STATE OF RHODE ISLAND AND PROVIDENCE PLANTATIONS
DEPARTMENT OF HUMAN SERVICES
APPEALS OFFICE
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May 6, 2015

Docket # 15-381
Date of Hearing: April 2, 2015

[redacted]

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, **0399.12.03 Preventive 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 Laurie Johnson, RN, Theodore Dobek, Annette Holloway and the Policy Unit.

Present at the hearing were: You and agency representative Laurie Johnson, RN.

ISSUE: Does the appellant meet the Preventive 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 representative testified that:

- The agency representative stated that the appellant applied for Home and Community Waiver services during December 2014. The appellant was found not to require a Preventive Level of Care. (LOC). The Medicaid Core waiver requires that an individual meet the Preventive LOC criteria in order to qualify for a limited range of home and community-based services.
- The agency therefore denied the appellant's request for Prior Authorization for a Preventive (LOC) by notice dated January 15, 2015. (Copy of notice submitted).
- The agency representative stated that agency policy #0399.12.03 identifies what requirements are needed for an individual to meet a Preventive LOC for the Home and Community Based Services Program. (HCBS).
- The beneficiary must have a chronic illness or disability that requires at a minimum supervision of 2 or more Activities of Daily Living.
- Beneficiaries who meet the Preventive LOC requirement shall be eligible for a limited range of home and community based services and supports along with the health care they are entitled to receive as recipients of Medicaid.
- Preventive care services optimize and promote beneficiary health, safety and independence through an array of care interventions that alleviate or minimize symptoms and functional limitations. Accordingly the goal of Preventive services is to delay or avert institutionalization or more expensive and intensive home and community based care.
- The agency representative stated that to qualify the Office of Medical Review (OMR) must determine that one or more Preventive services will improve or maintain the ability of the beneficiary to perform ADL's or IADL's and/or delay or mitigate the need for intensive home or institutional based care.
- Preventive services include homemaker services, general household tasks including basic home and household assistance for a health condition or to address functional limitations. The services include meal preparation, essential shopping, laundry and cleaning for beneficiaries without social support systems able to perform services for them.
- Preventive services also provide minor environmental modifications to the home including grab bars, hand held shower and also converter valve, raised toilet seats, and or simple devices or appliances such as eating utensils, transfer bath bench, shower chair, aids for personal care and adaptations intended for health or safety.
- Personal care assistive services provide direct support in the home to beneficiaries in performing tasks they are functionally unable to complete independently due to disability based on the individual's service and spending plan. These services may include personal assistance with activities of daily living such as grooming, personal hygiene, toileting, bathing, dressing and assistance with monitoring health status and physical condition.
- Preventive services also provide assistance with preparation and eating of meals but not the cost of meals. Assistance with housekeeping activities such as bed

making, dusting, laundry, cleaning, and grocery shopping. Assistance with transferring, ambulation, and use of special mobility devices.

- The agency representative stated that the records reviewed included the most current Provider Medical Statement, (PM-1), which was completed on January 10, 2015 by Frank Maggiacomo, MD.
- She stated that the PM-1 indicates that the appellant is diagnosed with Lumbar Spine Degenerative Disc Disease with chronic pain, Coronary Artery Disease, Depression, Anxiety, GERD, and COPD. The physician indicates that the appellant is independent in all ADL's, transfers, ambulation, bed mobility, dressing, bathing, toileting, eating, and personal hygiene.
- The physician indicates that appellant requires limited assistance with meal preparation and shopping, extensive assistance with housekeeping and laundry.
- The Case Management Assessment (CMA) dated December 18, 2014 indicates that the appellant requires limited assistance with cleaning, laundry and shopping. He lives alone. He is able to go out unaccompanied and is able to utilize public transportation. He has no cognitive impairments.
- The CMA indicates that the appellant is completely independent with dressing, eating, and medication management. He requires limited assistance with transfers and supervision with bathing.
- She stated that based on review of the objective medical evidence received the appellant did not meet the LOC needed for Preventive services.

The appellant testified:

- He stated that he also sees other doctors for treatment. He sees a cardiologist, Dr. Donat, and a pulmonary doctor, Dr. Christian. He stated that the evaluation forms do not provide all of the information about his medical condition.
- He stated that the other doctors have completed PM-1 forms in the past. He stated that he sent those forms to the agency caseworker.
- He stated that the evaluations from his other doctors were basically the same as the one from Dr. Maggiacomo. He stated that the doctors do not have knowledge of the big picture. His doctors do not see him when he is at his worst.
- He stated that his lower back especially causes such pain at times that he is unable to put his shoes and socks on. He stated that during those times he is helpless as he cannot do anything for himself. He stated that he recently had an epidural for pain that has helped him and that is why he is doing pretty well today.
- He stated that his pain interferes with his activity and movement. He stated that his major problem is with his ongoing sciatic nerve issue and degenerative issues with both knees.

Findings of Fact:

- The appellant has been living alone in the community and he applied for CORE Waiver services through the Preventive Waiver during December 2014.

- The appellant applied for services through the Medicaid CORE Waiver and the agency determined that the appellant did not meet the Preventive LOC criteria required for the CORE Waiver.
- The agency notified the appellant by notice dated January 15, 2015 that he did not qualify for Preventive CORE Waiver services.
- The appellant filed a timely appeal of the agency denial notice.
- The record of hearing was held open for 30 days, through May 4, 2015, at the appellant's request, to allow the agency to review PM-1 statements from Dr. Donat and Dr. Christian.

CONCLUSION:

The issue to be decided is whether the appellant is eligible for Preventive services through the Medicaid Core Waiver.

A review of Agency Policy regarding the Core 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, high or preventive 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 Preventive Level of Care. The agency representative submits that the appellant's case manager reviewed the appellant's functional abilities during a December 2014 home visit. The agency representative also reviewed a Physician's Medical Statement (PM-1) which was completed by the appellant's physician and indicates that the appellant is independent with all ADL's. The agency representative submits that according to the agency CMA the appellant needs limited assistance with cleaning, laundry, shopping, and transfers.

The appellant is independent with bathing, eating, dressing, meal preparation, and medication management.

The appellant testified that his doctors have not stipulated the severity of his need for assistance. He stated that the activities he needs assistance with at times hinder him from everyday living. He is unable to function normally due to chronic sciatic pain and degenerative issues with both knees.

This record of hearing was held open to allow for review of PM-1 reports from Dr. Donat and Dr. Christian. The PM-1 from Dr. Donat was completed on August 29, 2014. The statement indicates that the appellant is independent with all ADL's. The PM-1 from Dr. Christian is dated April 8, 2013 and indicates that the appellant is independent with all ADL's with the exception of housekeeping with which he requires extensive assistance.

Review of agency policy 0399.12.03 determines that beneficiaries shall be deemed to have a Preventive LOC when they require assistance with meal preparation, essential shopping, laundry and cleaning. The beneficiary also requires minor modifications to the home such as grab bars and other simple devices such as transfer bath bench, shower chair, aids for personal care and other minor modifications that improve home accessibility adaptation, health or safety. The beneficiary also requires assistance with activities of daily living such as grooming, personal hygiene, toileting, bathing and dressing, transferring and ambulation.

Based on the assessment records reviewed and lack of qualifying documentation from any of the appellant's medical care providers this Appeals Officer finds that the appellant does not meet the Preventive LOC criteria for Medicaid Core Waiver Services; therefore his request for relief is denied.

Michael J. Gorman
Appeals Officer

APPENDIX

ELIGIBILITY REQUIREMENTS 0399.05
REV: 07/2009

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. The general eligibility requirements for Medicaid are set forth in Sections 0300.25 and 0300.25.20.05 respectively. Income and resource eligibility rules for Medicaid eligible persons who are likely to be residents of an institution (as specified in Section 0399.04.01) for a

continuous period and who have a spouse living in the community are found in Sections 0380.40-0380.40.35 and 0392.15.20-0392.15.30. See also the applicable income and resource provisions in the long-term care Sections from 0376 to 0399. Clinical eligibility is determined by an assessment of a beneficiary's level of care needs. Under the Global waiver, the income and eligibility rules in these Sections will apply to

ELIGIBILITY REQUIREMENTS 0399.05

persons who are likely to receive home and community-based core services for a continuous period. That is, persons meeting the highest or high level of care who reside in the community. In Sections 0380.40-0380.40.35 and 0392.15.20-0392.15.30, all references to institutionalized spouses and continuous periods of institutionalization will include those institutionalized spouses receiving home and community-based services in lieu of institutional services.

OVERVIEW:

DETERMINATIONS OF NF LEVEL OF CARE 0399.10

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

OVERVIEW:

DETERMINATIONS OF NF LEVEL OF CARE 0399.10

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

OVERVIEW:

DETERMINATIONS OF NF LEVEL OF CARE 0399.10

REV: 07/2009

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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

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.

Preventive Need 0399.12.03
REV: 07/2009

Beneficiaries who meet the preventive need criteria shall be eligible for a limited range of home and community-based services and supports along with the health care they are entitled to receive as recipients of Medicaid. Preventive care services optimize and promote beneficiary health, safety and independence through an array of care interventions that alleviate or minimize symptoms and functional limitations. Accordingly, the goal of preventive services is to delay or avert institutionalization or more extensive and intensive home and community-based care.

To qualify, the OMR must determine that one or more preventive services will improve or maintain the ability of a beneficiary to perform ADL's or IADL's and/or delay or mitigate the need for intensive home and community-based or institutionally based Preventive Need 0399.12.03
care. Preventive services for beneficiaries include:

a) Homemaker Services- General household tasks including basic home and household assistance for a health condition or to address functional limitations. The services include meal preparation, essential shopping, laundry and cleaning for beneficiaries without social support systems able to perform services for them.

b) Minor Environmental Modifications: Minor modifications to the home may include grab bars, versa frame (toilet safety frame), handheld shower and/or diverter valve, raised toilet seats and other simple devises or appliances such as eating utensils, transfer bath bench, shower chair, aids for personal care (e.g. reachers) and standing poles to improve home accessibility adaptation, health or safety. Preventive Need 0399.12.03

c) Personal Care Assistance Services -Personal care assistance services provide direct support in the home or community to

beneficiaries in performing tasks they are functionally unable to complete independently due to disability, based on the individual service and spending plan. These services may include personal assistances with the activities of daily living, such as grooming, personal hygiene, toileting bathing and dressing; assistance with monitoring health status and physical condition. Assistance with preparation and eating of meals, but not the cost of meals; assistance with housekeeping activities such as bed-making dusting, laundry, cleaning and grocery shopping; and assistance with transferring, ambulation and the use of special mobility devices.

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.