department of Human Services Policy Manual.

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

DISCUSSION OF THE EVIDENCE:

The Agency representatives testified that:

- The agency conducted a recertification of the appellant's eligibility for the Personal Choice Waiver during July 2013. The appellant was on the Medicaid Core Waiver and was residing in the community. The Medicaid Core waiver requires that an individual meet the High Level of Care (LOC) criteria.
- The agency denied the appellant's request for Prior Authorization for a High LOC by notice dated December 27, 2013. (Copy of notice submitted).
- The notice states that the appellant did not meet the High LOC.
- The DHS policy manual section 0399.12.02 identifies what requirements are needed to meet the High LOC for Home and Community Based Services. (copy of policy submitted).
- Beneficiaries shall be deemed to have the High LOC when they require at least limited assistance on a daily basis with at least 2 of the following Activities of Daily Living (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 structured therapeutic environment, supportive interventions, and or medical management to maintain health and safety.
- The agency representative stated that the records that were reviewed (copies submitted) consisted of a Provider Medical Statement completed on September 24, 2013 by Dr. Andrea Bond, and the Case Management Assessment that was completed by an agency caseworker on July 22, 2013. The initial date of eligibility for Medicaid Waiver services was September 2009.
- The primary diagnosis was listed as Diabetes, Vertigo, and a fracture of the metatarsal bone of the right foot. Other conditions listed were Carpal Tunnel, Gerd, hyperlipidemia, depression and sleep apnea.
- Surgeries listed were a 2001 lumbar stenosis surgery, a right cataract in April 2013, and gallbladder has been removed. Medications were listed as Wellbutrin, Omeprazole, Lisinopril, Humalog insulin, Hydrochlorothiazide, Metoprolol, Fluoxetine, Simvastin, Flonase, Lantus, and Tylenol prn.
- The medical statement indicated under functional activities that the appellant is independent with transfers, ambulation, dressing, bathing, toileting, eating, meal preparation and laundry.
- The appellant requires supervision with personal hygiene, limited assistance with housekeeping, and dependent for shopping.
- On the pain scale no pain is listed, under cognition it is indicated that the appellant is not impaired, and independent with cognitive skills for daily decision making. No diet restrictions are listed.

- The case management assessment notes that the appellant is living in an in-law apartment, is independent with eating, and requires supervision for transfers, limited assistance with ambulation and toileting, extensive assistance with cleaning, laundry, and meal preparation. The appellant uses a shower chair. She is dependent with shopping and medication management.
- The appellant told the caseworker at the time of the assessment that she had blind spots due to an eye condition, and that she wears a hearing aid.
- Also noted on the assessment was that the appellant fell in the driveway in July and broke her ankle and sprained the opposite foot.
- The agency representative stated that a Preventive LOC provides a client with a total of 6 hours per week of in home services.
- Based on the objective medical evidence obtained the appellant did not meet the High LOC required for home and community based services but she did meet the LOC requirement for Preventive services.

The appellant's daughter testified:

- She has to submit today Provider Medical Statements from the appellant's eye doctor and from her primary care physician that were completed in April 2014.
- She stated that the appellant is not looking to have the High LOC but needs more services than would be provided with the Preventive LOC.
- She stated that her mother is forgetful, she falls constantly, her medication causes balance issues, she cannot shower by herself, and she has poor bowel control.
- In 2009 her mother was recovering from a fall and qualified for the High LOC. She stated that the doctor advises her mother to have assistance with showering and transfers but the doctor does not indicate that need on the medical statement.

The appellant testified:

- She stated that she has no sense of smell and poor hearing in both ears. She cannot see out of one eye due to macular degeneration. She cannot be left alone to do household activities because her balance is very poor.
- She stated that she needs 2 hearing aids and needs continued assistance in the home.

Findings of Fact:

- The appellant has been living alone in the community and was receiving in-home services through the Personal Choice Waiver.
- The appellant's case was due for recertification during July 2013. At that time the agency determined that the appellant no longer met the High LOC criteria required for the Core Waiver.
- The agency notified the appellant by notice dated December 27, 2013 that she no longer qualified for High LOC Waiver services.

- The appellant filed a timely appeal of the agency denial notice.
- The appellant submitted 2 additional Provider Medical Statements at today's hearing for review.

CONCLUSION:

The issue to be decided is whether the appellant is eligible for the Medicaid Personal Choice Waiver.

A review of Agency Policy regarding the Personal Choice Waiver determines that the authority 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 to beneficiaries as an alternative to institutionalization. Home and community-based long-term care services and supports (HCB/LTC Services) are in addition to the services otherwise provided under the Medicaid program. 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.

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 agency policies within section 0399 Waiver services are available to qualified long-term care beneficiaries who have been determined to have a highest or high level of care need.

In this matter the agency representative has testified that there is no clinical evidence in the record that the appellant meets the High LOC. The agency representative submits that the appellant's case manager reviewed the appellant's functional abilities during a July 2013 home visit and she also reviewed a PM-1 report from the appellant's doctor. The agency representative submits that the appellant requires supervision with personal hygiene, some assistance with homemaking, and is dependent with shopping.

The appellant and her daughter testified that due to her history of balance issues, poor vision and need for supervision the appellant continues to require the assistance. The appellant does not require the total amount of assistance that she qualified for prior to her recertification but she requires more than the amount of assistance provided by the Preventive LOC.

Review of agency policy 0399.12.03 determines that beneficiaries shall be deemed to have a 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.

Review of the Provider Medical Statement dated September 24, 2013, that was submitted by the agency indicates that the appellant is independent with transfers, ambulation, dressing, bathing, toileting, laundry and eating. She requires supervision with personal hygiene, limited assistance with housekeeping and is totally dependent for shopping.

Review of the caseworker assessment dated July 22, 2013 determines that due to an ankle fracture 2 weeks prior to the assessment the appellant required extensive assistance with housekeeping and meal preparation. She was totally dependent with shopping. The assessment indicates that the appellant required limited assistance with ambulation and toileting, supervision with transfers, independent with eating, required extensive assistance with dressing and bathing and medication management at that time.

Review of the Provider Medical Statement dated April 15, 2014 completed by Dr. Andrea Bond determines that the appellant requires limited assistance with transfers, housekeeping and laundry. She requires supervision with dressing, eating and medication management, She requires extensive assistance with meal preparation and shopping. The statement indicates that the appellant is independent with bed mobility, bathing, toileting and personal hygiene.

Review of the Provider Medical Statement dated April 24, 2014 and completed by Dr. McCoy, indicates that the appellant can go out unaccompanied and can utilize public transportation independently. The remaining sections of the statement were not completed.

A note from Dr. McCoy dated March 20, 2014 indicates that the appellant is treated for diabetic retinopathy and has limited/poor vision in the left eye. Also decreased vision in the right eye. The note states that the appellant needs assistance in her daily tasks and is unable to drive.

Based on the medical records and assessments submitted from the appellant's representatives, the agency and the appellant's testimony, this Appeals Officer finds that the appellant does not meet the High LOC criteria for Medicaid Core Waiver Services; therefore her request for relief is denied

Michael J. Gorman